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

November 22, 2013
10:00 a.m.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:

DR. DEBORAH SPITALNIK, PH.D.
SHERL BRAND
MARY COOGAN
EILEEN COYNE
THERESA EDELSTEIN
JOSE JIMENEZ, JR.
DENNIS LAFER
BEVERLY ROBERTS
DR. SIDNEY WHITMAN
WAYNE VIVIAN

MEMBERS NOT PRESENT AND EXCUSED:

MARY BOLLWAGE
DOROTHEA LIBMAN

STATE REPRESENTATIVE:

VALERIE HARR, Director
Division of Medical Assistance and Health Services

Transcriber, Lisa C. Bradley
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ATTENDEES:

Evelyn Liebman	AARP
Dan Keating	Alliance for the Betterment of Citizens with Disabilities
Cathy Chin	Alman Group
Jennifer Langer Jacobs	Amerigroup
Amy Smith	Autism New Jersey
Tom Grady	Brain Injury Alliance of New Jersey
Wendy Leore	Bristol Myers Squibb
Dean Roth	Burlin Consulting
Osato Chitou	CarePoint Health Plans
Lisa Knowles	CarePoint Health Plans
John Guhl	Centers for Medicare & Medicaid Services
Dominique Mathorin	Centers for Medicare & Medicaid Services
Nicole McKnight	Centers for Medicare & Medicaid Services
Felicia Wu	Centers for Medicare & Medicaid Services
Sue Saidel	Essex Court
John Indyk	Health Care Association of New Jersey
Andrea Cotton	Health First Plan of NJ
Chrissy Buteas	Home Care Association of NJ
Jean Bestafka	Home Health Services & Staffing Association
Mark Calderon	Horizon NJ Health
Karen Clark	Horizon NJ Health
Len Kudgis	Horizon NJ Health
Howard Lu	Horizon NJ Health
Joseph Manger	Horizon NJ Health
Erhardt Preitauer	Horizon NJ Health
John Covello	Independent Pharmacy Alliance
Phil Lachaga	Johnson & Johnson
Josh Spielberg	Legal Services of New Jersey
Christine Fares Walley	LIFE St. Frances
Carol Katz	Katz Government Affairs
Colleen Smith	Matheny Medical & Educational Center
Frank Cirello	Mercer County Board of Social Services
Michele Jaker	MJ Strategies, LLC
Phillip Lubitz	National Alliance on Mental Illness
Mary Abrams	New Jersey of Mental Health & Addiction Agencies

ATTENDEES:

Debra Wentz	New Jersey of Mental Health & Addiction Agencies
Maura Collinsaru	New Jersey Citizen Action
Amanda Melillo	New Jersey Health Care Quality Institute
Sarah Lechner	New Jersey Hospital Association
Ray Castro	New Jersey Policy Prospective
Selina Haq	New Jersey Primary Care Association
Brian Kelly	Novo Nordisk
James McCracken	Ombudsman
Julie Caliwan	Open Minds
Karen Shablin	Optum
Matt D'Oria	Perform Care NJ
Mary Kay Roberts	Riker Danzig
Cris Ciobaner	Rise
Barbara May	Southern New Jersey Perinatal Cooperative
Deepa Srinivasavaradan	SPAN
Tony Severoni	Sunovion
Vincent Ceglia	United Healthcare Community Plan
John Kirchner	Wellcare
David Drescher	Office of Legislative Services
Michael Fahncke	Office of Legislative Services
Brian Francz	Office of Management & Budget
Mark Moskovitz	Office of the State Comptroller/Medicaid Fraud Division
Pauline Lisciotto	Department of Health
Bonnie Teman	Department of Health
Dawn Apgar	Department of Human Services
Freida Phillips	Department of Human Services
Andrew Robertson	Department of Human Services
Devon Graf	Division of Aging Services
Lou Ortiz	Division of Aging Services
Janet Hand	Division of Developmental Disabilities
Elizabeth Manley	Division of Children & Families
Karen Kasick	Division of Family Development
Karen Brodsky	Division of Medical Assistance & Health Services
Carol Grant	Division of Medical Assistance & Health Services
Kim Hatch	Division of Medical Assistance & Health Services

ATTENDEES:

Roxanne Kennedy	Division of Medical Assistance & Health Services
Dr. Tom Lind	Division of Medical Assistance & Health Services
Phyllis Melendez	Division of Medical Assistance & Health Services
Heidi Smith	Division of Medical Assistance & Health Services
Irene Stuchinsky	Division of Medical Assistance & Health Services
Mollie Greene	Division of Mental Health & Addiction Services
Cheryl Sessons	Division of Welfare/Medicaid Essex County

DR. SPITALNIK: Good morning. I'd like to invite us all to begin with a moment of silence in memory of the tragic events 50 years ago.

(Moment of silence)

DR. SPITALNIK: Thank you.

Good morning. I'm Deborah Spitalnik. I'm the Chair of the Medical Assistance Advisory Council (MAAC). It's my pleasure to welcome you to this quarterly meeting.

We have a new location, as you have noticed, steeped in New Jersey history, named after General Norman Schwarzkopf's father, and I want to thank the Division of Medical Assistance and Health Services (DMAHS) for finding an environment that we could have better visibility and better interaction.

You will also notice that we have changed the length of the agenda to incorporate our business. I need to, however, begin with the Open Public Meetings Act, and to recognize that public notice for this meeting was filed with the New Jersey Secretary of State on December 17, 2012. The notice was published on the Department of Human Services (DHS) website, the Medical Assistance Customer Centers (MACC), County Boards of Social Services (CBSS), and appeared in a variety of New Jersey publications, and was published

in the New Jersey Register.

For those of you who are new to our process, we have prided ourselves on the ability to engage with all of you as stakeholders and as members of the public throughout the course of the meeting rather than through an isolated comment period. But what we will do is that as an issue is brought up, members of the MAAC have the opportunity to speak first, to ask questions first, and then I will call on the public.

I would ask that you be respectful of time limits and our shared commitment to be able to keep the ebb and flow of dialog going, which I think captures the essence of one of the aspects of our role of seeking public comment and stakeholder involvement.

In terms of membership, I am pleased to announce that the Department of Human Services has brought forth names to the Governor's Office of Appointment for individuals who have been serving on the Council but continuing to serve until reappointed.

We're delighted that, from the Department's perspective, that the reappointment nomination of Wayne Vivian, Mary Coogan, Dot Libman, Dennis Lafer, and Mary Lund have been moved forward.

Let me just review our agenda. We will look for approval of the Minutes. We will discuss the

Medical Assistance Advisory Council Guidelines. We will talk about the new NJ FamilyCare, and Valerie Harr, the Director, will brief us on that. We will also have informational updates, as listed on the agenda. We will announce our dates for 2014 and entertain any other business at that time.

We have a couple of items for follow-up, but let me start with turning to the members of the MAAC for an approval of the minutes of our last meeting, which was June 10th of 2013.

Do I have any comments or corrections?

Any comments or corrections from the public?

May I have a motion for the Minutes motion?

MS. ROBERTS: I motion.

DR. SPITALNIK: A second?

MS. COOGAN: I second.

MS. ROBERTS: Second.

DR. SPITALNIK: Mary Coogan -- I'm going to let Bev second it, since she had no questions.

All those in favor?

MAAC MEMBERS: Aye.

DR. SPITALNIK: Opposed?

Abstentions?

MS. COYNE: I do. I wasn't here.

MR. JIMENEZ: Yes.

DR. SPITALNIK: Abstentions, Coyne and Jimenez.

The Minutes are approved as written.

And then this gives me the opportunity to thank our transcriber, Lisa Bradley, and Kim Hatch for this excellent record. Thank you.

One of the things that I want to recognize is Director Harr and the staff of the Medical Assistance Advisory Council for is the work to get materials to the members earlier, prior to the meeting, which is a Herculean effort, not only given the workload of the DMAHS, which you'll hear about, but also because some of the information comes from other sources. So I want to, again, thank and commend the Division.

What we will try to do going forth is as non-confidential materials are sent to the MAAC members, the Division will post them on the Division's website. So if you are interested in seeing materials before the meeting, you need to take the affirmative step of going to the website and then advising your constituency. But I think that will provide yet another increased level of public engagement. So thank you so much for that.

What we are turning to now on our agenda is

the Medical Assistance Advisory Council Guidelines. And I need to explain both what those are and what this process, which has been relatively protracted but I think importantly detailed, is.

For a state to have a Medicaid program, we are required by the Federal Medicaid both law and regulation to have an Advisory Council. The guidance in the federal regulations is fairly vague, but through a lot of work of the Division, Phyllis Melendez, and Bob Popkin, the Council to Medicaid, a series of guidelines have been developed for our functioning to govern our operation.

The Guidelines are drafted. A subcommittee of the MAAC, Mary Coogan, Bev Roberts, and myself, have met continuously with the staff of the Division. As a draft document, the steps in the process are that we as a MAAC have to approve them for transmittal to the Commissioner of the Department of Human Services who will then transmit them to be turned into an Administrative Order. So our functioning will be governed by a State Administrative Order.

So depending on our action, even if these move forward, we are still not necessarily in full compliance with them today.

So the members of the MAAC, you've had the

opportunity to review these draft Guidelines. Are there comments, suggested changes?

MR. LAFER: Yes.

DR. SPITALNIK: Dennis Lafer.

MR. LAFER: I think the rest of the Guidelines look very good. I would like suggest that the opportunity for draft agendas to be sent to the members of the MAAC ahead of time so that we would have the ability to comment on them before the final agenda is set.

Secondly, what was done this time was excellent, that there was an opportunity to review many of the materials that were going to be discussed today ahead of time. It may not always be possible, but to the extent it is possible, I'd like to be able to review documents prior to the meeting.

DR. SPITALNIK: Thank you.

Do other members feel that this needs to be part of the written Guidelines, or is it part of the good faith process of working together?

MS. ROBERTS: I think the advantage of having it memorialized is I think based on what we saw this time, it worked really, really well. But we are doing this for something that's going to be in effect for the future when we don't know who is going to be

the Chair, who is going to the Director of DMAHS, et cetera. So I think it would be helpful to have something added even to the sentence where it says, "All proposed agenda shall be reviewed by the Chairperson," it could be the Chairperson and the members of the MAAC before each regular or special meeting, or something very simple like that.

I don't think I have any concern about the way things are going at this point, but, again, my concern would be looking down the road in the future.

MS. COOGAN: I agree.

MS. BRAND: Agree.

DR. SPITALNIK: Other thoughts about?

I would like to ask Director Harr if that poses an administrative constraint for you, or if there's some way of honoring the spirit of this that would not be overly burdensome, given your staffing and other responsibilities?

MS. HARR: We could do that. Thank you, Dennis. It's a challenge to get materials out in advance of the meeting. We'll continue make our best effort to do that. So as long as it's not some sort of mandatory requirement for us. And then every effort should be made to provide materials in advance to the MAAC members. That would be fine.

DR. SPITALNIK: So do we need specific language before people feel comfortable with this, or can we take the spirit of that and then --

MS. ROBERTS: I'm comfortable with what Valerie just said.

MS. BRAND: Yes, the statement that the agenda will be distributed in advance to MAAC members and all effort will be made to also provide other materials in advance.

DR. SPITALNIK: Okay. Thank you.

Any other comments?

Any comments from the public?

Would you stand up and introduce yourself.

MR. LUBITZ: Phil Lubitz. I was wondering if the MAAC has By-laws?

DR. SPITALNIK: Yes. Perhaps I was remiss in not reviewing this. I know this has been distributed, but let me just review that the Guidelines, the sections include objectives and functions which reflect the federal law. It speaks to appointments and membership of 12 members up to 16. Terms, direct appointment through Governor's Office by the State Board of Human Services. The intent IS to reflect the diversity of the beneficiaries of the Medicaid program of the state. It provides for

officers, committees, how we provide recommendation. By-laws are covered by meetings, quorum, and voting. How we amend these rules of order are in terms of the Open Public Meetings Act and the Robert's Rules of Order will govern all meetings.

MR. SPIELBERG: Yes. Josh Spielberg from Legal Services of New Jersey. So I think what you're talking about has not been distributed to the public at-large so it may be a little hard for people to follow. And you started out by saying that when materials went to the MAAC, at least in the future, they would posted on the website. So I just wonder if what you're talking about could be posted on the website so in case members of the public have comment on that, that would be available. I don't know if this is something that can be postponed to a vote until next time or not, but I would raise that as an issue.

DR. SPITALNIK: Thank you for that. I'd ask the perspective of the MAAC members in terms of the length of time and also Director Harr in terms of the Department's concerns about making sure that, particularly given the role of the MAAC with the Comprehensive Medicaid Waiver (CMW) and other important changes, whether you feel comfortable postponing this further?

I thought these had been distributed previously, because this has been going on quite a while. But I ask your pleasure.

MS. HARR: So we just heard that there needs to be an amendment to one item. I would prefer that the MAAC agrees to finalizing it with the amendment today. It could be voted on today, and when approved, we would post it to the website so that it's available to the public for review.

DR. SPITALNIK: Thank you. So that is perspective from the Division.

What's the MAAC's perspective on this?

MR. JIMENEZ: I would support that. Having reviewed the Guidelines, there doesn't seem to be anything here that is overly overt or overshadowing. And I'm sure that if there were some comments from the public that really needed to be addressed, we can address that when it comes and make the necessary amendments. So this, in fact, would make us diligent in proceeding with the guidelines and we have something to guide us in our activities.

DR. SPITALNIK: Thank you.

Any other comment?

MS. ROBERTS: What I'm hearing is if it were approved today and then posted and there were comments

of significance, that we would then take up that feedback.

DR. SPITALNIK: No. If we approve it today, we are approving it for transmittal to the Commissioner from the MAAC. That's what approving it means. And then it goes forth from the Commissioner as an Administrative Order. I assume any comment that was received to the Department after that, in no way do I mean to cut off public input. These are very general. But either we table them today, or we approve them for transmittal. I think those are our only two choices at this point. And we have been laboring for a long time without a full complement of membership. We're up to a full complement of membership. I have some feeling that it would be important to have this administrative base underlying our activity. And let me remind myself and all of us, this is not a fast process going forth. So it's a question of whether we want to take another year, so...

MS. BRAND: In reviewing this, I do agree with all of the comments. I know there is a provision for amendment to the Guidelines. So to speak to Director Harr's comment, I think it would be appropriate to go ahead and move forward, unless there are other reasons not to, make the recommendation to

move this to the next point.

But one thing that I don't see in here is I think there should be some minimum timeline for review of the Guidelines, perhaps on an annual basis or some other time frame. Just like it's customary to review By-laws at a certain time and that would occur via a subgroup of the MAAC members, at which point any recommendations could then be presented to the public.

DR. SPITALNIK: I hear the spirit of what you're saying. We can review them. But if we then recommend changes, then the Commissioner is in the position of requesting a new Administrative Order. So even when we approve these, we are not governed by them. We're governed by the spirit of it, but it is an Administrative Order which is a process that's very lengthy. So if we choose to amend these on an annual basis, we will probably be in the same kind of limbo of authority that, in effect, we are now.

MS. BRAND: There is a provision in here, though, to amend the Guidelines.

DR. SPITALNIK: It is, which is what we're doing now. We're amending a set of Guidelines. But if we build in an annual review, we will not likely have an annual new Administrative Order. The provision is there if there's a felt need.

MS. EDELSTEIN: I want a clarification. If we review them and make no amendments, does the Administrative Order change?

DR. SPITALNIK: No.

MS. EDELSTEIN: So it stays the same.

DR. SPITALNIK: Yes.

MS. EDELSTEIN: So there's no harm in building in a year or every two review. If we have to make an amendment, there's probably a pretty good reason for making the amendment that would warrant going through the process, just like when you make a By-law change, it's an arduous process in any organization. So I hear what you're saying, but I think in the spirit of keeping up with the changes in the Medicaid program over the next several years, there may be amendments that need to be made.

DR. SPITALNIK: There's nothing that precludes us from having an annual review. The question is whether we want to detail that here, because I just want to mention that the process of appointment is outside of these Guidelines. It's still within the Governor and the State Board of Human Services. So trying to reflect changes in the composition of the MAAC or things like that would not necessarily be affected by the Guidelines. But that's

a different process. But it is our decision as a MAAC to make. So is there a motion amend that addition to the issue of the agenda, is there a motion to proscribe an annual review of this?

MS. BRAND: I move to amend to incorporate language that would speak to an annual review.

DR. SPITALNIK: Is there a second?

MS. EDELSTEIN: Second.

MS. ROBERTS: May I suggest. I just wanted to say it could be an annual or every two years. No one knows what's coming down the road in the future, and I think that I'm comfortable with the way things are now, and I'm not hearing that anybody isn't comfortable with the way it is now, but we don't know what might happen. So I don't see any harm in having a review, which might very well produce no changes at all. And as Theresa said, if changes are recommended, it probably would be for a very good reason.

DR. SPITALNIK: So we have a motion on the floor for an annual review. There was a suggestion of two years. Is that a friendly amendment that the mover accepts?

MS. BRAND: Yes.

DR. SPITALNIK: Okay. So the motion on the floor is that these be reviewed at least every two

years.

Are we ready to vote on this motion?

All those in favor of these being reviewed at least every two years?

(Show of hands.)

DR. SPITALNIK: Seven.

Opposed? Jimenez.

Abstentions?

Okay. We will include language that these be reviewed at least every two years.

Are there any other changes or recommendations that people would like to make?

Are we ready, with these changes, approve these and transmit them to the Department of Human Services?

If so, may I have a motion to that effect?

MR. JIMENEZ: So moved.

DR. SPITALNIK: Jimenez moves that will vote to approve them.

A second?

MS. COOGAN: I'll second.

DR. SPITALNIK: All those in favor.

MAAC MEMBERS: Aye.

DR. SPITALNIK: Opposed?

Abstentions?

We are moving these forward. Thank you very much. And I, again, want to thank Phyllis Melendez for her staff support.

And with that, I turn to Director Valerie Harr, to the Director of Division of Medical Assistance and Health Services to discuss the new NJ FamilyCare.

MS. HARR: Thank you.

On October 1st, our program went through some significant changes and continues to go through changes, in that New Jersey has elected the optional Medicaid expansion. So beginning October 1st, we are accepting applications for parents and caretaker relatives up to 133 percent of the poverty level, as well as single adults and couples without dependent children, age 19 to 64, up to 133 of the poverty level. For those newly eligible individuals, the methodology for determining eligibility is now through Modified Adjusted Gross Income (MAGI), as well as this new methodology applies to almost all of our Medicaid population, really with the biggest exception being the Aged, Blind, and Disabled Program. But our traditional Medicaid categories, there is a new methodology, in accordance with the new health law, called MAGI, and it is a tax-based system. So it's different way of, looking at household composition and looking at

essentially gross income. So it's a difference from how we have previously been calculating financial eligibility.

We have a streamlined application. So for essentially anybody but the Aged, Blind, and Disabled, we would encourage online application through njfamilycare.org. You can also go to healthcare.gov. So again, the healthcare.gov and the streamlined application are not for people applying for our Aged, Blind, and Disable Program. Although, you could complete one of these applications and we try to get people to the right door if they indicate that there is a disability. We would try to get that person into the appropriate program.

So there's a screen shot of our new NJ FamilyCare online application. The application can be downloaded and printed in English and Spanish, or you can apply online by answering the questions and going through the application. It very much mirrors, the streamlined model application distributed by the federal government.

(MS. HARR conducts a presentation on the new NJ FamilyCare).

DR. SPITALNIK: Thank you so much, both for that excellent update, but most significantly for what

has been accomplished.

I'd like to ask you about the training and the materials. Are people from the deaf community being trained in terms of outreach and is there an effort for accessible materials in alternative formats?

MS. SMITH: When people sign-up for training, one of the questions, besides the location that you would prefer your training, is if you have any special needs. You can click the radio button. And then someone personally will reach out to you to see what those needs are, and you will be accommodated at the training.

DR. SPITALNIK: Thank you.

Questions for Director Harr from the MAAC first.

MS. ROBERTS: The screen from the online application, question No. 3 says, "Are you disabled?"

Now, in the sample it says, "No." But then underneath it says, "If yes, you can continue with this application or you can..."

But you would say that for the ABD, it's not appropriate for them for them to do this application?

MS. HARR: We had met and we took your feedback very seriously. So we changed the flow here. So if you answer yes, you can still continue with this

application. But if click where it says "click here," it will take you to our website. It gives you information about going to a county welfare agency and applying for an Aged, Blind, Or Disabled, or other Medicaid program.

MS. ROBERTS: So, if they click yes, and they just want to continue --

MS. HARR: They continue with the application. They keep going through questions.

MS. ROBERTS: Okay. But earlier you had said that really this is not geared toward the ABD.

MS. HARR: It's not. So if you want to apply for and you need nursing home level of care or you want Age, Blind and Disabled Program, this is not the application for you. But you had given us examples of people that have a disability, but they don't qualify for another medical assistance program. You can have a disability and still qualify for the MAGI-based program or for the expansion program. It also is an indicator because if you're eligible under the expansion population but you're medically frail, that opens up a different set of circumstances. So it's also trying to capture somebody who may be medically frail but eligible under the Medicaid expansion population.

MS. ROBERTS: All right. Thank you.

Then my other question is: For people who are going to get Medicaid expansion and would like to be covered January 1st, but here we are at the very end of November at this point, is card cutoff still the middle of the month? So what would happen if information doesn't come to you until the middle of the month or later, are they going to able to be covered January 1st.

MS. HARR: Yes. Coverage for January 1st could occur with individuals that are made eligible through especially the last week of December. Managed care selection and enrollment would not occur for January 1st. So if they're Medicaid eligible, there would be a period of Fee-for-Service (FFS) until the enrollment goes into effect.

MS. ROBERTS: But they still would have the coverage.

MS. HARR: Yes.

DR. SPITALNIK: Other questions from members of the MAAC?

MS. COOGAN: Going back to the file exchange. If this isn't fixed do we have a plan as to what might happen? Are we going to suggest to people that they reapply?

MS. HARR: I think we have to continue to work with CMS, because I don't think CMS would want us telling someone to reapply. So I know that CMS is very, very concerned about getting the transfers functioning. We've also asked CMS, to expand the fields that are in the flat file so that we have enough information. I've made it known to CMS at the highest level that I'm very concerned about these applicants. I think every state is, and I'm sure CMS is very concerned too. And I'll make the efforts to get the account transfers functioning. But there's a risk. There is definitely a risk there's going to be a gap in coverage for those individuals.

DR. SPITALNIK: Wayne.

MR. VIVIAN: Will this information go directly to the State, or does it go to the County and then to the State if they do the application online?

MS. HARR: So if they go njfamilycare.org and apply, the system is set up that some cases go to a county and some go to Xerox, our Health Benefits Coordinator. Some are going the County Welfare Agency (CWA).

MR. VIVIAN: Will it take longer if the goes to the county? The person won't know where it goes?

MS. HARR: Right. I don't think the

applicant knows where it's going.

MR. VIVIAN: It doesn't go into effect January 1st anyway.

MS. HARR: Right. Coverage begins January 1st.

One of the things that we've done for the expansion, if the application looks like it's for the expansion population, the single adult or couple without dependent children, if they are above the cash assistance level right now, someone can be run through the old rules first. Those cases are being sent to the counties. Anybody above 24 percent of poverty, those applications are going to Xerox. So we are trying to maximize the opportunity that Xerox has to process the MAGI applications. Aged, Blind and Disabled applications still all go to CWAs. And I think they traditionally take longer.

MR. VIVIAN: I just worry about things getting lost in the transition.

MS. HARR: Well, it's electronic. So when you apply to njfamilycare.org, it is electronic information that goes to a CWA, and they are pulling up screen shots. So it's not a paper transfer.

MR. VIVIAN: Okay. So how does the applicant provide documentation of income?

MS. HARR: Anything that can be verified electronically, we do. They have access to different databases, including wage and labor data. Both Xerox and county welfare agencies should be verifying as much as they can electronically. If they can't verify something and there's missing information, they outreach the applicant.

MR. VIVIAN: And can it be faxed, or has to be delivered or mailed?

MS. HARR: I think that would vary by county welfare agency. I'm sure Xerox takes faxes.

MR. VIVIAN: I'm just thinking like for the case managers who do a lot of this work for their clients, how will that process go if they do the application online? We know how it goes now with the paper transfers and all those kinds of things.

MS. HARR: Well, the MAGI is a streamlined process, and as much should be verified electronically as possible. That's what we are all striving to work. Toward so, hopefully, the determinations will be made quicker for these cases.

DR. SPITALNIK: Thank you.

Dennis.

MR. LAFER: Thank you. I was wondering if you could talk a little bit more about the 510. I see

these are the MAGI people who have enrolled, so we're in this period of time where, I assume, applications are taken but you can't formally enroll until January 1. So if this were to say applications through October versus -- what would that number be?

MS. HARR: They all must be people that have coverage beginning January, because they can't have coverage beginning on our MAGI calculation now. So they are teed up for January. That's it. The number, I know, is growing for the month of November, but I don't have a final November number.

MR. LAFER: If I remember the past numbers you talked about, so if we look at MAGI, the new populations, we're talking about one hundred to 150,000 people.

MS. HARR: Yes.

MR. LAFER: So this is 510 that number?

MS. HARR: That's right. So we have a long way to go. That's the bottom line. It's very small. I know the number is growing for November. But I would say that the is out of basically the hundred-some thousand newly eligible population that we're trying to get coverage.

DR. SPITALNIK: Theresa.

MS. EDELSTEIN: Thanks for the update. We

have a few questions.

Valerie, can you clarify? Has the State Plan amendment (SPA) process for the Alternate Benefit Plan (ABP) been completed? Is that all processed at this point?

MS. HARR: It has not been filed. The State Plan Amendment doesn't have to be filed until March 31st; but, we have a draft that hasn't been filed yet, but it should be filed soon.

MS. EDELSTEIN: My second question has to do with the ABP and the eligibility process for them. Given your comments about past implementation, we don't have to rehash the delays in eligibility determinations at the county level, depending on which county you're in, but is there a plan for addressing that? It affects not only people in the nursing home, but people in the community awaiting eligibility who can't be served. What's the approach to that if Medicaid doesn't go first in going forward with the Consolidated Support System (CASS).

MS. HARR: That's under review now. It's part of a CASS discussion and the re-strategizing. So I can't answer it now, but I can tell you it's a serious consideration of what we're going to do when discussing how CASS will function and what we can do to

continue our efforts to modernize the determination process for Medicaid.

DR. SPITALNIK: I'll note that is an agenda item to pick up next meeting in January, at least for an update. Thank you for that.

Any other questions from the MAAC before I open this to the public?

I will now open this to the public for brief questions for Valerie.

Yes. Please stand up and give us your name.

MS. COLLINSGRU: Maura Collinsgru with New Jersey Citizen Action.

As you know we have been really promoting the NJ FamilyCare website, driving as many people as we can. In this room, I'll say the numbers look pretty abysmal right now, given all of the work on the ground that's going to drive people, so I had a few questions.

In terms of the letters that are being sent out, can those letters be shared with us?

And second, can you clarify who will be auto-enrolled and who is just being given the option to enroll? And are there any stop-gap measures for people we are throwing off the rolls who can't get into another plan because the system's not functioning yet?

DR. SPITALNIK: Let me ask everyone to try

to break down your questions.

MS. HARR: So the njfamilycare.org website is working and is working well. So I would encourage you to continue to use it and to keep people applying there.

The numbers are very small. So we need you to be working to take the training opportunity we have and to be working and having people apply.

So the numbers that came out of the federal Marketplace are still small. Our numbers are still small, but in October we were just beginning. So I feel very optimistic that we'll continue to see enrollment growing.

Again, we were No. 2 in Medicaid applications to the Marketplace for the month of October. And we have seen the same; it was almost matching numbers of what's happening at njfamilycare.org.

For those that have their coverage terminated because our federal authority to cover them expires under our waiver, that's why the letters went out when they did, to give them enough opportunity to apply to the Marketplace for coverage. They have until December 15th to apply and enroll through the Federal Marketplace for subsidized or Marketplace coverage. So

the letters went out on November 8th. They will have a month to enroll through the Marketplace.

MS. COLLINSGRU: Does it tell them where to go to apply, give them navigator information?

MS. HARR: No. If there was just one navigator number, we would offer a navigator number. We gave them the healthcare.gov website and phone number. The letters that have been sent, we are going to post them to our website for the MAAC and the public.

DR. SPITALNIK: Thank you.

Yes?

MS. BESTAFKA: Thank you. I've already gotten three copies of the letter this morning from people. So people who are even currently enrolled in NJ FamilyCare should go to www.healthcare.gov, because you were already aware of them, correct? The letter that said your insurance is going to be discontinued.

MS. HARR: They're no longer eligible for NJ FamilyCare, that's why they got the letter, because they're over the 133 percent of the poverty, so that's why they should go to healthcare.gov so they can go to the Marketplace get subsidized coverage.

MS. BESTAFKA: And if by December 31st, if something doesn't happen at healthcare.gov, are you

going to continue to cover them until they get a notice?

MS. HARR: I have no state or federal authority to cover those individuals beyond December 31st.

MS. BESTAFKA: Okay. Thank you. Then my second question is, in your first or second slide, for the parents and caretakers and single adults, is it better for them to go to njfamilycare.org or to go to healthcare.gov?

I was very confused about how the system's going to work. If they go NJ FamilyCare, you will know exist; if they go to healthcare.gov, you might not.

MS. HARR: I think either one is fine. There's an upside and downside for both. If somebody applies to njfamilycare.org and they're over income, we've got to find a way to get them to the Marketplace. It has to work in order to do that.

If they apply right now to the Federal Marketplace and they're determined Medicare eligible, we have to receive that information from the Marketplace. So I think either one is what we have been suggesting.

MS. BESTAFKA: But not both?

MS. HARR: Not both.

DR. SPITALNIK: Thank you.

Ray Castro.

MR. CASTRO: I have two questions. One is, if you could just clarify what the comparable number is to the Federal Marketplace number of 17,000, because it's not the 500, because they're including people who are currently eligible, as well. So what is the number that's comparable to that?

MS. HARR: I have to go back and check. There are 17,000 applications to the Marketplace who were eligible for Medicaid.

MR. CASTRO: Right. So they could be new eligible or currently eligible?

MS. HARR: Right, newly eligible or currently eligible.

MR. CASTRO: I know you had that first table, but that didn't look like it was cumulative. So I was just a little unclear.

DR. SPITALNIK: I'm in awe of the complexity of this, as I think the rest of the country is.

MS. HARR: I think the comparable number is slide 8. So those are individuals determined eligible for the month of October, but that's not a complete picture because it doesn't include all the county welfare agency activity. But I think that's the

comparable number that we're looking at.

MR. CASTRO: For October?

MS. HARR: Through October, so they would be --

MR. CASTRO: We have to add those two, then?

MS. HARR: Add the two.

MR. CASTRO: All right.

MS. HARR: I think it was 21,000-something, if I remember.

MR. CASTRO: Right. Okay. So we're more than double what the Marketplace said when you add yours, maybe even more than double.

MS. HARR: That's exactly right. That's how I'm seeing it. Except that, as Jean said, I don't know how many of those people have applied in both places yet, how many are duplicates. And I won't know that until we get the data.

MR. CASTRO: Right. But you also don't have the county data.

MS. HARR: Exactly. That's true.

MR. CASTRO: So my second question is that as you know, the State has another option available to them, which is the Basic Health Plan. And I know the State had looked at that a year ago. And this would extend eligible or at least you could extend

eligibility from 133 percent to 200 percent and capture many more people. And a lot of us have interest in this because we're very concerned about the cost sharing in the Marketplace, which frankly we think it's going to be unaffordable for many low-income New Jerseyans. And I know the State had looked at this about a year ago. The regulations never came out. They are proposed regulations. I'm wondering if the State is looking at this. It's a complicated issue, because you have to determine whether it's cost effective to do it or not. And I'm wondering if you have done that analysis and if you have a position on this and if you're looking at it and what the timetable might be for a decision. Because as I understand it, the final regulation will be in March, but you have to make a decision by summer if you want to do it in 2015, which is the earliest you can do it.

MS. HARR: We haven't looked at it since the regulations weren't finalized. We had worked with the Department of Banking and Insurance a year ago, and we could not demonstrate that it was cost effective. I think it's not something that we have been actively looking at.

MR. CASTRO: Okay. I would just urge that the MAAC perhaps consider a recommendation for the

Division or the State to look at this and report back to the MAAC at our next meeting in terms their recommendations.

ATTENDEE: I think the Washington Post reports this morning that there is a fix to allow the Marketplace to transmit accurate information to the insurance companies, so hopefully there's a fix that's going to be in the works very soon to transmit the Medicaid information.

MS. COOGAN: If someone is calling you because they've gotten a letter from the Marketplace to say, "Can I get my insurance," is it possible then for the State to at least try to get those people enrolled? Or do you still have to wait?

MS. HARR: We have to wait for the account transfer. So we have scripted and said "as soon as we get the information on your enrollment, you will be receiving additional information from the State and your coverage will begin," something to that effect.

DR. SPITALNIK: Thank you.

Joe Manger.

MR. MANGER: Joe Manger with Horizon NJ Health. With regard to NJ FamilyCare training, we cannot endorse that enough right now. That program has been phenomenally helpful. We have sent our marketing

representatives through it. And I encourage everyone to attend. Jean, the questions you're asking, will be addressed there.

And also, the other comment is that the Division continues to partner with the health plans. DMAHS always shares specific member information with the health plan so we reach out to those individuals to make them aware of other insurance options. So partnership is critical right now; and we know it continues. And I want to thank you for that. The goal for all of us is to make sure that people get and/or keep their coverage. So I think we're on the right track there.

DR. SPITALNIK: Thank you very much.

Josh.

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

First, I want to say also that I think the Division has done terrific job in being prepared for the Medicaid expansion, and I think it's ahead of many states on a number of these issues. You have the ABP and the enrollment collaboration with other social service programs. So I really think the Division needs to be congratulated on that, and thank you for that.

Two questions: One goes to the 510 slide,

which I think you were working through exactly what that might represent. And I think your thinking right now, Valerie, is that the 510 are the people who have been approved but won't be eligible until January 1st.

MS. HARR: Yes.

MR. SPIELBERG: So that's kind of an important number to watch. They're eligible under the new criteria. And I wonder if you could continue to monitor that, because it should grow in November and in December. And I think that the statistics online are actually the numbers enrolled.

MS. HARR: That's right. The public statistics won't reflect the expansion population until January.

MR. SPIELBERG: But I think the public would be interested in knowing how many people each month in November and December are in this new category who will be eligible January 1st. Some if you could continue work on that. And even if there's a way to add the statistics from the CWAS to that, that would be very helpful.

MS. HARR: Yes, that's the goal. And the counties are working with us. We've asked them to submit the same information in the format under the definitions that CMS has asked and that we've been able

to provide through the Health Benefits Coordinator. So I think the data is only improving as we go through this.

MR. SPIELBERG: And you will try to put that online?

MS. HARR: Yes. Part of it is we'll have coordinate with CMS because if the numbers start to get combined -- these are our State numbers, but CMS may start producing monthly numbers that reflect both, so we'll figure it out. But we'll make sure that we -- yes, we plan to provide the monthly information.

MR. SPIELBERG: And one other short question. Regarding the new eligibility criteria, you've been referring to it as 133 percent, but with the automatic disregard it's actually 138 percent. So I wondered how you are thinking about getting that information out that actually people up to 138 percent are eligible?

MS. HARR: I know that's a nuance.

Heidi, did you want to clarify?

MS. SMITH: We only apply the five percent if the applicant is not eligible at the 133 percent level. It's something our eligibility process does. We speak of and write about 133, but we use 138, if we need to. Everyone isn't eligible at 138 percent of the

Federal Poverty Level (FPL).

DR. SPITALNIK: Thank you.

Beverly. And then I'd wrap this section up if we can so we can move on.

MS. ROBERTS: I think what might be helpful, to the extent that you could promote numbers rather 133 percent. If it's promoted as a family of one, or two, etc. If it has a dollar amount attached instead of a percentage, I think that would be so much more helpful to people who don't have a clue where they fit with FPLs.

DR. SPITALNIK: So the way that you're using numbers is an amount of income that would make this process more accessible and understandable.

MS. ROBERTS: Yes.

DR. SPITALNIK: Thank you for that. We have, you may have noticed in our agenda, tried to organize our information a little differently so that there is more of a rhythm to the meeting. So the presentation we just heard on the new NJ FamilyCare had coherence. And what we've tried to do with other items that are both informational, that are new information, or that is information that we have as a group and the public been tracking over time, we've organized that into a section of Informational Updates. And so that

will include now information from Director Harr, but also others who are involved in the Medicaid program across state government. But we'll turn back to Director Harr to begin her section.

MS. HARR: Thank you. We're pleased to announce that WellCare will be serving NJ FamilyCare members, effective December 1st. They will be the fifth managed care organization available to our members, so we're very excited that we have an additional choice for our members. So they will be operational in Essex, Hudson, Middlesex, Passaic, and Union Counties. They are required to be statewide, per our contract by June 1, 2015. And WellCare is a Medicaid managed care program currently in eight other states.

(Director Harr provides an update on WellCare Health Plan).

MS. HARR: With respect to our dual eligible special needs plans, I want to let everybody know that United Healthcare will be leaving the Dual Special Needs Plan (D-SNP) market.

(Director Harr provides an update on D-SNPs).

DR. SPITALNIK: Are there any questions so far from the MAAC at this point?

May we go on?

Thank you.

MR. ARYE: Good morning. So we have a number of updates with regard to Managed Long Term Services and Supports (MLTSS), and the first one is that, as you all know, on September 30th, we made a decision to delay the implementation of MLTSS, until July 1, 2014.

A decision was made on September 30th, and we contacted the Steering it Committee of MLTSS, as well as a number of other stakeholders about this to let them know. We did this because Valerie and I have always said that if we're not ready and the Plans aren't ready, and the providers aren't ready, then we're going to consider that.

And now I'll talk a little bit about readiness. Readiness reviews are both required for the health plans in our Standard Terms and Conditions (STCs) by CMS. In addition, we can also do a readiness review for the State, and the State chose to do that. Readiness reviews have already been in place for the managed care organizations (MCOs) when we moved to managed care over the years.

So, it's an ongoing process where we work with Mercer, who our consultants, to assess State

policies and operations in preparation for the move and MLTSS.

So we started State readiness reviews really in July with Mercer. We did a request for information (RFI) to list out a number of areas. Mercer conducted a desk review of our State policies and procedures, and then actually spent two days with us in late September to actually go through that. So they looked at a variety of issues, which I can go through, including: General administration, marketing informing and enrollment, provider and delivery system management, care coordination, care management, grievance and appeals. I'm not going to go through all of them. There are about 14 of them that they actually go through.

They then sat down with us for two full days where they split us out by area: Fiscal management, care management, et cetera, to go through it. When Valerie and I sat down with them at an exit interview, they really said to us that you all are very far along and doing great things; however, at the same time we're not so sure that you're there yet. But, they said, where you generally are, where most states have been, you're much further along.

So one of the things they said is all of

your staff interact. In many other states, people didn't always work together. Mercer said "you all clearly are working together." You have a created a project management office staff, et cetera.

So they thought that our clinical and operational staff were working very well, that they have assimilated their work in MLTSS with their day jobs.

And please, I need to acknowledge and thank all of the staff who are here and everybody else because they are doing their day job and they're also doing MLTSS.

We've also worked very closely with the care management agencies to ensure our capacity in our current system and beginning to figure out the transition to the move to MLTSS.

We already had a project plan, but now we have a full project plan which we are now implementing. And we also have just created operational workgroups. We have an implementation committee, as well as, now, an operational committee that's much more into the weeds and going through every single step that needs to be done.

The second thing we also did was, as required, and even though we decided -- we knew we were

delaying, but we made a decision to do the MCO readiness review now rather than into the future. We'll be doing more readiness reviews because it's required 90 days before implementation, we need to do readiness for MCOs. But we felt Mercer needed to come in as our consultants to work with them.

So what the Mercer folks did was really an integrated process where they looked at plan preparation, desk reviews, and then on-site reviews. And they did a similar process with the MCOs.

The RFI included a lot of information that they asked for, everything from fiscal management to data management and information technology (IT) issues, similar to what they had asked for us.

I can tell you that State staff also participated in the process not only to hear what Mercer was asking, but also for future reference because in the future, state staff will be going out and we will be doing a lot of those types of readiness reviews, as well.

The MCO will be putting together their own project plans, and we will be working with them to ensure that they have project plans in place and that they are also following through with them.

Other updates regarding MLTSS -- I know that

we have not had an MLTSS Steering Committee meeting in a while, partially because of what we've been working on. We will be scheduling one in January to get everybody up to date.

We have been doing a lot of work and meeting with the providers. There's been provider transition work groups comprised of the different home and community based-services providers, as well as the nursing home industry to go through all of issues. There were subcommittees for those groups for specific areas that we've been doing.

We also have developed a set of Frequently Asked Questions (FAQs) for both consumers, as well as for providers, which I know we've shared with you all and have gotten input both from the Steering Committee and from the MAAC, and we made some changes based on that.

One of the areas that we have been going through is the Personal Care Assistant (PCA) tool. PCA is a State Plan service, but it is also part and parcel of MLTSS. We have been working to develop a PCA tool, which is now being worked on with the MCOs.

One last update - which is technically not part of the MLTSS, but it is our Balancing Incentive Payment program (BIP). We just received from CMS

approval of our BIP work plan. It will be posted on CMS' website hopefully shortly, if it hasn't already been posted. I think we have to give them one more document to make it 504 accessible. So we're doing that. The BIP gives us a lot of opportunities to expand home and community-based services and also helps us to develop our infrastructure for MLTSS.

There are three requirements in the BIP.

One is that you have no wrong door or a single point of entry, which we've already been working towards and moving towards with our Aging and Disability Resource Centers (ADRCs) and our Aging and Disability Resource Connections.

The second is conflict-free case management. We have developed in our contract with the MCOs very specific language on conflict-free case management. And what you should know is that both the technical assistance people for CMS, Analytics, as well as CMS themselves have looked upon our conflict-free case management for MLTSS as something that they've asked us to be on their webinars to let other states how we're doing it because they believe that it's quite good.

The last thing is a single assessment tool for populations. We have been using the New Jersey Choice tool. And in addition, we are looking at a

variety of tools for our other populations, i.e., mental health and addiction services, as well as for people with developmental disabilities.

So we're using BIP not just for MLTSS, but in general as to ensure that we move forward and we do what we need to do to promote home and community-based services.

So with that, I'll stop.

DR. SPITALNIK: Thank you so much, Lowell.

Lowell, is the BIP plan on the website?

MR. ARYE: I don't believe it's yet on CMS' website. It will be on CMS' BIP website probably within the next two weeks.

DR. SPITALNIK: So could I also ask that it will be on a New Jersey website?

MR. ARYE: We'll have a link to the CMS website.

DR. SPITALNIK: In whatever way would make it most accessible to people, either directly on our website or the link. Thank you so much. And good to hear of the progress.

Questions from the MAAC?

Theresa.

MS. EDELSTEIN: Lowell, can you give us an update on the status of the contract between the State

and the plans for MLTSS?

MR. ARYE: Sure. We put forward the full plan with MLTSS a little bit more than a month ago. At the same time when we made the decision to then delay, we had given them, in effect, the MCOs our agreed upon changes, but then because of the delay we had to pull out the MLTSS part of that contract. We hope we will have the final contract, with MLTSS included, reviewed by CMS and signed sometime in the early spring.

DR. SPITALNIK: Beverly.

MS. ROBERTS: Thank you, Lowell. Can we receive a PCA Tool update at the next meeting. We're all very interested in knowing how that turns out.

MR. ARYE: Carol Grant's Office has taken the lead on the PCA tool.

MS. GRANT: I think we can do an update and a timeline at that point.

MS. ROBERTS: My question is with the waiver population. As you know, they are going to be folded into MLTSS. The numbers are small, but the needs are pretty great. So just a question; for example, looking at the people in the Community Resources for Persons with Disabilities (CRPD) Waiver right now, can you talk about how we can be sure that they won't be lost in the shuffle and that they're going to get the care

management that they need?

And that also, people who would have gone through the CRPD process to be eligible for the waiver, once the waiver doesn't exist anymore, I just want to be sure that the people who are eligible will be able to get the services.

DR. SPITALNIK: And would you please define the acronym for all of us?

MS. ROBERTS: Community Resources for Persons with Disabilities, which is a waiver for individuals who have very, very complex needs, people who need nursing at home.

MR. ARYE: I can speak broadly. We have four waivers. Right now, there are approximately 13,000 individuals total, and about 12,000 of those are the Global Options waiver folks, so I can't know how many of those are off the top of my head. One of the biggest issues that we've been focussing on is the importance of care management because, to us, for this population, that is the most important piece, to keep that running. And that was actually one the reasons why we felt that it was important to delay because we weren't quite ready on care management. We wanted to make sure that the current care managers who provide those services would continue it if we said we needed

to provide it, so that was why we decided to delay on September 30th.

One the things that we've done, and that's certainly a big part of the contract, is the issue of care management to ensure that there is care management. We also have been very concerned and working with the current care managers to ensure and linkages with the MCOs as we transition. For example, one of the things we're doing is there's going to be an electronic transfer of information from care managers over to the MCOs on all the information that they have.

In addition, we have a timeline as to how we're going to do the care management reviews when the MCOs get people. So there will continue to be continuity of care, as always. People, until they get reassessed, will continue to receive the services that they have been receiving.

MS. ROBERTS: Thank you. And for anybody who would be newly applying, for example, who isn't currently in and then the waiver will go away, how do we know that they will get the services they need going forward?

MR. ARYE: There are two pieces of that. One are the folks who are already in the MCOs who aren't yet in this level of care. What will happen

then is that the MCOs will do the assessment for those individuals. And then at that point, if denied, they will get -- at that point, even if they're not denied, the Office of Community Choice Option (OCCO), in the Division of Aging Services, review of the assessments to ensure the MCOs are actually doing it correctly. And that's part of this conflict-free case management that I was talking about for the BIP. CMS is very happy that we as the State are keeping final ownership of these individuals. And so the MCOs, because they'll get a higher capitation rate, of course, than just general acute health care for individuals, will be making sure to see if those individuals will need those type of services and then will assess their needs.

For the people who are new individuals, what will happen is that if somebody comes in new, there's option counseling through the ADOCs, and they'll be able to provide people with those options. There will be a Level 1 screening for those individuals, and then they will then be assessed first for financial eligibility to the CWAs, but also for clinical eligibility by OCCO, the Office of Community Choice Options.

When we talk about the waivers are going away, yes, they're technically going away, but there's

still an operational process in place for all individuals to get the services they need.

MS. ROBERTS: Thank you.

MS. BRAND: Just sort of going along the line of the care management piece, I know there's been some concern out in the community, because as we get closer to that transition date, the existing care management sites, people are starting to leave. So there's a little bit of concern about the capacity for the existing case management sites to serve the population that they currently are. So has there been some talk about that as we get closer to the transition?

An employer can't mandate someone to stay, so what if that happens? Is there enough capacity elsewhere to serve those folks?

MR. ARYE: That has been one of our biggest concerns all along. We have been doing a lot of things over the last several months to ensure that. We added several organizations for MCOs, including a couple of the Program of All Inclusive Care for the Elderly (PACE) programs. I kind of alluded to this, about the need to transition and plan for transition, and we are really very close to what I hope we will announce shortly to you in transition plans.

We've been looking at that for a long time. We are absolutely concerned about that, which was one of the reasons why, especially since some of the counties had the care management, and that was one of the reasons for announcing the delay on September 30th, because they needed to figure out what they were going to do in the counties because of Civil Service requirements for their care management organizations. It's something that we are absolutely focused on.

MS. BRAND: Thank you. And one other question.

With respect to the BIP, can you just elaborate a little more on the comment, "Gives us the ability to expand home and community-based services"?

MR. ARYE: Yes. In the funding, what we've included are dollars that we're able to add to our home and community-based services. The BIP is specifically intended as a balancing incentive payment to provide and ensure that there's additional funds for the home and community-based services side. So we're including it. It was included in our base this past year, this current fiscal year and will continue forward.

DR. SPITALNIK: Thank you so much for this comprehensive review. And we look forward to hearing from you again.

Can we now turn to our colleague Elizabeth Manley who's Director of the Children's System of Care to discuss the elements of the comprehensive waiver that affect children.

MS. MANLEY: So my name is Liz Manley and I am the Division Director for the Children's System of Care, and I'm happy to be here.

(Director Manley provides an update on the Children's Pilots).

DR. SPITALNIK: I had a couple of questions. You talk about interpreter services.

MS. MANLEY: Yes.

DR. SPITALNIK: I'm assuming that's sign language.

MS. MANLEY: It includes sign language.

DR. SPITALNIK: And translation.

MS. MANLEY: Yes.

DR. SPITALNIK: The question is would that not be available for all services as an Americans with Disabilities Act (ADA) requirement rather than being funded out of the pilot, but the accessibility by both culture, language, and form of communication?

MS. MANLEY: Sure. Actually, that's been part of our work within the pilots. We don't necessarily anticipate a significant change or use of

that because interpreter services is one of the things that the Children's System of Care (CSOC) has always utilized.

DR. SPITALNIK: Right. But I think the access to sign language interpreters, with limited waiver dollars is an issue.

MS. MANLEY: Absolutely.

DR. SPITALNIK: I noticed you've established an under-13 criteria for autism services. And so I'm particularly interested in children who would still be under your responsibility, but particularly in this very crucial transition age bracket, why they might not be eligible for these additional autism services?

MS. MANLEY: That's a fabulous question. We have to start somewhere. So part of our work is that we're only talking about 200 cases a year. So in our Children's System of Care we have about 56,000 who we're working with across our full continuum. So we had to start somewhere.

Our goal is to watch and see. The work that we're doing with PerformCare is really about looking at the trends, looking at the requests for services, understanding those requests for services, and understanding who gets those waiver services and the pilot services, but who also does not. And when they

don't get it, what is the rationale for that? And on top of that, what do we need to do in the future to be able to offer those? So it's really about us paying attention.

DR. SPITALNIK: Thank you.

MS. HARR: I just wanted to go back because the building of the CMW took place before Liz was on board with the State; So, I can tell you going back, this pilot was really prompted by trying to provide equity among what was available through commercial insurance and Medicaid. But there's a lot of caution. And so we said the pilot is a good approach to try this, but it was definitely around the emergent care piece like applied behavioral analysis (ABA) therapy. At that time, we were advised by our outside consultants that the best clinical practice and the best opportunity was to have that intervention, and it was really even an age younger than 13. So going back, that was the rationale.

DR. SPITALNIK: And the reason I raised the transition age is at 14 through the schools, children should be getting preparation to transition to adult life. And it is likely that these young people will continue as Medicaid beneficiaries, so the more investment possible, but I appreciate the limitation.

One final question. Under the services that are authorized, I would really want to advocate for assistive technology, that in addition to therapies, the most exciting developments is in the use of technology, including smart phones, iPads, as communication devices for youth and young adults with autism. And the lack of the availability of that sort of makes people more person-dependent in other ways. So I wondered if those things were covered here and would be authorized through the MCOs?

MS. MANLEY: I don't think that they are specifically addressed in the pilots. But I agree with you in terms of the assistive technologies being in charge of managing the assistive technology components of the family support work. We actually see that has some really important work, and we want to spend some time moving forward, but I don't think that it was included in this particular part of the pilot.

DR. SPITALNIK: I would really urge us to. We are way behind the rest of the country in this and way behind the education system. And I think it's a very important investment.

Others?

MS. ROBERTS: Thank you, Liz. Two questions.

On the component where it says inclusionary criteria is Medicaid or NJ FamilyCare eligible, if somebody had private health insurance but was 18 or older and also had Medicaid, would that make them eligible?

MS. MANLEY: Potentially.

MS. ROBERTS: It wouldn't make them ineligible?

MS. MANLEY: That's correct.

MS. ROBERTS: Okay. And then the second question is the natural supports training, would you talk a little bit about what that is?

MS. MANLEY: Sure. So the natural supports training is really about training care-givers and folks who are involved in that youth's life, to both have more skills in terms of their ability to work with and to manage that individual, but also to include support for them as well. So not just the training piece, but really the support that's necessary to continue to be a caregiver. So it really expands our whole definition of what we're going to be able to provide. And we're still developing that piece. That is some of the work that we're going to need a lot of help from all of our partners, is around the natural supports as we figure out how to not only develop it, but also how to roll it

out.
DR. SPITALNIK: I would really urge that the way that that is being developed be comparable with the natural supports element in the supports program, even though it's a different age; and also that component within the home community-based services waiver so that individuals who go through the pilot can have continuity across the program and not age out of one service or another.
MS. MANLEY: Great suggestion.
DR. SPITALNIK: Others?
MS. ABRAM: Hi. Mary Abram, New Jersey Association for Mental Health and Addiction Agencies. I was just curious will we be able to access the presentation online?
DR. SPITALNIK: Yes. We're going to have these posted on the MAAC website.
Other questions? Comments?
Thank you so much, Liz. It's wonderful to see the progress, and we look forward to the rollout.
MS. MANLEY: Thank you very much.
DR. SPITALNIK: Thank you.
I now turn back to Valerie Harr.
(Director Harr presents an update on the Administrative Services Organization (ASO)/Managed

Behavioral Health Organization (MBHO)).
DR. SPITALNIK: Are there any questions or comments about that? Anything from the MAAC?
Wayne.
MR. VIVIAN: In the mental health stakeholder community, there is concern that the Department, after the ASO go, will move forward with the Managed Behavioral Health Organization (MBHO), the risk-based model even if the data that you collected or the outcomes are not what you're hoping that they might be. And I think the stakeholder community would like the Department to consider staying with the ASO and not go with the risk-based model.
MS. HARR: We'll certainly hear the concerns. I want to alleviate any fears. To me, we are far from making that decision. I think we're still back at making sure we're taking incremental steps. Like I said, we are doing the rate analysis of moving from contracts to Fee-for-Service. I wouldn't want people to have that fear.
MR. VIVIAN: So all possibilities could be on the table.
MS. HARR: Yes.
MR. VIVIAN: It sounds like you are very cautious about proceeding.

MS. HARR: Yes. Exactly. We are cautious.
DR. SPITALNIK: And we appreciate that.
MS. HARR: That's the goal. If things are moving well, I think that's the vision, but it's not something that would be a flip of a switch. We will all be together as we make this huge transformation.
MR. VIVIAN: Thank you.
DR. SPITALNIK: Anything else?
MR. LAFER: So you can imagine having to approximate a discussion here about the value of going to risk versus non-risk before that decision is finally made.
DR. SPITALNIK: Certainly. And the experience to date is that the decision to move in this direction has not only been engaged in the MAAC, but with a much broader stakeholder community around planning for the ASO. So while we will certainly track it, we have every confidence and expectation that the movement in that would be depart from the participatory process, as we've seen. But we will track that, of course. Thank you.
Yes, in the back, please. State your name.
MICHELLE: Michelle of the Medical Society on Telepsychiatry, did you say it's only for one provider type, and does it apply for adults and

children?
MS. HARR: It's adults and children. There's no age limit. It's limited to psychiatrists, advanced practice nurses, and in the setting. So it was limited to independent clinics and hospital-based outpatient locations.
DR. SPITALNIK: Other questions?
MS. HARR: Dr. Lind, our Medical Director who's been spearheading that, is available for more information.
DR. SPITALNIK: Thank you so much. The next item is statistics on and the provider rate increase.
(Director Harr presents an update on the Provider Rate Increase).
DR. SPITALNIK: Thank you.
Any questions?
Yes.
MS. COLLINS: Maura Collins for NJ Citizen Action.
What is the actual deadline for making that decision on the provider rates extending beyond 2014?
MS. HARR: That's a good question. I would say it will need to be factored into budget discussions, because that time period where it ends will be overlapping the State fiscal year, so it will

be part of the State fiscal year 2015 budget discussion.

The State will make that determination. We could probably even amend or file a new SPA with CMS. We would have until March of 2015, I think, to go back to January 1, 2015, if we wanted to continue the enhanced rates. But it will definitely need to be part of this upcoming budget deliberations.

DR. SPITALNIK: Ray Castro.

MR. CASTRO: In line with that, as you know, the State just generated over $200 million this year in the budget as a result of the Medicaid expansion. And as I understand it, those funds were used mainly to balance the budget. They were not reinvested into Medicaid. And those payments run for a six-month period, so in your next year's budget, it will be annualized so, I assume, the savings will be more than doubled.

Is anyone looking at reinvesting these enormous savings that are going to be accrued to the State for purposes like this that could keep some of these funds to meet the growing needs in Medicaid overall?

MS. HARR: That savings definitely factors in the discussion, but we're going through our growth

estimates, so I would say the savings that we're achieving through that expansion in no way offsets the overall need that we have in the Medicaid program. If we didn't have that savings, then we would have needed additional funding for our program this year and the same for next year, so it's factored into it but it doesn't offset the need entirely we have for the growth of the program.

DR. SPITALNIK: Thank you.

Back there, please stand up, say your name.

MS. LEONE: Claudia Leone with the New Jersey Academy of Family Physicians.

I just wanted to ask the fee for services amounts that are going out retroactive, you're going all the way back to January 1st, one shot in mid-December?

MS. HARR: Yes.

DR. SPITALNIK: Thank you.

Debra.

MS. WENTZ: Debra Wentz, New Jersey Association of Mental Health and Addiction Agencies.

I just want to really applaud and thank you, Valerie, for your leadership, and everyone on the team for moving forward in the very quick rise to the occasion to make Medicaid reimbursement for

telepsychiatry a reality. I think we've had that on our advocacy list for about 15 years. It is something that's celebratory. But it's really going to make a huge difference in terms of with the expansion and serving a greater number of individuals. So that's fabulous news, and we really thank you. We advocated strongly for it. I think the engagement that you showed in terms of trying to move toward that end and succeeding this year is huge, so we thank you. I think it will make a huge different in the population that we serve.

MS. HARR: Thank you.

DR. SPITALNIK: Thank you.

Seeing no other points, we will move to ACO, the Accountable Care Organization.

Director Harr presents an update on Accountable Care Organizations).

DR. SPITALNIK: Thank you very much.

And I'm delighted to turn to Dr. Thomas Lind. Medicaid's Medical Director for an update on provider credentialing.

(Dr. Lind presents an update on Provider Credentialing).

DR. SPITALNIK: Thank you.

Sherl.

MS. BRAND: Thank you. You may have mentioned this, but is this specific to physicians, dentists, or is it all providers?

DR. LIND: That was one of the first decisions that we made as a task force that we were not going just tackle the medical end, we were going tackle dentistry, behavioral health, and nontraditional providers. So we were going to do all as one unit.

MS. HARR: It's just Medicaid. We're starting with Medicaid.

DR. LIND: Correct.

MS. HARR: I think the long-term goal is could there been a universal sort of process.

DR. LIND: To cover the commercial side.

MS. HARR: We're starting with Medicaid.

MS. BRAND: Is there similar to like the college application process? Is there any discussion around, like, this would be the common tool. Let's say, a physician completes the documentation in whatever time frame annually, whatever the case and that it can be accessed in a central location.

DR. LIND: Yes. The goal really is to synchronize what is a very scattered system that is very cumbersome on providers.

MS. COOGAN: I know this process has been

going on for many years at this point. Is there any discussion about streamlining the process for a recent graduate who, let's say, doesn't have a background to check for. This was a suggestion made at a meeting I was at recently.

DR. LIND: The short answer is yes. The long answer is that is a much more complicated question than it seems on the surface.

MS. EDELSTEIN: Not to belabor Sherl's question, but you said nontraditional medical providers. In my mind, I'm thinking that institutional providers like nursing homes, home care agencies, hospitals, they have to do provider credentialing forms for MCOs, too. Are they contemplated in this standardization, as well?

DR. LIND: I think we are open to all interpretation.

MS. BRAND: We welcome that.

MS. EDELSTEIN: Absolutely, we welcome that.

DR. LIND: I don't think we're at the point now where we're not taking a suggestion as far as how wide the net we're going to cast.

DR. SPITALNIK: Anything else as we get very close to our ending time?

Follow-up items, we were talking about both

transmitting the Guidelines through the operation of the MAAC to the Commissioner of Human Services for the development of an Administrative Order, if they will also be posted for the website.

There's a commitment by the Division that the letters that have been sent out to the MAAC will also be posted on the website.

We will at our next meeting, and I'll deal with the date in a moment, have a continuing update on CASS.

When the BIP is approved, it will be posted on the link to the CMS website and/or the plan itself will be posted on the DHS website.

Also, we will have an update on the PCA tool, as well as a timeline; an update on access about community care management.

What have I left out or what do people need to add to this for the next agenda?

Mary, then Beverly.

MS. COOGAN: The State SPA in terms of the Alternative Benefit Plan is going to be submitted. That was my understanding. So maybe we can get a little bit of detail about that, because I'm thinking The MAAC might want to make some recommendations in terms of how that might extend that to other

populations, but it would be good to have a little bit of that information.

Also, the discussion about the reimbursement rates to the providers, if that's going to be ending, and if we can get an update on that, as well, in case we wanted to make any recommendations along those lines.

DR. SPITALNIK: Thank you.

Anything else?

Dennis.

MR. LAFER: I'd like to add parity for the next discussion parity. We know that the ABP will require parity in the discussion of whether and when that parity will be extended to the rest of the population.

DR. SPITALNIK: Thank you.

We meet again, and I'll give you the 2014 dates. These are posted on the website. Monday, January 13th; Monday, April 7th; Wednesday, June 11th; and Monday, October 6th.

We will continue to meet here from 10 to 1. And I think that the reorganization of the agenda to consolidating informational updates, at least to my ears, seemed to be an effective way of proceeding.

Again, I want to, as always, thank Director

Harr and the staff of both the Division of Medical Assistance and the whole Department and sister agencies for their both incredible efforts about the work and also their support of the MAAC.

Have a good Thanksgiving, good holidays, and we will see you in 2014. Thank you.

(Meeting adjourned at 1:06 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 compressed transcript of the proceedings as recorded.

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Lisa C. Bradley, CCR

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