MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
New Jersey State Police Headquarters Complex
Public Health, Environmental and Agricultural
Laboratory Building
3 Schwarzkopf Drive
Ewing Township, New Jersey 08628

October 24, 2019
10:08 A.M.

FINAL
MEETING SUMMARY

Members Present:
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Theresa Edelstein
Beverly Roberts

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Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/.

CHAIRWOMAN SPITALNIK: Good morning, everyone. I'm Deborah Spitalnik, the Chair of the Medical Assistance Advisory Committee Meeting. And it's my pleasure to welcome to you the Thursday, October 24th meeting.

In accordance with New Jersey's Public Meetings Act, the due notice of this meeting has been made.

It's also my responsibility, as we are guests in this building, to let you know that in the unlikely case of an emergency, if you heard a fire alarm or evacuation announcement, that we would ask that you leave the building via the nearest exit, which might be here or there, and that you assemble in the parking lot at Designated Area 9, waiting for instructions.

I want to welcome everyone and, as always, review how we have been able to function as a Council. In a moment, I'll ask both the members of the MAAC and the members of the public, our stakeholders, to introduce themselves.

We have always prided ourselves as not having to isolate a very limited amount of public comment, but rather to be able to engage in dialog on an issue-by-issue basis. In order to do that, our convention is that if there are questions or comments, we ask that the members

of the MAAC speak first, and then we will call upon members of the public to either ask questions or make brief comments. We've never had to depart from that, but we need to reserve the ability to do so.

So with that, I will ask the small number but mighty number of members to introduce themselves and to speak loudly. And then we will ask the members of the public to introduce yourselves. We do maintain a transcript of the meetings for a record and to move our business forward.

(Members of the MAAC introduce themselves.)

(Members of the public introduce themselves.)

CHAIRWOMAN SPITALNIK: Thank you all, and welcome.

I want to thank Lisa Bradley for the minutes, but I'm going to postpone the approval of the minutes until either we have a quorum later in this meeting or to our next meeting.

So we have our agenda divided into two sections. One is an update on current programs, the other is initiatives and planning and implementation.

The PowerPoints that are projected this morning are posted on the DMAHS website for your review.

So the first item on our agenda is the New Jersey SAVE Online Application. And I look towards

Michael Alpaugh, who is the Administrator in the Division of Aging Services.

Good morning. Thank you for being with us.

MR. ALPAUGH: Thank you for having me.

Good morning. So my name is Michael Alpaugh. I'm with the Division of Aging Services. I'm here today to talk about the NJ SAVE Online Application for Benefits.

Last November, we created the NJ SAVE Online Application to assist the elderly and disabled individuals of New Jersey with applying for the benefit programs that we have run in the Division. These are the Pharmaceutical Assistance of the Aged and Disabled, the Senior Gold Discount Program, the Lifeline Utility Assistance Credit Program, Medicare Savings Program, Specified Low Income Beneficiary, and Qualified Individual.

(Slide presentation by Mr. Alpaugh.)

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CHAIRWOMAN SPITALNIK: Michael, thank you so much.

Any questions from the MAAC?

Beverly.

MS. ROBERTS: Thank you for this presentation.

So for folks with disabilities who have Medicaid but perhaps they would be eligible for LIHEAP or Lifeline, should they be applying for this?

MR. ALPAUGH: They can apply. Now, obviously, if they're on SSI, they already receive Lifeline, our program, but they should apply for the LIHEAP. Now, LIHEAP and USF, we only screen for those benefits, and it's based on their eligibility for applying for PAAD and Lifeline.

MS. ROBERTS: That was my question. They're not applying for PAAD because they've got Medicaid.

MR. ALPAUGH: Correct. So they might be better suited to apply directly with Community Affairs rather than through us. But if they did, we would still submit that information.

MS. ROBERTS: So it wouldn't create or look like fraud or something like that, that they have Medicaid?

MR. ALPAUGH: No.

MS. ROBERTS: Is there a way for them to indicate that they do have Medicaid?

MR. ALPAUGH: Not on the online application at the moment, no.

CHAIRWOMAN SPITALNIK: I'll turn to members of the public. Please speak loudly and say your name so we can record it in the minutes.

MR. BLAUSTEIN: Paul Blaustein.

Thousands of individuals with developmental disabilities live in licensed facilities. Typically, the utility bills come in the name of the provider, not the individual. They might live in a group home where there are four to six individuals, and one bill comes to the provider. Or they could live in supervised apartments where two people live in an apartment and the bill may not even come to the apartment, it may come to a complex of eight apartments or four apartments. How would these individuals be able to satisfy the documentation requirement of utility bills for LIHEAP?

MR. ALPAUGH: Well, for LIHEAP or for Lifeline?

MR. BLAUSTEIN: Either or both.

MR. ALPAUGH: Applying Lifeline, our main benefit, there's two ways to be eligible: You can be a utility owner, meaning bills are in your name; or you're a tenant and you're paying rent. So that sounds like they would fall under the tenant's benefit. That information, of course -- once they apply for Lifeline -- again, we don't oversee LIHEAP or USF. We only screen, again, based on their eligibility for Lifeline.

So when it comes to LIHEAP and USF, really, the only information that we submit over to them is household

information, annual income, and how their rent is paid. So if they are eligible for Lifeline, in this case, based on the tenant's side of it, then we would submit their overall information and then DCA would make that final determination.

MR. BLAUSTEIN: I mean, these individuals would be paying 30 percent of their income in rent, 30 percent of their SSI or SSDI.

MR. ALPAUGH: Right. So they should be eligible based on -- if they're eligible for Lifeline, they should be eligible for USF or LIHEAP. Well, USF, as long as they spend 6 percent of their annual income on heating.

CHAIRWOMAN SPITALNIK: Yes.

MS. MCGEADY: I'm Sinky McGeady (phonetic). I'm going to talk pretty much feeding off of the family member and also a shift counselor. And Michael and I had a conversation out in the lobby. So to piggyback to what Beverly was talking about -- and we're right in the process of filling out the PAAD app for my son. So I think what Beverly was getting at is, can you fill in the gap? So if the person doesn't have SSI but they are receiving SSD, so, yes, they can, just to clarify, they can fill in the PAAD application?

MR. ALPAUGH: They can, yes.

MS. MCGEADY: And they should.

MS. ROBERTS: But they have to have Medicaid for DDD.

MS. MCGEADY: Yes.

MS. ROBERTS: And if they have Medicaid, then they probably have PAAD.

MS. MCGEADY: So can you leave out pages 5 to 10?

MS. ROBERTS: A part of it could be useful.

MS. MCGEADY: Just omit that, they'll know that you have Medicaid and you still need to -- I mean, it's still beneficial because you'll get the Lifeline.

CHAIRWOMAN SPITALNIK: Thank you.

Any other?

Gwen.

MS. ORLOWSKI: Gwen Orlowski.

So thank you very much for the presentation, and I do think having this online ability to sign up for these programs is fabulous.

I have a question about people who lose Medicaid eligibility and it's legitimate, right; it's not that they've been screened for other Medicaid programs. They're at a point where they're no longer eligible for Medicaid, but they would be eligible for PAAD. And historically, there's been a problem making sure that those two things could match up without a gap in the past.

It's been a while since I've done one of these, but I've been told you can't really do the PAAD application while the person's still Medicaid active for the purpose of getting PAAD, not for the other reasons people are talking about. So with this online application, have you guys looked at that so it can be seamless? The person can stop Medicaid one day, if they've done the online application, and be eligible for PAAD on the first of next month? Or is there still that gap that happens?

MR. ALPAUGH: What I would say is it's ongoing. The creation of Medicaid's online application, as well as ours, has got us into discussions about a smoother process for all the programs; coming off Medicaid, going onto SLMB or PAAD and vice versa. So currently, for the last few years, what we have been doing at SLMB -- Medicare Savings Program, SLMB and QI -- is receiving the individuals who were aging out of Affordable Care Act. So that was kind of a precursor to this. We are in the process of creating a smoother process going both ways.

MS. ORLOWSKI: One quick follow-up on that, which is, I was asking about Medicaid to PAAD for prescription drug coverage, and I appreciate what you said. I say this a lot, and I'll continue to say it. The Medicare Savings Programs are, in fact, Medicaid programs and they must be screened for prior determination for

Medicaid. I know you guys are working on that, but I would be remiss if I didn't say it again. So SLMB and QI, that has to be seen under federal law. But thank you so much that you're working on it.

CHAIRWOMAN SPITALNIK: Thank you.

Any other comments? And then we're going to move on. Thank you.

MS. SICLARI: Ryaan Siclari with Central Jersey Legal Services.

I often am one of the 35 percent who are uploading applications for my clients. And this is more of a comment. Most of my clients don't have e-mail addresses. They're low income individuals. They don't have e-mail addresses. I can't use my e-mail address as an assistant more than once. We did it once, can't do it again. So now I have to go through the process of opening an e-mail account for them so I can help them apply. If there's any way that that can be addressed, it would be extremely helpful for the assistants.

MR. ALPAUGH: Always ongoing issues with the e-mails. When we first creating it, we were finding individuals who were signing up individuals on their e-mail and then that was the only time they ever saw them. Like you were saying, you were getting their e-mails but you had nothing really to do with them after the fact.

That's really why we created the county worker portal so that county offices, AAA's, could see individuals because if there was one time, you'd be able to sign them up. That's always an ongoing thing, and that can definitely be looked into.

MS. SICLARI: Maybe there's a way Legal Services could have something similar to that.

MR. ALPAUGH: That can always be looked into, yes.

MS. SICLARI: Thank you.

CHAIRWOMAN SPITALNIK: Thank you. One more and then I'm sorry that I have to move us forward.

MR. AFSHAR: Pedram from Sage. I was wondering if you ever advertise on Google or potentially purchased advertising using search queries, things like that?

MR. ALPAUGH: Not through Google that I know of. Not specifically.

MR. AFSHAR: Is there a thought that that is a way to get the eyes on these programs?

MR. ALPAUGH: To my knowledge, when we started the promotional tour, it was primarily for social media and local-type newspapers. I was able to see myself in some paper in Morristown which I had never heard of, some local town. So I think we kept it localized rather than

more expanded. That's always an idea, though.

CHAIRWOMAN SPITALNIK: Michael, thank you very much.

MR. ALPAUGH: Thank you very much.

CHAIRWOMAN SPITALNIK: Again, these slides will be on the portal.

We'll now move to Elizabeth Brennan, the Assistant Director of the Division of Aging Services, to give us an update about Managed Long-Term Services and Supports.

Welcome, Elizabeth.

MS. BRENNAN: Good morning. Thank you, Dr. Spitalnik.

So I'll be presenting for you the dashboards on our Long-Term Services and Supports. We present these historically. We always have a three-month gap in what we're presenting, so we're presenting for July 2019.

(Slide presentation by Ms. Brennan.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Thank you so much.

Questions from MAAC?

Beverly.

MS. ROBERTS: Thank you very much for the presentation.

I have a quick question on Slides No. 33 and 34. I didn't see private duty nursing in those slides, and I'm wondering if you happen to know the answer or would be able to provide it for next time.

MS. BRENNAN: Sorry. What's the slide label?

MS. ROBERTS: Slides No. 33 and No. 34.

CHAIRWOMAN SPITALNIK: Entire LTC Population's Services Utilization.

MS. ROBERTS: You have a breakout on the utilization and show PCA for both, which is helpful. Do you have PDM numbers?

MS. BRENNAN: I'm sure we do. Basically, we show the top five. So if that's an interest, we can certainly take that request back.

MS. ROBERTS: Yes. I would very much appreciate it. Thank you.

CHAIRWOMAN SPITALNIK: Members of the public?

MS. BRODSKY: Karen Brodsky from Health Benefits Associates.

On the behavioral health at the end, it looked like the utilization doubled between 2017 and 2018. I was just wondering what changed that would account for that.

MS. BRENNAN: I don't know. It's really

related to the carve-in of the services. I know we have Steve here who might --

MR. TUNNEY: Specific about the dates, that's going to move the three subpopulations into -- the responsibility is Managed Care.

MS. BRENNAN: I think we can take and we can present a little bit more detail at the next presentation on that. But basically, there was originally a carve-out of certain services, and then gradually more services were carved into Managed Care. But we can provide more details on that timeline and correlate it.

MR. TUNNEY: The one part is that from '17 to '18, we gave it a year that we kept services within Fee-for-Services for the new programs we created, and then they moved into MLTSS coverage.

MR. LUBITZ: Phil Lubitz.

I think we have to be careful that we're not confused, though. I mean, that you double a small number really isn't that significant. I mean, essentially we're saying about 2,000 out of 59,000 people received mental health services. It's either they're the healthiest, have the best mental health of any population segment in the entire country, or the service remains abysmal. I would tend to think the latter. So I think we still have a good ways to go in providing mental health -- behavioral

health services for this population.

MS. JACOBS: I hear you on that. And I want to point out two things. Number one, we do want to make sure that Medicaid is providing access to mental health services. And there's always work to do on that. I think there always will be.

And then number two, this is a population that sometimes has other coverage, actually, frequently has over coverage. I think we should just note that this is Medicaid data only. It wouldn't include Medicare and other insurance. So just sort of putting both of those thoughts out there. Very much a work in progress, ensuring that we're coordinating across medical care, behavioral and mental health care, and Long-Term Services and Supports, and acknowledging maybe some of the limitations of the data we have.

CHAIRWOMAN SPITALNIK: Ev Liebman.

MS. LIEBMAN: Hi. Ev Liebman, AARP. Thank you for the presentation.

I have two questions. One is you said we have 2,000, I think it was, fewer nursing home residents. I was wondering if you had any insight as to that drop. It seems to me relatively significant. And within that, whether or not we have any information on if our Money Follows the Person efforts in terms of moving

people, moving residents out of nursing facilities into home-based services.

And the, two, my second question -- I'll just get it out now -- the state auditors report identified a small group of MLTSS recipients who are receiving no services. And I was wondering if we could as part of dashboard or at least as part of these presentations get information about that, whether or not we continue to see that number grow, fall. Obviously, I'm concerned that we have folks out there with no services but we're paying for that.

MS. BRENNAN: Okay. To start with the first number about the nursing facilities being down 2,000, that number has been variable. At one point, it was a thousand. At another point, it was 1300. This dip to 2,000 occurred a few months ago. It's something that we are looking at. Sometimes it's very cyclical. We see different numbers at different times of the year. The 2,000 has been in place, like I said, for a few months. We don't have any data at this point to present on why that dip has occurred. It's not as if the number of available facilities has changed. I think some of it is cyclical. I don't know how much we can dive into it, but it's certainly something that we're keeping an eye on to see if there's additional information behind that number.

In terms of the Money Follows the Person Initiative, so that initiative is still in place. As we all know, the federal government has called for extensions on that program. The three divisions that participate in that program continue to do transitions. And I know that the Division of Aging Services continues to work with the Managed Care Organizations on those transitions. The transition numbers have been pretty consistent over time. We set goals every year, and every year we have been meeting and exceeding those transition goals. And the other thing to remember is that Money Follows the Person is just one piece of the component. Some individuals transition out and they're not eligible for Money Follows the Person because of their length of stay. Additionally, Money Follows the Person does not capture nursing facilities diversions. And the fact that individuals, if they're able to receive their supports in the home, might be able to divert from entering that nursing facility or have a shorter stay. So I think it's certainly something that we're committed to continuing to look at to try to see the trends.

In terms of the auditor report, I know that the divisions are looking at that report and services. We can certainly take the feedback about providing more data about those numbers. They were very small numbers, so not

to lose sight of that. But we'll certainly take it back and see if there's additional data that we can incorporate to meet that request.

CHAIRWOMAN SPITALNIK: Thank you.

Elizabeth, thank you very much.

MS. JACOBS: Can I jump in?

CHAIRWOMAN SPITALNIK: Of course.

MS. JACOBS: I'm just thinking about the question about transitions, and I want to make sure that folks do understand that Money Follows the Person is a program that applies only to certain individuals based on how long they've been in that facility transitioning out to community. And so there are folks who will have been in for a shorter period of time or for some other reason might not qualify as a transition. But we all know that story of someone who goes into the hospital, gets discharged to rehab, rehab turns into custodial and they never go home. That individual who is helped to go home through the support of a care manager would never qualify for MFP. They wouldn't have been there long enough. So we not only need to think about MFP transitions and community transitions in general, but also that rehab to custodial moment where you still have the opportunity to go back to the community. And then as Elizabeth said, the diversion concept, meaning, I am getting the

community-based services, I need at home, and I don't ever go to the nursing home. And I think that there's a compelling statistic kind of buried in the tables here which is out the population that was in HCBS waivers in July of 2014, yes, a certain number of that population has passed on, and that is expected in this group, obviously. But out of those who remain, only 1 in 5 has gone into a nursing home. I find that to be a compelling statistic. The researchers in the room would say dive deeper and look at the comparison and look at other populations, and I think that does make sense to do. But with what we expect for a long-term care level of care population over time -- and we saw a significant, obviously, populations are passing away during that time. What we would expect, I think only 1 in 5 entering a nursing home over a five-year period is a compelling statistic.

So the program is one that is evolving. We will talk about that in months ahead, but I just want to make sure we don't forget that there's a significant role with respect to helping people remain in the community, as Elizabeth described, and also coordinating those transitions, hospital to rehab and then back to community to avoid the custodial stay.

CHAIRWOMAN SPITALNIK: Thank you so much.

Carol is with us, Deputy Director of the

Division, to update us first on New Jersey FamilyCare enrollment highlights and changes in the Managed Care Contract.

Welcome, Carol.

MS. GRANT: Thank you.

Good morning, everyone. These are just some highlights briefly.

(Slide presentation by Ms. Grant.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Carol, thank you.

Enrollment questions before Carol proceeds?

Hearing none here.

Yes?

MR. SPIELBERG: Josh Spielberg, Legal Services of New Jersey.

You mentioned that enrollment, I think, was down 6,000 from last month. It's down 17,000 from our prior meeting. And it's down about 100,000 from the high point, which I think was March of 2017. So there is a trend. And I just wonder if you could dig deeper into why that trend is occurring.

You said it's happening in other states?

MS. GRANT: It is.

MR. SPIELBERG: It would be useful to try to compare with similar. But also, we've seen an uptick in terminations at the county level, maybe some more than others. If you could dig down on that.

And also, to pick up on a point that Gwen raised earlier, one of the things we see is people are being terminate from one Medicaid program but not screened and transferred to other Medicaid programs, which is an issue we've been raising. So that may be part of the reason, too. But if you could comment on digging deeper and what else can be done.

MS. JACOBS: So that was three things, and my tine brain can only keep track of probably two at a time. But the first one about the sort of declining population overall, we have had extensive discussions about this on our end, lots of talk at the national level about patterns, and I think there are a few things at play. One of them is the economy, and people are getting jobs that offer insurance or they are getting sort of higher income level in general and moving into the marketplace. We are seeing, for example, more families in the upper incomes of Medicaid. We're seeing that trend where folks may not have moved out of Medicaid, but the population is shifting a bit into the upper income levels, if that makes sense;

and then a noticeable concern around the public charge rule; and, frankly, fears among immigrant communities, particularly the mixed household there are children born in the United States but families are fearing access and community leaders are talking about avoiding programs for that reason. So that is something that we've had a lot of concern about and a lot of conversation about.

To your second point, which is more New Jersey specific, there's important activity going on at the counties which we're monitoring. As you said, volume varies from county to county. And we could talk about that in a little bit more detail down the road here. But there are critical functions that need to happen there, and there's accountability expectations in terms of turnaround time for applications.

And, Greg or Carol, if you want to jump in on any of the other points.

MS. SMITH: What was the third one?

MR. SPIELBERG: The screening for other programs. It's a requirement before you terminate from one you have to screen for Medicaid eligibility for all programs. It's something that hasn't been happening that advocates have been advocating for for a while. So that could be one the reasons. And I wonder what the progress is in implementing that so if that happens, before anybody

is terminated there is a screening process so that it's made sure they're not eligible for any other Medicaid programs.

MS. SMITH: So that is on our radar. Thank you. You always keep reminding us that that's something we should be working on. One time I presented here and we talked about how we're doing that with the SSI population and we're moving on with the -- those that are aging out because of 65 or getting on Medicare, we are moving on to the end of processes with that. And I think earlier they talked about how systems connect so that they come out of Medicaid, then we can look at them for these other programs that are offered. Those are our concerns also.

CHAIRWOMAN SPITALNIK: Also, as we always do, we keep track of the issues raised to incorporate into our planning for the next meeting and subsequent meetings.

Gwen, one more comment.

MS. ORLOWSKI: Gwen Orlowski. I just want to follow up on that. I echo everything that Josh said and I just want to put from the perspective DRNJ that there's a heightened importance for the individuals who are receiving DDD services as well, because the loss of their Medicaid, if they're not being fully screened for all other program eligibility before termination, imperils their

DDD services as well. And I know we've had this discussion. We're hoping to have a follow-up with you on that, Jen. And we really appreciate that. But one of the things I'd like to ask DRNJ, but this may be a legal services issue as well, if we can please have some stopgap measure. We've been waiting a very long time, and we need something that makes sure that we can protect the Medicaid benefits and the DDD benefits while you guys are working out systems change.

CHAIRWOMAN SPITALNIK: Thank you.

MS. ROBERTS: Just a quick follow-up to what Gwen just said.

NJ Workability, as just an example, not a lot, but some folks that hit age 65, immediate termination. So if they're DDD, it's like there's a spiral where all of a sudden the next day they're out. So things like that is part of the stopgap.

CHAIRWOMAN SPITALNIK: And we will have an update from Jen on NJ Workability.

MS. ROBERTS: Good. So I can mention it again.

CHAIRWOMAN SPITALNIK: It's duly noted now. Thank you.

Carol, thank you for this. And we'll ask you to move on to the Managed Care contract changes.

MS. GRANT: Sure. In general, we normally don't post our contracts until they're fully approved, signed by plans and the State and approved by CMS. Given the number of spas and other kinds actions that we have and CMS's own processes these days, this process is taking longer than it normally does. So we've had conversations. Jen has had conversations with CMS to try to figure out how to do this and to keep people apprised of proposed contract changes. As long as people understand that until it is fully approved by everybody under the sun, including our federal partners, we do want you to be aware of at least what we're proposing, always subject to some change if CMS says, well, you've got to say it this way or do it this way. So I think this is how we're going to do this in the future. We probably won't post until it is fully authorized, but we are going to share with you proposed changes. Today, we're just going to do July's. We're already past July, so we can talk about what we have, in fact, proposed in the July contract. And we will do that for January when that is ready as well. So we'll keep the MAAC informed at least of what's being proposed.

(Slide presentation by Ms. Grant.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us

/humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Carol, thank you so much for corralling so much information. And I just want to note and commend the provisions that bring us closer to integration of behavioral and physical health. Thank you.

Comments or questions?

Beverly and then Theresa.

MS. ROBERTS: Thank you very much, Carol. This was very, very helpful.

A couple of questions. The members in need of MLTSS slide, which is 49, requiring New Jersey screen for community services before the NJ Choice, et cetera, et cetera. So I think a lot of thinking within MLTSS is for the older population and sort of the plan and the process for them. So my specific concern is for parents of very young children who need private duty nursing. So I'm just wondering what is being done or can be done to ease the way for this small group of folks that will need the MLTSS specifically for PDN.

MS BRENNAN: So we actually have a separate screening process for children for MLTSS. It's actually handled administratively out of the Division of Disability Services. And the reason we have that separate process for children is, as you pointed out, their needs are

different; and, really, you're looking at private duty nursing and those medical complexities. So the Division of Disability Services which has that expertise as they manage those waivers prior to MLTSS, they conduct a screening process. We've adapted the screen for children to specifically address their needs and what would be appropriate under MLTSS. And then we've added an additional physician certification process so that we're able to get from a physician what those medical complexities are so that we can have a good understanding of what that child's needs are in order to go through the MLTSS process.

For a child who is already being served under a Managed Care Organization, if they've already identified that private duty nursing need, generally the transition won't occur until that child ages out and reaches adulthood and they switch from that EPSDT benefit into the MLTSS. And that was what was referenced in terms of initiating that assessment at age 20 and a half, to make sure we're doing that transition, that assessment of clinical eligibility in advance so that there's absolutely no disruption of services. We understand that once they hit 21, private duty nursing needs to continue, so we try and make sure we put some processes in place to make sure that that transition is just automatically occurring.

MS. ROBERTS: This is great. Is there a particular contact person at DDS who is sort of "the person" at DDS for the PDN issues?

MS. BRENNAN: So Dianna Maurone who is sitting right there. She has helped us to implement that process and oversees that.

MS. MAURONE: So if you contact our line, our 888 number, 888-285-3036, the first prompt is for information referral, Managed Long-Term Services and Supports, it's our information referral team that initiates those screens for services. And then we go ahead and work with the families throughout that process until the benefit is actually kicked in and they've begun using the service to make sure everything is being coordinated between the OPAL offices and the CWAs and that the family understands all the things that are happening because, as we know, it's complex. Please tell folks to call us.

MS. ROBERTS: Oh, this is great. I had a situation not long ago where somebody had a terrible time not knowing about this, and I didn't know about this. So this is really good information.

CHAIRWOMAN SPITALNIK: Thank you.

MS. ROBERTS: Just one last question for Carol.

On Slide No. 55, you talk about the PPP, expands the definition. Could you talk a little bit more about the changes within PPP, like eligibility requirement, et cetera?

MS. GRANT: I think that, obviously, eligibility for PPP is sort of twofold. One, you have to have a medical need for PCA. And then the plan actually does options counseling to determine whether or not self-direction is the appropriate methodology for delivering this service. That's really the issue. I mean, self-direction is not what everybody wants. They may not understand, especially since the PPP Program is the employer of record. It's like really running a small business. We are really attempting to put together program materials, fact sheets, FAQs, and a member handbook so all of that is much clearer to participants both before they want to talk about self-direction as a methodology for delivering the service, and during. And we're very close, I think, to having those kinds of materials available for people. I know one of the things we wanted to do was once we had sort of a more final draft that had been vetted within the Department is to actually share with some stakeholders, to say, is this making sense, is the clear, do you understand it, can we use more user friendly language, that kind of thing. So that's coming.

MS. ROBERTS: Thank you very much.

CHAIRWOMAN SPITALNIK: Yes?

MR. HAUSNER: Sandy Hausner, CareFinders Total Care.

In connection with the expansion of the PPP program, Carol, what is State anticipating doing in terms of the monitoring of the family members that are providing that service? We talked about that a couple of meetings ago.

MS. GRANT: Are you talking about EVV? Are you talking about electronic visitor?

MR. HAUSNER: No, PPP.

MS. GRANT: Monitoring. Quality of care.

MR. HAUSNER: Quality of care.

MS. GRANT: Well, we're working very closely with Managed Care on those kinds of issues. We have a very small state project office. There are metrics. We do monitor and meet and talk weekly with our fiscal agent to make sure it's all going well. We monitoring complaints, grievances, and appeals around the program. And we are in the process of setting quality metrics. Whatever standard we hold PCA to, self-direction can't really be very different. It's just people need more support because they may be using family members or neighbors or whatever to provide the care. Part of the electronic

visit verification, I believe, will apply to self-directed individuals so that we, in fact, can be sure that workers are actually there, the service is actually being provided and not different from the others.

More to come on that. We're only at the very beginning of that process. But, again, we'll work with stakeholders around these quality issues so that everybody understands. It's unique a program, I think people who are in it. And it has grown tremendously, I think, over the last -- I'm trying to think how long it's been in Medicaid now -- only maybe two years or so, from around 9,000 people to almost 16,000 people, so it's a popular service.

CHAIRWOMAN SPITALNIK: I'm going to ask people to hold followups.

My apologies, Theresa, for not calling on you.

MS. EDELSTEIN: That's okay.

Carol, I may have totally missed this. Is the New Jersey screen for community services a tool that we can seek?

MS BRENNAN: So the New Jersey screen for community services has been in use since, I believe, 2009. We actually use it in our Aging and Disability Resource Connections, our ADRCs. So when callers call for information, if they trigger or it appears they need that

clinical eligibility, the screen for community services will be conducted. It's not currently a public document, but I'll certainly take it back. I don't see why we can't share it.

We did put screening into the MLTSS contract several years ago, but noting that there just wasn't a lot of consistency so now we converted to requiring the screen. Just to let you know, we actually differed the July implementation because they really have to program it with all of its algorithms and things that score out of it, so it actually will be effective January 1, 2020. But I'll certainly take it back. I don't see why we can't share it.

MS. EDELSTEIN: I didn't know if it was the same thing the ADRC has been using.

MS. BRENNAN: It is.

MS. GRANT: It's just a little more formally applied, I think, to at least do an initial screen. However, Elizabeth, even if they don't meet the screen but wants to be screened for MLTSS --

MS. BRENNAN: Yes, they receive an assessment. Absolutely.

MS. EDELSTEIN: Just one other question. It's more of a comment than a question.

I'm really glad to see the annual training on

the medical day care regulations in here because I still consistently receive information from medical day care providers, especially on the pediatric side, that they are just hammered with denials. And then they go through the appeals process, and 95 to 98 percent of the time it's overturned, which is an incredible waste of resources for everybody. And the child in the meantime and the family is stuck in the middle of that. So this is something I think that's going to need definitely education but more oversight.

MS. GRANT: Definitely.

CHAIRWOMAN SPITALNIK: Thank you.

MS. GRANT: Duly noted.

CHAIRWOMAN SPITALNIK: One more comment and then we're going to move to the next item.

MS. ORLOWSKI: So the question I have may actually be a good topic for a future meeting.

So around this issue of children who may be eligible for private duty nursing and MLTSS, I'm just going to go quickly back in time. Children who had high needs historically were served through CRPD, and many of them transitioned to MLTSS. And it came to light that some of them needed PDN, some did not but yet needed to be on Medicaid because there were complication issues around their needs, their behavioral health, et cetera. And I

remember very clearly several years ago as the State was clarifying that MLTSS was a PDN standard that we were told, don't worry because we're amending the waiver to make sure that we still capture all those children, they just may not be captured through MLTSS. And I believe where they're captured -- and I can't remember the exact name. It might be special term condition number 36 or somewhere around there. CSOC waiver, that's what I call it. And I know there are questions about whether or not that's fully implemented for what I'll call middle class children, children who need the spousal impoverished and protection applied to them. So it would be rally great to have a presentation from CSOC on that so we can understand as advocates for families and help explain to parents the difference between the MLTSS option and private duty nursing and a CSOC option, and making sure that CSOC option gets operationalized, which I'm not certain that it has been. So that's one thing I'd say.

The other thing I'd say is I, too, am really great to here about the PDN screen for children in DDS. I don't think there's clarity and transparency about what that level of care really is and how that tool works compared to the New Jersey Choice tool in adults. I think under Medicaid, there has to be clarity and transparency about that. So it would be really great to have breakdown

at a future presentation about what those standards really are.

MS. BRENNAN: And just to clarify, so the standards are in the waiver, the amendment and the renewal that was done with the waiver. We do not use a separate tool for children. So the same tool, the New Jersey Choice is used for children as well as adults. It's simply the criteria that is different. And, again, that's spelled out in the comprehensive waiver.

MS. ORLOWSKI: I appreciate that, but that doesn't necessarily match with the regulations.

CHAIRWOMAN SPITALNIK: I'm sorry, but I need to sort of enforce time. But the concerns that have been raised are duly noted, and we will accommodate them in appropriate form.

So, Carol, thank you so much.

I'm not sure in the burst of cool air in the fall how we've wound up with such a loaded agenda, but we're delighted that Steve Tunney is with us to talk about office-based addiction treatment.

MR. TUNNEY: Thank you. Good morning. I'll be very quick.

Office-based addiction treatment is exactly what it says. This is addiction treatment that's provided by physician practices in an office-based setting, so it

provides a little anonymity. Clients can go in, they can see their doctor, they can discuss whatever their needs are, and they can receive treatment. So this is something that the Division of Medical Assistance Health Services and Mental Health and Addiction Services have worked with providers in the community to try and grow and to expand.

(Slide presentation by Mr. Tunney.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Thank you. Such a complete presentation. And, again, we are all in admiration on the work that's being done on opioid treatment by the Division.

Dr. Thomas Lind, Medical Director, Medicaid Utilization Review Audits.

DR. LIND: Good morning. I'm coming to talk to you today about changes that the Division's made to its process for utilization review. Since 2010, as a matter of background, the Division has contracted with an organization called Permedion, which is a subsidiary HMS, to provide an evaluation of hospital services. This has been strictly done on a Fee For Service level until this point, but we are now changing directions and we are going

to include Managed Care Organizations in that process.

Permedion hospitalized are going to include the following areas: Whether the admission was appropriate; the length of stay; whether there was medical necessity and medical record is consistent with the services that were provided; DRG validation; review of billing practices; discharge planning; and readministration criteria.

The audit process, just so everyone is clear on this, consists of hospital will be sending electronic medical records request lists by Permedion in the DOTS system, which is the Document Online Tracking System. The hospitals will be given 30 days to respond to that. The provider, the hospital will be asked to submit medical record either transferred by electronic data exchange or uploaded through the DOTS System. UR certifications, which is a sheet of paper that list the day of the stay and the acuity level of each day either in the category of acute, SNF, or residential. Filling documentation, including the UVL4 forms and the New Jersey FamilyCare eligibility form which can be found on the NJMMI website.

During the Permedion review process, Permedion is given 30 days of a maximum review period from the receipt of the records to arriving at a decision for a determination letter, which would be posted on the DOTS

System.

Permedion, if there is an adverse determination letter, that would be posted on the DOTS System. And access to the letters is available to the hospital, to the State Office of Utilization Management, and to the appropriate Managed Care Organization.

The hospital would have the opportunity to dispute any adverse determinations as long as the appeal is submitted within 20 calendar days of the posting of the letter on DOTS. Of course, in the first level of appeal, the hospital would submit the letter of appeal with supporting documentation to Permedion, and the first level of appeal would be processed within 20 days of having received the appeal letter.

If the first level of appeal results in a reversal, the letter will be posted in DOTS within 20 days.

If Permedion upholds its initial decision, it will post a final determination letter on DOTS. Then the hospital would have 20 days to either adjust the claim to the MC0 or the Fee For Service, whichever is appropriate, to satisfy the issues noted on the adverse determination, to void the claim entirely or to request a fair hearing, which is their right.

The hospital may proceed to fair hearing if a fair hearing request form is submitted to DMAHS within

20 days of the date of Permedion's final determination letter, and the decision of the fair hearing is final.

Are there any questions?

CHAIRWOMAN SPITALNIK: Questions?

Thank you so much, as always, Dr. Lind.

We'll now move to Heidi Smith, who is Chief of Operations of the Division for First Family Planning Program, and then an update on the ABD online application.

Good morning, Heidi.

MS. SMITH: Good morning. Heidi Smith. Thank you very much for having me present on this piece of the agenda. Planned First Program, that's the name of our family planning program. It launched on October 1, 2019.

(Slide presentation by Ms. Smith.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Any questions? Comments?

UNIDENTIFIED SPEAKER: How many?

MS. JACOBS: We have 31 people signed up to date. We launched October 1st.

CHAIRWOMAN SPITALNIK: Now we'll move on to

the Aged, Blind, and Disabled.

MS. SMITH: So the Aged, Blind, and Disabled online application is a work-in-progress. We're constantly making changes as we see what needs to be done.

(Slide presentation by Ms. Smith.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: Thank you so much for this.

So the wording, especially with the IDD, is that currently there in the forms?

MS. SMITH: Yes, it is.

MS. ROBERTS: So if somebody goes online today, they're going to see those questions?

MS. SMITH: That's correct.

MS. ROBERTS: Excellent. If somebody has a son or daughter with very severe disability where they could answer yes to the first one, but they might also answer yes to dressing, bathing, et cetera, because they do need help with both but they certainly don't want to have MLTSS and lose DDD, is there something that indicates that they wouldn't answer yes to both?

MS. SMITH: So with the ABD application, it's for one person. It's not for the whole family.

MS. ROBERTS: I know. But a parent filling it in for son or daughter, and its a son or daughter who has an intellectual disability but also has very severe needs with all their ADLs.

MS. SMITH: Okay. We added the very first question because that helps us to know whether we should seek -- a lot of times we need some kind of clinical eligible to go along with financial eligibility. So this question helps us to think through do we need a functional level of care from DDD or do we need a clinical eligibility from OCA. So it just helps the processor to know which road to go down. We don't want to flood OCA with certifications.

MS. ROBERTS: Right. So they could answer both? They could?

MS. SMITH: They could answer yes to both.

MS. ROBERTS: And that would trigger OCA if they answered yes.

MS. WRIGHT: Kelly Wright. I just want to if he help out a little bit.

Part of the reason we've been working with Medicaid and it's been a collaborative approach. This is really going to help our population because often if the

income exceeds the 100 percent, the first question would be MLTSS because it allows you to go up to that 300 percent income. So the first is kind of like screening tool so that we'll work with each other and that it's not an inaccurate referral to MLTSS if the individual actually wants DDD services. So it really will help out by having that. So, yes, they can answer yes to both. And it will, as long as you indicate yes to the first one, it will help ensure that the application is directed in the right way.

MS. ROBERTS: Thank you.

CHAIRWOMAN SPITALNIK: Thank you so much, Kelly.

Others?

Thank you so much, Heidi.

We're now going to turn to turn to New Jersey Workability eligibility clarification. Jen Jacobs, who is the Assistant Commissioner for Division of Medical Assistance.

MS. JACOBS: Hi, everyone. I guess I should start by saying I'm not the WorkAbility expert in the room. Dianna Maurone is the WorkAbility expert in the room, so point at her. And I'm also not the Medicaid eligibility expert in the room; that's Heidi.

But NJ WorkAbility's community kind of experienced the intersection of Medicaid eligibility and

the WorkAbility Program in a funny way this month, and I wanted to talk about that a little bit. So don't ask me hard questions; ask them.

But what I wanted to describe was just this: Some guidance came out in 2019 in a different format than folks had seen it in prior years. So that raised some questions and concerns. WorkAbility is a program that is designed to give people with disabilities Medicaid eligibility even when there is a higher income level than you would normally provide that Medicaid eligibility for. And the question that came up was around the guidance that was issued for that upper income level. How much money can you make and still qualify for WorkAbility?

There was a format that had been used in the past to provide that guidance, and the format was modified because I think the Medicaid eligibility team saw that it was maybe a little oversimplified; consumer friendly, frankly, but a little oversimplified. And there what were some gaps there that we really needed to provide a little more clarity on, and then kind of got into eligibility weeds and said, well, really, it should look like this. And so the guidance that came out was clear and, frankly, was accurate from an eligibility calculation point of view. I'm not going deep in the weeds on this on purpose. We can certainly do that, but let me come back to this.

That didn't help folks. They said, oh, my goodness; it looks like now I have to make so much less money to qualify for Medicaid than I did before. Folks are nodding because we had this experience as a community.

What we did in response to that very important concern was we went back and revised the guidance to look more like what people were accustomed to seeing in the past but to include the sort of important pieces of information that folks had felt were missing in the first place. So the total income level for someone looking to qualify for WorkAbility is exactly where community members and stakeholders and advocates thought it was, and the communication has been revised to show that. The income disregards that exist on the Medicaid eligibility side are also still there. So the numbers that were provided previously were also correct, but Medicaid recognized that from a consumer point of view, folks really needed to see that upper income level reflected on the page in a way that it hadn't been in the 2019 guidance.

So that's a long way of saying to you we have new guidance to share with you. I needed one more signature or I would have been able to bring copies of today. We're very close to done. Dianna has seen it. Heidi has seen it. Everybody's on the same page. I think it will look like consumers need it to look. You'll notice

a few tweaks from prior years, and that's intended to bring in that fidelity, just a level of nuance and detail that's important that was left out. But I think on the whole, we've gotten to a better place.

So the moral of the story is, of course, the programs are supposed consumer-friendly. Consumers, advocates, stakeholders, should provide input when our communication is not. And then we will get all over it and improve as we need to. So thank you for your input on that.

CHAIRWOMAN SPITALNIK: Thank you so much, Jen. When the signatures are complete, we'll bring that back and we'll make that an agenda item to share that. But also, I just want to add the reflection that there's still the need for much more communication about the availability of this program and that the need for benefits need not be an obstacle to employment and full community life. So anything we can do to encourage that.

MS. MAURONE: I just wanted to add that our Division -- I know in the past we had a WorkAbility specialist and some people may have heard that no longer have that specialist position, but it's merely a function of our information and referral. So we're all very familiar with WorkAbility and the guidelines and can really help folks understand what it is, who's going to

be eligible. We don't conduct a formal screen. We don't do the eligibility, but we can run through it behind the scenes with you to find out if you are going to be eligible and should go in that direction. That's our role in this. So please let folks know that that's a function of the Division of Disability Services. And, again, they would just call that 888 number that I mentioned before to get in touch with us.

CHAIRWOMAN SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: This is great information; very, very helpful. I'm just wondering. You said one signature and then it's going to be official. When that happens, I know you have a large group list. I get e-mails periodically. Could you do an announcement, an e-mail announcement, with this information? It would be nice discuss it next time. Rather waiting a few months for the MAAC, if that could go out to your list, that would be really helpful.

MS. JACOBS: Yes, we'll be sharing it right away.

MS. ROBERTS: Great. Thank you.

CHAIRWOMAN SPITALNIK: Thank you so much.

MS. EVANS: Lillie Evans, Horizon. I just have one question.

Did that guidance and/or fact sheet now include the fact that should a NJ WorkAbility member become eligible or in need of MLTSS that they cannot get it in programs that are NJ WorkAbility? Because we run into that a lot when we need to transition people and they don't understand that they need to go back to the County, et cetera, and be screened for long-term care, Medicaid versus NJ WorkAbility.

MS. JACOBS: That's a good point, Lillie. So a lot of discussion happened about what this communication should look like, and that's actually why we were just a little bit delayed. We were trying to have it for you today. Do we provide all the information or do we just provide the very clear kind of one-pager and then all the other information is somewhere else? And so there was a philosophical question. We decided that we would just give the clearest, simplest explanation and take the nuance to a more elaborate document which we will work on for you.

I just wanted to point out, we're at sort of transition point in the agenda where the first half of the meeting we wanted to talk about things that were already in motion. And we're now just transitioning into topics -- Greg's going to kick us off here -- initiatives that are in planning and implementation stages. So I just

wanted to point out that we're kind of making that little shift.

CHAIRWOMAN SPITALNIK: Thank you.

Greg, the 1115 Demonstration Amendment Request.

MR. WOODS: Thank you very much. Good afternoon, everyone.

So I briefly want to talk about what we're intending to do with respect to our 1115 Demonstration and an amendment request that we expect to submit to CMS in the not-too-distance future.

Just to orient everyone, and I think I'll be telling most of you things you already know, we have the New Jersey FamilyCare Comprehensive 1115 Demonstration. This is a demonstration with CMS that was initially approved back in 2012 for a five-year period, was renewed for an additional five-year period in 2017, so we're currently in that period and will run through 2022. This predates me, but I know this Council is heavily involved in the process of stakeholder input into that renewal. So we will need to do another renewal in 2022. That is not what I am talking about today. That's for future meetings.

What I'm talking about today is during each five-year period, it seems constantly in a cycle of

submitting amendments to CMS to change or add something to the demonstration. We recently had one set of changes approved through an amendment, so that means we're on tap to submit another set of changes. We wanted to talk what we're intending to submit and solicit stakeholder feedback on that.

(Slide presentation by Mr. Woods.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Thank you so much, Greg. This is a period for public comment, and the MAAC serves as one of the vehicles for stakeholder comment.

Any comment from MAAC?

Hearing none.

From the public?

MS. ABRAMS: Hi. Mary Abrams with NJAMHAA. Just to reiterate what we've been advocating for a couple years. The mental health providers are in need are in need of the same infrastructure, whether new or updated HR systems interoperability that would go with it. And a lot of them are one in the same when they're doing both, they can have the eligibility, but they're leaving out -- when we try to integrate care and to leave out that piece when

there's so much comorbidity.

CHAIRWOMAN SPITALNIK: Thank you so much.

Josh.

MR. SPIELBERG: On the extension of the pregnancy coverage, the comment is that this seems like a very positive program. I had a few questions about it.

Number one, do you know if other sites have extended beyond the 60 days?

The related question is, and I don't know if you can have an educated guess on this, whether you anticipate any problems with CMS in approving it?

And then thirdly, if you don't get federal approval, will the program go forward with State funds?

MR. WOODS: So I think the first question was are there other states. I don't think there are other states that have -- to my knowledge, there are no other states that have had a program with this structure approved. There are some related things that other states have done for more limited populations of pregnant women, but I don't think there's a perfect analog that we can point to from other states.

With respect to the question about whether we expect resistant from CMS, I'm sort of hesitant to speculate about that. I will say we have had some initial conversations with them where they have neither said

definitely yes nor definitely no. So I think we're hopeful, but we'll just have to see what kind of response we get.

I think the third question was if CMS does not approve, whether we would move State-only dollars. My understanding -- and I'm not on our legal side, but my understanding is the actual budget language that was enacted is contingent on federal approval. So I don't know that we could just move forward with this as-is without federal approval. I suspect, and I think we have to cross that bridge when we came to it, but I suspect we would want to look at whether there were opportunities to -- what other opportunities they would need to provide continuity of coverage for that population. But I don't know exactly what direction that would take, and I think we're going to pursue this route first.

CHAIRWOMAN SPITALNIK: Yes?

UNIDENTIFIED SPEAKER: When do you want the comments by? And is there going to be another notice we should comment on, or should we use the slide deck?

MR. WOODS: If you can use the slide deck just because we're trying to move quickly on this, and I think the sooner the better.

CHAIRWOMAN SPITALNIK: Thank you.

MS. HIGGS: Hi. Kimberly Higgs, New Jersey

Psychiatric Rehabilitation Association.

I certainly want to echo and support what my colleague Mary Abrams shared about the concerns for folks on the behavioral health side of the house in terms of having access to these types of dollars. And I think it ties into so many other things that came up over the course of the meeting, like the low rate of behavioral health penetration and MLTSS. And we look at opportunities being created in FQHC to deliver more behavioral health services. What we're continually forgetting is that there is a significant percentage of people who have mental illness, who receive behavioral health services, and the place that they're the most comfortable to go for any of their health services is where they get those behavioral health and psych rehab services. And so we need to be mindful of that, and there needs to be a mechanism for that to be the door that people enter into the system and get that access through.

CHAIRWOMAN SPITALNIK: Thank you.

Thank you, Greg.

And you don't have a firm date that you need comments by?

MR. WOODS: I don't have a firm date. I would say we'll continue to look at comments as they come in. And even after we submit the request, there will be an

ongoing conversation with CMS. I would say, obviously, the sooner we receive comments, the more helpful it is.

CHAIRWOMAN SPITALNIK: Great. Thank you so much.

We now turn to an additional series of policy implementation and updates from Jen Jacobs.

MS. JACOBS: So I have kind of the last set of topics. I'm going to try to move through them pretty quickly in the name of lunch. And so I'll start with autism.

We have been working very closely with Molly and Michele and the team at the Division of Children and Families to really identify the best path forward for new autism benefits. I thought it might be helpful to share with you where things are today and then where they will be tomorrow. So we have two slides for autism, today and tomorrow.

(Slide presentation by Ms. Jacobs.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

MS. ROBERTS: So the person with the child would have to be eligible for Medicaid Managed Care in order to get the ABA therapy?

MS. JACOBS: I'm focused on the Medicaid benefit only.

MS. ROBERTS: Do you think there will be away for CSOC child severe autism needs ABA to get that outside of being Medicaid eligible?

MS. GRANT: We need to probably direct that to --

CHAIRWOMAN SPITALNIK: That is definitely a CSOC issue. Just a reminder, this is a benefit under Medicaid early periodic screening diagnosis and treatment. But I would continue to raise the issue that there needs to be clear and accessible information for families describing the different pathways and what the different systems. Bit I think the decision is a good step to providing some clarity. We just need to make that decision accessible to people.

MS. JACOBS: That's such a good point. And I would say in response to that, that was actually a big part of the discussion we were having. We said we have to be able to explain this to families in 20 words or less. And as we walked through the different options, we found that some of them were just too complicated and it wouldn't have made for easy access to the system and the services. So I completely agree.

CHAIRWOMAN SPITALNIK: I do want to raise an

issue, though. In the proposed State Plan amendment, the requirement for access is a diagnosis of autism from a licensed provider. Under PerformCare, the requirement for a diagnosis of autism is the Autism Diagnostic Observation Scale. So there are different eligibility issues that also have to come back to the planning.

MS. JACOBS: Thank you.

MS. ADAMS: My name is Chona Adams, and I'm an office manager for an agency that serves children with autism. So I just I had a couple of questions.

First of all, when you just mentioned about the difference between diagnostic criteria so that now for PerformCare they need to be diagnosed through the ADOS. Are you saying that for the ABA through Managed Care would have to diagnosed by a licensed clinician so that would mean that they don't necessarily have to have the ADOS done?

MS. SPITALNIK: At least the way that the recommendation was made, it's diagnosis by a licensed clinician, which doesn't require the ADOS. But I think this is an issue that has to be aired here, but I don't think people can really comment on that until the system is engaged.

MS. ADAMS: One other question. I get called every day from families who were on Medicaid with children

with autism, and the question that they ask me is: If all private insurances are mandated by ACA to provided unlimited ABA services for children with autism, how could it not be covered under Medicaid? What's the answer to that question?

MS. GRANT: Well, it will be as a EPSDT benefit. That's what we're implementing now.

Right now, yes, it's a requirement for commercial insurance to cover. It is also a CMS requirement that it be covered by states under EPSDT. And we are, in fact, operationalizing that as we speak.

MS. ADAMS: Do you think that by the beginning of 2020 this is going to be available?

MS. GRANT: That is our goal.

MS. JACOBS: There are services available right now through Medicaid and through PerformCare. And these are additional services that we're implementing for 2020.

MS. ADAMS: Do you plan to work or get a behavioral health company for the UM? Or this is going to work straight through Medicaid?

MS. JACOBS: Through the Medicaid -- well, the specific ABA and floor time will run through the Medicaid Managed Care Organizations in addition to the services that are already offered today.

MS. GRANT: More to come.

CHAIRWOMAN SPITALNIK: Thank you.

MS. JACOBS: One of the things I love about my new job is I get to touch all the different pieces of Medicaid. And so the next piece is a little bit different. This is a new program around providing community doula care for our Medicaid members. And if you have ever had experience with doulas in your life, it is likely, yourself, family, friend, neighbor, who paid a lot of money for a doula to support her through her birth. And I have always sort of thought that was a cool concept, but it's not one that has really widely distributed across socioeconomic diversity. So the goal of this program is to take a pilot program that has been in the works between the Department of Health, some foundations, some regional health hubs, perinatal collaborative, and others, and really say, can we use community doulas, women who come out of our Medicaid communities, to support women who are having babies in our Medicaid communities? And in doing so, can we address the incredible disparity in maternal morbidity and mortality here in New Jersey?

If you sit with our doula stakeholders for five minutes, I assure you, you will find their passion and their argument and their experience very compelling, and we did. So we are in discussions now with the doula

community, with the Department of Health, the foundations that are already working with them, and all the community groups. Those stakeholder meetings are really focused on how do we take this pilot program, this really pretty amazing concept, and build it into our Medicaid program while maintaining the spirit of the thing, bringing it into a larger system. So when you go to scale on something, right, it can change a little bit. And we want to make sure that as it's going to scale, it maintains the integrity of what it began as.

And so we're having those conversations. We're now a couple of months into it with the doula community and really focused on what are the core competencies of a doula, what should her training look like, what should her experience be, and then also what cultural competency would we expect that doula to be able to demonstrate in order to serve our Medicaid moms.

This is an ongoing discussion. It's a compelling discussion. It's one that we're all excited about. So I'm happy to answer any questions you have on that.

CHAIRWOMAN SPITALNIK: Thank you. We'll look forward to updates on that also.

MS. JACOBS: So next up, Electronic Visit Verification. For those who have experience with EVV,

please bear with me for a second while I describe it for those who don't. The consent of electronic visit verification is if I am an aide coming into your home to provide personal care, when I arrive at your home, I will use a device -- and the type of device can vary. I will use a device that indicates to the agency I work for that I am, in fact, in your home and providing services to you. So there is a check-in and a check-out kind of concept. And it actually gets a little more complicated than that, but we'll stick there for now. Check-in and check-out at the member's home to say, "I was here and I provided services at this time."

There is a federal mandate to do this January 1 for our home delivered services. And so all of the states are now in the process of implementing this EVV initiative.

The concept behind EVV is kind of twofold. There's really a quality piece and an efficiency piece. The quality piece is, is the member getting the services they need? And the efficiency piece is, let's make sure that we're paying for the right amount of services.

And I would just suggest to you, people have kind of mixed feelings about the EVV mandate. On the one hand, I think people appreciate the quality piece. On the other hand, people worry about the aide's ability to manage that process and person's needs at the same time; and to

some extent, folks worry about privacy.

So we are implementing this program, as all other states are. And we're doing it with the understanding there's pretty significant stakeholder impact here. Providers are certainly impacted because they will have to train their staff to use these devices. There is an expectation that the technology will work in such a way that their claim only pay if there is verified visit. As you can imagine, the complexity behind that is enormous. And then members will have to get used to the fact that the device is being used.

And when I say the device, sometimes it's a cell phone. Like, it's an app on your phone, right, you can imagine it. Other times if no cell service is available in that area or there's other complications with using an app on a cell phone, there might be an actual fob device in the home. Maybe it's just inside the spice cabinet and they're using that. Or they can dial into the agency that way.

So there are a few different ways it can happen, but you can imagine there's a member experience of that going on. So as we're implementing, we're considering all of that. And really, the updates for you today are there's no update on the RFP. We're still in that process. We hope to be out of it soon. We are, in the meantime,

submitting to CMS a good faith -- a waiver request so that we, hopefully, will not have to implement on day one, January 1, 2020, but we get a little bit of an extension, frankly, because of the procurement process and also the desire to really do this as thoughtfully as possible once we have a vendor selected. So that's our status with that.

Any questions about EVV?

MS. SHEN: Hi. Maureen Shen with NJACP.

Are there any plans for stakeholder engagement with the IDD community?

The last meeting that we're aware of that took place on this topic, on EVV, was over a year ago. So I'm just asking if there's any stakeholder engagement, and/or we included also the IDD community and the environmental scan listed on the PowerPoint?

MS. JACOBS: I'm just getting caught up here myself as I'm hitting my 90-day mark in the job. But certainly, we will have member and provider engagement. We'll make sure that we have a special session to reflect specifically the concerns of the IDD community. And I really think that this is something we need to implement as a larger -- as the Medicaid community in the State of New Jersey, because this one will be tricky. And I think the providers will have plenty of technical issues. Members will have perception issues, what is happening

here, and we'll need to walk through all of that together.

MS. BUEHRER: Nancy Buehrer. So thank you for the update.

Assuming that CMS gives you the waiver and knowing it will take six months from when a vendor is chosen, do you expect in the next month perhaps that the RFP be awarded?

MS. JACOBS: That would be exciting.

CHAIRWOMAN SPITALNIK: I would posit that that's beyond the control of the Division of Medical Assistance and Health Services and resides elsewhere in State Government.

MS. JACOBS: It does. Thank you.

This is my last slide. I don't know how many folks followed this bill when it moving through the State House, but this is legislation that addresses the partnership between DMAHS and the counties with respect to Medicaid eligibility.

(Slide presentation by Ms. Jacobs.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

CHAIRWOMAN SPITALNIK: Theresa.

MS. EDELSTEIN: Thank you for this, Jen. It's

helpful to hear this. Just a couple of questions.

At what point will stakeholders know what the rewards and penalties look like, and who was included in the stakeholder portion of the development? So that's my first question.

My second question is, in the beta set of counties -- and I know there's sort of different schools of thought on this -- but did you include at least one county that has significant volume where you know there are problems so that you can really road test this system with a problem county?

And my third question is, is this customer service liaison team available to providers who are working with applicants, like in a residential setting?

MS. JACOBS: When we would make that public, I think it's important that we have that conversation with the counties, obviously. And then as we are finalizing that, we'll be able to share it with you.

And with respect to the stakeholder input, we really took a very meaningful approach to this, frankly. We took the eligibility issues that we hear people saying they have, and we looked at the different options through that lens. So in a few ways, most of you have actually participated in that process. We just took your issues because we know them. And you are not shy about sharing

them, and we know them well.

Road testing with the counties, so do you want to speak to that, Heidi?

MS. SMITH: We first had to work with the smaller counties just to see how it worked. So in the first rendition, we pushed this in full functionality. The next the beta test, we would be bringing in the larger counties like Ocean, Passaic. But we first have to give full functionality to the two, that's going to be Salem and Mercer. And then during the course of November, December, the rest of them will go on.

MS. JACOBS: So the beta counties right now are Salem and Mercer. Mercer's got a significant chunk of volume, and they're good partners to us.

MS. ROBERTS: There was the last question about the providers' access.

MS. EDELSTEIN: Right, the customer service team, is that available to providers that assist applicants?

MS. SMITH: So we've always had a customer service liaison team. This just sort of legitimizes what we've been doing. So that really hasn't changed for us. It is under the state monitoring unit of the conduit contract. And then we have Jody in the Director's Office where issues for consumers come in and then they're able

to be addressed.

MS. EDELSTEIN: I just know that in the past, we've been told to direct provider issues related to eligibility to Kathy Martin. So I just want to be sure what's supposed to happen.

MS. JACOBS: We can drill down into that at another time. I think it depends on whether it's an individual member issue or a trending issue, a systemic issue, but we can dig into that with you.

CHAIRWOMAN SPITALNIK: Thank you.

Josh.

MR. SPIELBERG: I may ask multiple questions, too. So the first one is the statute speaks to application process and eligibility determination. The eligibility determination not only on initial application but on renewal or when new information is reported. Are you looking at all of those processes?

MS. JACOBS: Yes.

MR. SPIELBERG: Secondly, the criteria that you're using or the metrics, I'm unclear. You said you drafted out reasonable incentives for year one. Have you drafted out the criteria that you're using, the statute lists a few criteria but it says included but not limited to.

MS. JACOBS: I'm so sorry. I did not

understand the question.

MR. SPIELBERG: So when you're evaluating the performance of the county or you're also evaluating the State eligibility agency, what criteria are you using? Are you using accuracy? Are you using speed? Have you drafted those things out?

MS. JACOBS: Heidi, I'm going to give one-second answer and then you can give the full detail.

We have metrics already in use which we can describe to you. And then we have these new incentives that we're also developing. So there's kind of a little bit of both, to answer your question.

Heidi, do you want to give the specifics there?

MS. SMITH: Josh, if you would just indulge us. We wanted to have conversation with the CWA. We've been talking and working with them since the summer telling them this was coming. In November at the CWA Director's, we said that we would go through with them what we put together based on their feedback and the legislation. So we'd like to first let them see all the details first before we talk about it here, all the details that you're asking the MAAC.

MR. SPIELBERG: Okay. It just might be helpful if you get stakeholder input on those categories. If you're taking it to the County, stakeholders might have some ideas, too. You don't have to do it at this meeting,

but if you could reach out. Stakeholders may have some ideas about that.

MS. JACOBS: Thanks, Josh.

MR. SPIELBERG: And the other thing, I'm a little unclear about the liaison. The statute talks to an ombudsman being identified. So is there a specific ombudsman, or is it a team?

MS. JACOBS: That was in the original legislation, Josh, but not actually in the bill that was signed at the end of the day. And I wasn't here for that legislative process, so I don't know how that evolved. So there is not an ombudsman in the bill.

MS. LIEBMAN: I just wanted to reaching out to stakeholders for input into the criteria being used for rewards and penalties. I appreciate that you're talking to the CWAs, but I think those representing consumers/beneficiaries would have a lot to offer here.

MS. JACOBS: Okay.

CHAIRWOMAN SPITALNIK: So we have gone through a tremendous amount of information. I will attempt to pull out the items that need to be addressed in the future. That doesn't guarantee that they're on the agenda in our January meeting, but they have been raised and are ongoing.

I'm going beginning of the agenda. We had an item raised about behavioral health utilization in Managed

Long-Term Services and Supports; the issues raised in the State Auditor Report on individuals who are in MLTSS but not receiving services; the issues of transitions, including Money Follows the Person, as well as others who are not eligibility for Money Follows the Person but who may have been making transition from hospital to rehab to nursing home. There was interest in digging deeper in an understanding of the decrease in Medicaid enrollment from the last report; the issues of declining population of screening for other programs; an issue raised about clarity about the Personal Preference Program and sharing that information with stakeholders; the New Jersey screen for community services; a request for seeing and understanding that instrument. There was a request about the private duty nursing screen in terms of the Division of Disability Services; new guidance around WorkAbility, as well as publicizing WorkAbility. I reiterate the request for stakeholder input on the 1115 Demonstration Amendments; an update on the autism benefit and clarity about that; an update on doulas; the interest in both continued update on the electronic visit verification with special reference to the community of intellectual and developmental disabilities providers; an interest in seeing the draft performance standards in terms of the improved eligibility; and the stakeholder input, both from

the county perspective, but also from the beneficiary perspective and the criteria for eligibility.

Anything else?

UNIDENTIFIED SPEAKER: I've asked for this before, but it would be helpful if we would get periodic updates on the number of individuals with intellectual and developmental disabilities who are in nursing homes under either the Community Care Program or MLTSS.

CHAIRWOMAN SPITALNIK: Thank you.

MS. ROBERTS: I like what you said. Everything was great. With regard to PDN, I'm wondering if it can be a bit broader where we can actually get numbers, because there are some children PDN, EPSDT, some are MLTSS. Just some numbers so we can sort of see the big picture. And then CSOC, I think Gwen had mentioned something with regard to CSOC and exactly what's happening there for children.

CHAIRWOMAN SPITALNIK: Thank you.

UNIDENTIFIED SPEAKER: Regarding of the autism services, can the other people start putting together the network of providers so that when the legislation finally comes through, you don't have to then begin with a three or four-month process, at least, of creating a network before anyone is able to actually access services.

CHAIRWOMAN SPITALNIK: Thank you for that.

UNIDENTIFIED SPEAKER: As a provider, we would love to begin that process even though everything is not set up so that as soon as everything is in place, children can start getting the therapy that they need.

CHAIRWOMAN SPITALNIK: Thank you.

I think this brings us, at least, to the end of our endurance, if not our time. I, again, thank everyone for their consideration of our need to move along.

Do I have a motion to adjourn?

MS. ROBERTS: Motion to adjourn.

MS. EDELSTEIN: Second.

CHAIRWOMAN SPITALNIK: We are adjourned. We will publish the dates for the 2020 meetings as soon as they are confirmed. The next quarterly meeting will be in January of 2020. So we will publish those dates.

Thank you all, and thank you particularly to the staff of the Division of Medical Assistance and Health Services.

(Meeting adjourned at 12:40 p.m.)

CERTIFICATION

I, Lisa C. Bradley, the assigned transcriber, do hereby certify the foregoing transcript of the proceedings is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate transcript of the proceedings as recorded.

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Lisa C. Bradley, CCR

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