1 2 3 4

ATTENDEES:

Evelyn Liebman AARP
Michael Rooney Akermes, Inc.
Dan Keating Alliance for the Betterment of Citizens with Disabilities
Jennifer Jacobs Amerigroup New Jersey, Inc.
Cathy Chin Alman Group, LLC
Eric Uderitz Boehringer Ingelheim
Barbara Geiger-Parker Brain Injury Assoc. of NJ
Lisa Knowles Care Point Health Plans
John Guhl Centers for Medicare and Medicaid Services
Doretha Howard Centers for Medicare and Medicaid Services
Nicole McNight Centers for Medicare and Medicaid Services
Mary Katherine Bohan Community Care Behavioral Health
Sue Saidel Essex Court
Andrea Cotton Healthfirst Plan of NJ
Karen Clark Horizon NJ Health
Len Kudgis Horizon NJ Health
Joseph Manger Horizon NJ Health
Phil Lachaga Johnson and Johnson
Michelle Paulik Johnson and Johnson
Carol Katz Katz Government Affairs
Eric Orlando Kaufman Zita
Josh Spielberg Legal Services of New Jersey
Andrew Robertson Legislative Liaison
Sabeen Kaylan-Masih Legislative Liaison
Christine Walley LIFE St. Francis
Colleen Smith Matheny Medical & Educational Center
Barbara Johnston Mental Health Association in New Jersey
Michele Javer MJ Strategies, LLC
Carolyn Bray New Jersey Association of Mental Health Addiction Agencies, Inc.
Philip Lubitz National Alliance on Mental Illness
Gurpreet Kaur National Holistic Counseling
Maureen Shea New Jersey Association of Community Providers
Deborah Polacek New Jersey Family Planning League

Melissa Chalker New Jersey Foundation for Aging
Ray Castro New Jersey Policy Prospective
Selina Haq New Jersey Primary Care Association
Mike Bond Novo Nordisk
Alison Handler Novo Nordisk
James McCracken Ombudsman for the Institutionalized Elderly
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Molly Aucillo Wellcare
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Nancy Hopkins Department of Human Services
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Brian Franz Department of the Treasury
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Margaret Springer Division of Medical Assistance and Health Services
Irina Stuchinsky Division of Medical Assistance and Health Services

PANEL:

Dr. Deborah Spitalnik, Dr. Sidney Whitman
Dorthea Libman Dennis Lafer
Theresa Edelstein Eileen Coyne
Mary Coogan

ATTENDEES:

THE SCRIBE
Transcriber, Lisa C. Bradley
6 David Drive
Ewing, New Jersey 08638
(609) 203-1871
thescribe@gmail.com

STATE REPRESENTATIVE:

Valerie Harr, Director
Division of Medical Assistance and Health Services

NJ Forensic Science Technology Center
1200 Negron Drive
Hamilton, New Jersey

April 8, 2013
10:00 a.m.

FINAL MEETING SUMMARY

Final Meeting Summary

Panel:

Dr. Deborah Spitalnik, Ph.D.
Mary Coogan
Elder Coyne
Theresa Edelstein
Dennis Laper
Dorothea Libman
Beverly Roberts
Dr. Sidney Whitman
Ryan Vivian

State Representative:

Valerie Harr, Director
Division of Medical Assistance and Health Services

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DR. SPITALNIK: Good morning. My name is Deborah Spitalnik. I’m the Chair of the Medical Assistance Advisory Committee, and it is my delight to welcome everyone. Adequate notice of the meeting has been provided and the meeting has been advertised publicly. The public notice was filed with the New Jersey Secretary of State on December 17th of 2012. It was posted on the Department of Human Services website. It was also posted in the Medical Assistance Customer Centers and the County Boards of Social Services, and appeared in the following newspapers on December 20th: The Atlantic City Press, The Bergen Record, The Camden Courier Post, The Star Ledger, The Trenton Times. And this public notice was also published in the New Jersey Register on January 7, 2013.

We have new membership today, which we are delighted and grateful to Governor Christie and to the staff of the Appointments and Authorities Office, and a particular thank you to Judith Lieberman and the staff of the Department of Human Services. In a moment, I will ask the new members to introduce themselves and then the members of the public.

I ask that when there is the opportunity for comments and discussion and questions that the members of the Medical Assistance Advisory Council (MAAC) have the opportunity to do so first, and then the members of the public, including our sister state agencies. We’ve never had to enforce a time limit but I will assert the prerogative of the chair if we need to move along.

So having said that, I am delighted that we have now come up to complement in membership of the MAAC. I want to thank our colleagues and former MAAC members Valerie Power-Smith and Patricia Kleppinger for their service on the MAAC. Our colleagues Mary Coogan and Wayne Vivian are in holdover status, so were not formally announced. And now joining us, the MAAC members are Sheri Brand, Eileen Coyne, Mary Coogan, Theresa Edelstein, Jay Jimenez, Dennis Lafer, Dot Libman, Mary Lund, Beverly Roberts, myself, Wayne Vivian, and Dr. Sydney Whitman. I have the listing of how people were appointed. And some of us who have been in some status have now shifted into others. So Beverly Roberts is now in a consumer slot, replacing Pat Kleppinger who was a holdover whose term expired in 2008. Dennis Lafer replaced Linda Garibaldi, who resigned. I’m replacing Ellen Grassman resigned. Eileen Coyne is replacing Valerie Power-Smith, whose term expired in 2006. Jay Jimenez was reappointed. Dr. Whitman is reappointed. Theresa Libman replaces Carol Kent, who resigned. Mary Lund replaces the slot that Beverly Roberts was in. And Sheri Brand is replacing the slot that I was in.

We are exceedingly grateful that we are now up to compliment. The State Board of Human Services will need to confirm the appointments and reappointments, and we will receive official notification from the State Board. We also understand that candidates who had applied to the Governor’s Office for appointment and who may have been vetted but not selected do not receive formal notification from the Governor's Office. So I will say informally a thank you to everyone for their interest in the MAAC.

We will continue to work with the Department of Human Services and the Governor’s Appointments Office to gain a fuller understanding of people’s status.

I want to welcome everyone, and I’m going to ask people to introduce themselves. I’m going to ask everyone on the MAAC to introduce themselves. I’ve explained the seats that people are in, but I’d ask you to very briefly describe the constituency you represent each other. And then, as is our custom, I’ll ask the members of the public to introduce themselves.

So may I start with Eileen Coyne, please.

MS. COYNE: Good morning. My name is Eileen Coyne. I guess first and foremost I am parent of a 24-year-old son that has developmental and intellectual disabilities, which threw me in a world from being an insurance producer into developmental disabilities and human services. I used to work at the Council on Developmental Disabilities under family support. Then I moved on to support coordination working first for UMDNJ, then Neighbors, and now Caregivers of New Jersey. We do support coordination in self directed services. I’m also the Vice Chair of the Ocean County Long Term Recovery Group for those who are recovering in Ocean County from Super Storm Sandy. And I’m very pleased to sit on this Council. Thank you.

I’m Chairman of Pediatric Dentistry for Beth Israel Medical Center. I’m also Chairman of Head Start for New Jersey for the dental section. I’m also Chairman of Pediatric Dentistry for Beth Israel Medical Center. I’m also Chairman of Head Start for New Jersey for the dental section. I’m also Chairman of Pediatric Dentistry for Beth Israel Medical Center. I’m also Chairman of Head Start for New Jersey for the dental section. I’m also Chairman of Pediatric Dentistry for Beth Israel Medical Center.

MR. VIVIAN: Thank you. My name is Wayne Vivian. I’m the president of the Coalition of Mental Health Consumer Organizations, and in my day job I work...
1 for the Residential Intensive Support Team as a Senior
2 Staff Specialist. I represent consumers and mental
3 health consumers. And I'm also a Medicaid recipient
4 who gets Medicaid through WorkAbility. Thank you.
5 MR. LAFER: Good morning. My name is Dennis
6 Lafer. I'm currently a consultant in the mental health
7 field. My previous job had been as Director and Deputy
8 Director of the Division of Mental Health.
9 MS. HARR: I'm Valerie Harr, I'm the
10 Director the Division of Medical Assistance and Health
11 Services (DMAS).
12 DR. SPITALNIK: I'm Deborah Spitalnik. I'm
13 the Executive Director of the Boggs Center on
14 Developmental Disabilities, New Jersey's federally
15 designated University Center for Excellence in
16 developmental disabilities at Robert Wood Johnson
17 Medical School, where I'm also a professor of
18 pediatrics.
19 MS. EDELSTEIN: Good morning. I'm Theresa
20 Edelstein. I'm Vice President of Post-Acute Care
21 Policy at the New Jersey Hospital Association where I
22 work with our long-term care, home health, PACE and
23 other members. And a little known fact, I'm a licensed
24 nursing home administrator as well.
25 MS. COOGAN: Mary Coogan, Advocates for

1 Children of New Jersey.
2 MS. ROBERTS: Beverly Roberts, I'm Director
3 a health care advocacy program called Mainstreaming
4 Medical Care at the Arc of New Jersey. We serve those
5 with developmental disabilities.
6 MS. LIBMAN: Hi. Dorothea Libman, better
7 known as Dot. I'm Director of Pride Programs, which is
8 the programs for adults over 21 with developmental
9 disabilities for the ECLC of New Jersey schools. We
10 have three Centers, plus a Work Center in Chatham and a
11 Center in Paramus. And I'm very honored to be
12 appointed to this Council.
13 DR. SPITALNIK: And Valerie, are you on the
14 phone?
15 MS. POWER-SMITH: Yes, I am.
16 DR. SPITALNIK: And we have on the phone
17 Valerie Powers-Smith who recently just rotated off the
18 MAAC.
19 MS. POWERS-SMITH: Good morning.
20 DR. SPITALNIK: Good morning. Before I ask
21 the public to introduce themselves, I want to thank
22 Director Harr, Phyllis Melendez, and Kim Hatch for
23 their support of the MAAC and these processes.
24 (Attendees introduce themselves.)
25 DR. SPITALNIK: Thank you all and welcome

1 all. As we can see there's always continuing interest
2 in our work, and we're deeply appreciative of that.
3 From our last meeting in January, we experimented with
4 having a transcript of the meeting rather than bullet
5 point minutes. Let me ask if there's any input on
6 corrections to the transcript?
7 So may I have a motion to accept the
8 transcript as minutes.
9 MS. ROBERTS: Make a motion to accept the
10 transcript as minutes.
11 DR. SPITALNIK: Roberts. Second?
12 MR. HITTMAN: Second.
13 DR. SPITALNIK: Whitman.
14 All those in favor?
15 MEMBERS: Aye.
16 DR. SPITALNIK: Opposed? Abstentions?
17 Those are accepted as minutes.
18 We had moved to the format of doing a
19 transcript because our proceedings are so voluminous,
20 so it's really almost impossible to take full notes.
21 I'd like a sense of the MAAC whether we would like to
22 have bulleted minutes or highlights from the
23 transcript, or whether we would continue to rely on the
24 transcript or whether we would experiment between now
25 and the next meeting and see what feels helpful. And

1 maybe we should reserve decision until the new members
2 have a sense of process.
3 What's your pleasure about that issue?
4 MS. COOGAN: I would say let's see how it
5 goes with the transcript. And then if people feel like
6 the bulleted mechanism would be better, we can always
7 decide that later.
8 DR. SPITALNIK: Other thoughts.
9 MS. ROBERTS: I'd like to give an
10 opportunity for the new members to also to give their
11 input.
12 DR. SPITALNIK: Okay. And my sense would be
13 that reading through the transcript would be useful to
14 the new members as an orientation.
15 MS. COYNE: I did read the transcript. I
16 thought it was very helpful for me to be here today.
17 MS. LIBMAN: Me too.
18 DR. SPITALNIK: Thank you. So we'll proceed
19 in that way.
20 And I thank the transcriptionist for your
21 assistance.
22 The next item of business is a report from
23 the Consumer Assessment of Healthcare Providers and
25 Valerie, do you want to give us a quick
orientation with what the CAHPS® is and then we can
1 report out where we are with that? Thank you.
2 MS. HARR: The CAHPS® is a consumer survey
3 of Medicaid recipients. It is a federal requirement
4 that states that have a Medicaid managed care program
5 do an annual consumer satisfaction survey. And we
6 subcontract with a vendor to conduct the survey, pull
7 the results together and issue a report.
8 There are a standard set of questions that
9 you must use under the CAHPS®, and then there is also
10 optional questions. There are limitations to the
11 extent that the CAHPS® survey really gets at meaningful
12 information from a survey, but it’s essentially the
13 national standard and nationally recognized. All
14 states that I know are using the CAHPS® survey.
15 So we have struggled through the years on
16 how to maximize the benefit of the consumer
17 satisfaction survey. And with that, every year as we
18 plan for the next year, the MAAC reviews the previous
19 year’s results, and then we look forward to what can we
20 do to improve the response rate as well as the quality
21 and the meaningfulness of the result. So that led us
22 to create this workgroup to try to continue to improve
23 the quality of that product.
24 DR. SPITALNIK: Thank you so much for that
25
26 orientation. So a workgroup was convened on February
27 15th. Mary Coogan, Beverly Roberts, and myself from
28 the MAAC; and from the Division of Medical Assistance,
29 Valerie Harr, Richard Hurd, Holly Arnold, and Phyllis
30 Melendez. There are standard questions, and then there
31 are also supplemental questions. And the CAHPS® is
32 divided into child and adult questions. We agreed to
33 add 11 adult supplemental questions and 5 child
34 supplemental questions.
35 There is also a CAHPS® tool that is a
36 national survey of children with special health care
37 needs. There's the Centers for Disease Control and
38 Prevention's National Survey of Children with Special
39 Health Care Needs that Beverly Roberts suggested.
40 There's also a supplemental questionnaire of children
41 with chronic conditions. The constraints or the
42 requirements of the CAHPS® requires that if you are
43 administrating an additional tool to say about children
44 with chronic conditions, it has to be administered to
45 all children. And in a subsequent e-mail exchange, we
46 tabled adding an additional children's questionnaire,
47 with the idea that we would like to consider that in
48 the broader context of quality. DMAHS is currently
49 reviewing quality measures for the new Comprehensive
50 Medicaid Waiver (CMW) Managed Long Term Services and
51 Support (MLTSS). And we thought that there might be a
52 more fruitful avenue than the CAHPS® with its
53 limitations for getting at the issues of quality.
54 Does anyone from the MAAC or from the DMAHS
55 staff who want to add anything at this point?
56 MS. COOGAN: No. I think that is was
57 discussed at the MAAC.
58 An additional thought that I had after the
59 meeting was that once the survey goes out, if it was
60 possible to notify us when it was going out then maybe
61 members of the MAAC and also members of the audience
62 who do send out E-news on newsletters could reference
63 it that it's going and alert our population to be on
64 the lookout for it and to please respond. We thought
65 that might help generate more responses.
66 MS. HARR: Dick, can you tell me did the
67 survey go out?
68 MR. HURD: 35,000 were sent out the middle
69 of March.
70 MS. HARR: And when are the surveys due.
71 MR. HURD: They have to report to the
72 national organization by the end of June, so between
73 now and the end of June, Xerox will be compiling all
74 the data when we get the responses.
75 MS. HARR: But there's no deadline for the
76 consumer in returning the survey?
77 MR. HURD: No. Xerox sends out two or three
78 reminder notices if they don’t get them, and that's
79 going on over the next month or so.
80 MS. COOGAN: So are the surveys coming from
81 Xerox, or are they coming from the State?
82 MR. HURD: The surveys come from Xerox, but
83 they are printed on NJ FamilyCare letterhead.
84 DR. SPITALNIK: What I would ask is that the
85 Division prepare a standard paragraph that could then
86 be disseminated to members of the MAAC and other
87 advocacy groups so that a standardized prompt is sent
88 out to encourage people.
89 MR. HURD: I can get copies of the letter
90 and the reminder notice that is mailed to clients.
91 DR. SPITALNIK: Thank you.
92 Anything else? Anyone from the public?
93 MR. MANGER: Joe Manger from Horizon NJ
94 Health. I would just caution everyone about that it’s
95 the standard message given and not any message about
96 how to respond, because you get into a fine line when
97 you're doing those surveys and there's a lot of
98 guidelines about what you can and should not say or do.
99 So if we can just make sure that that accompanies that
100 notification.
<table>
<thead>
<tr>
<th>Time frame going forward that we would need to have questions for the children's survey? What would be the when would we engage the issue of the supplemental database at the end of June, but the Report is available in November, approximately.</th>
<th>actuated or made recommendations?</th>
</tr>
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<tbody>
<tr>
<td>to talk now about the next step?</td>
<td>MR. HURD: The Survey has to go out in early March so we have to address the issue in the December or January timeframe.</td>
</tr>
<tr>
<td>DR. SPITALNIK: Next, we want to look at quality in the larger context of the broader quality strategy.</td>
<td>DR. SPITALNIK: So that seems like a workable time frame. Does that feel comfortable?</td>
</tr>
<tr>
<td>MS. ROBERTS: What I would like to do is to start now with thinking about what we're going to do with the next Survey. I would like to start that process.</td>
<td>MR. LUBITZ: I think I was suggesting something other than that, not tying your quality strategy to that one Survey. Because if you do that, you're caught with the limits of that Survey. So again, thinking of time frames, consider the time frames of that Survey has to be placed, but that should only be one small element of a quality strategy.</td>
</tr>
<tr>
<td>DR. SPITALNIK: Thank you.</td>
<td>DR. SPITALNIK: Yes. I think we're very much in concurrence. And that's why I was suggesting that we wait about talking about the CAHPS® so that it's in the context of the broader quality strategy.</td>
</tr>
<tr>
<td>Anyone else?</td>
<td>So we very much in agreement with that point of view.</td>
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<tr>
<td>MR. LUBITZ: Phil Lubitz. You may want to consider making a decision whether you want to have a subcommittee now that you have a larger group working on the CAHPS® or merely a subcommittee who specifically would be thinking about quality, including the CAHPS® or who may consider other endeavors that you might think worthwhile for the Division.</td>
<td>Anything else on the issue of quality?</td>
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<tr>
<td>MS. ROBERTS: Moving forward, were you going to talk now about the next step?</td>
<td>Will we have an update prior to October?</td>
</tr>
<tr>
<td>DR. SPITALNIK:</td>
<td>MS. HARR: Yes.</td>
</tr>
<tr>
<td>DR. SPITALNIK:</td>
<td>DR. SPITALNIK: So at our next meeting, which is in June, we can have an update on quality and then figure out how we organize ourselves in our advisory role relative to that strategy. Is that acceptable?</td>
</tr>
<tr>
<td>DR. SPITALNIK: Beverly, are you comfortable with that?</td>
<td>MS. ROBERTS: Yes.</td>
</tr>
<tr>
<td>MS. ROBERTS: Do you have any idea of the timeframe that we're talking about for working on the next CAHPS® Survey?</td>
<td>DR. SPITALNIK: All right. Thank you.</td>
</tr>
<tr>
<td>MR. LAFER: When do the Survey results have to be in in order to get the information prepared for next year? What's the time period in that respect?</td>
<td>We'll move on to the Director's Report and to Valerie Harr.</td>
</tr>
<tr>
<td>MS. HARR: For the CAHPS®, January.</td>
<td>MS. HARR: Thank you. So I am going to backtrack a little bit because we have new members.</td>
</tr>
<tr>
<td>MR. HURD: The results get uploaded to a database at the end of June, but the Report is available in November, approximately.</td>
<td>Originally, under the Federal Affordable Care Act, it was mandatory that states expand their Medicaid for all non-elderly adults up to 133 percent of poverty. With the challenge at the Supreme Court level and the ruling from the US Supreme Court, Expansion became optional to states. So you may have seen every time a state made an announcement, there was a lot of press. So as part of Governor Christie's recommended budget for State Fiscal Year 2014, the Governor announced that New Jersey would elect to do the optional Medicaid Expansion.</td>
</tr>
<tr>
<td>DR. SPITALNIK: The question is for 2014, when would we engage the issue of the supplemental questions for the children's survey? What would be the time frame going forward that we would need to have</td>
<td>This Council had provided a letter of recommendation to the Governor to expand the Medicaid program in New Jersey, so I want to thank the MAAC for that letter.</td>
</tr>
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<td></td>
<td>The last time we met was prior to the Governor's budget address. So I do want to go over some numbers with you.</td>
</tr>
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With the Expansion of Medicaid, states must start accepting applications for the Expansion on October 1, 2013. The Expansion would be effective January 1, 2014. New Jersey has a history of having done multiple Expansions previously, so our picture of the impact of the Expansion is different from other states. So with that, there is one adult population that we have not previously covered. And they are adults without dependent children or childless adults.

We had covered that group up to only 24 percent of poverty previously. So by expanding Medicaid in 2014 to 133 percent of poverty, we’re expecting about 101,000 childless adults to become newly eligible for Medicaid.

In addition, as states have done the analysis and there’s been different groups across the country analyzing what would happen under the Expansion, they do expect, as people learn about the federal Marketplace and the topic of insurance becomes more than norm, that people that have not been previously eligible for State Medicaid programs will take advantage of the program.

If that’s the case, based on our estimates, and we work closely with the Rutgers Center for State Health Policy in refining our estimates, we could have

| 1 | They changed the terminology. It’s not the Exchange any longer. |
| 2 | MS. ROBERTS: A quick question. I’ve dealt with families currently when they have a certain income, but then if there's a certain month where they get five paychecks instead of four during that month, it throws things off. Is that going to be rectified within the system? |
| 3 | MS. HARR: I think you’re probably talking about someone who’s applying through the Aged, Blind or Disabled program. |
| 4 | MS. ROBERTS: I’m concerned specifically about the coverage for the child when the family income has more paychecks in a month and, it has been detrimental for the child through NJFC. |
| 5 | MS. COOGAN: You mean it would bump them up. |
| 6 | MS. ROBERTS: It would bump them up over because of a certain month. A month where they got four paychecks during the month, they’d be fine. So I’m trying to differentiate Aged, Blind and Disabled eligibility versus our Medicaid and NJFC. |
| 7 | My question specifically now is children under the age of 18 who are getting NJFC because of the family income all together. |
| 8 | MS. HARR: We have submitted all of our

So that summarizes where we are with the Expansion.

Any questions?

MS. COOGAN: The new Marketplace would be the federal Exchange?

MS. HARR: The federal Marketplace, yes.

| 1 | expansions, there's significant savings to the State of New Jersey by electing the Expansion because of the change in the federal matching rates of those groups. |
| 2 | We do have about 14,000 parents between 134 percent of poverty and 200 percent of poverty. That program's been frozen, but we still have 14,000 parents. Our authority to cover them expires in December 2013. We will do a renewal and those parents may become newly eligible under the new way that income will be calculated under the Affordable Care Act. It's called Modified Adjusted Gross Income (MAGI). So regardless of whether or not we would be doing the Expansion, we will be changing the way Medicaid eligibility is determined for most of our population, excluding the aged, blind and disabled and some other populations. But those parents would either become newly eligible or they will be transitioned to the federal Marketplace where they may be eligible for a premium subsidy. |
| 3 | So that summarizes where we are with the Expansion. |
| 4 | I'm trying to differentiate Aged, Blind and Disabled eligibility versus our Medicaid and NJFC. |
| 5 | My question specifically now is children under the age of 18 who are getting NJFC because of the family income all together. |
| 6 | MS. HARR: We have submitted all of our

Since New Jersey had done previous
1 documentation to the Centers for Medicare and Medicaid Services (CMS) in terms of how we do eligibility now.
2 It is with Rand, their contractor. We're waiting to hear back from Rand on how we do eligibility and how that will be converted.
3 Elena, can you address this? I don't know if sometimes having extra week or the fifth week of pay gets resolved under MAGI.
4 ELENA: No, it's actually an Social Security (SSI) rule. It's not on the Medicaid side, it's on the SSI side where they count all the income received in that month, where we do prorated share. I don't know that it's going change because, again, it's on the disabled side, so I don't know that any of that changes, but we'll certainly take a look at it.
5 MS. ROBERTS: The particular question I was asking was for children who have a disability but they're not SSI because they're under the age of 18 and they were getting NJFC and looking at the whole family income. But in times when the family income exceeded the maximum amount --
6 ELENA: I could talk to you later, but that's not our rule. Our rule is monthly income, we prorate it. SSI does look at it differently.
7 MS. HARR: As I said, I think with MAGI, it would be based on your most recent income tax filing.
8 It won't be a calculation of pay stubs the way we do it today. I can't say with certainty if that will be an improvement in terms of those families until we see some actual cases after the change.
9 DR. SPITALNIK: Thank you. Other questions just about Medicaid Expansion from the MAAC?
10 Dennis.
11 MR. LAFER: So when we read about Medicaid Expansion, it's usually out of the eligibility side.
12 I'm wondering if you can just talk a little as what would they be eligible for? What are the services?
13 MS. HARR: Our team has been meeting regularly to work through a lot of these issues. We received technical assistance from the Robert Wood Johnson Foundation and the Center for Healthcare Strategies and a Consulting Group.
14 We have to select a benefit package. It's called the Alternative Benefit Plan (ABP). We're going through the analysis right now. The ABP must include ten essential health benefits that are also required for the Marketplace products. By June, we expect to have some idea of the ABP.
15 MR. LAFER: Some of the most effective programs are the optional service package programs. So

1 I hope those will be considered in your analysis.
2 DR. SPITALNIK: A Medicaid Expansion question from the public?
3 MR. ROONEY: Michael Rooney with Alkermes.
4 The 101,000 single adults and childless couples are they considered newly eligible?
5 MS. HARR: Yes. MR. ROONEY: Are the 44,000 part of the 101,000?
6 MS. HARR: No. They are in addition to the 101,000. We have historically been covering the 44,000 childless adults only up to about 24 percent of poverty. So by going from 24 percent of poverty to 133 percent of poverty, we will have an estimated another 101,000 individuals.
7 MR. ROONEY: Thank you.
8 MR. CASTRO: Ray Castro, New Jersey Policy Perspective. I want you to comment on the issue of coordinating benefits and families where the parent is now eligible for the Medicaid Expansion and the child is in NJFC. There seems to be a management issue and a funding issue. The management issue being that the federal government requires that the Medicaid agency coordinate those benefits. It seems to indicate that Medicaid or the County Welfare Agency (CWA), would need some understanding of the Marketplace. I'm wondering organizationally are you going to have special units to deal with that?
9 And the other issue is funding, which is that now in addition to the parent having to pay the cost share for the child, they're also going to have to pay for their own cost share, which could be quite considerable in the Marketplace. And I know some states are considering providing a waiver for the child so that the parent is not overwhelmed with both payments. I'm wondering if you looked at that issue as well.
10 MS. HARR: The issue of coordination has been raised, and I've had a call with the U.S. Department of Health and Human Services (HHS) Regional Office. I think there are still a lot of unknowns.
11 There's an expectation about coordination and yet I don't know what will be offered in the Marketplace for New Jersey residents. So it's very difficult to try to plan coordination when I don't yet know -- it would be a lot easier if I know that a health plan that Medicaid is contracting with will also have a product in the Marketplace and what that product will be. That coordination, in some respects, happens now as people lose coverage and become Medicaid eligible. I'm still expecting that the Medicaid benefit package will be
1 richer than what's offered in the Marketplace. So we
2 know that there are Medicaid services like
3 transportation that will not be offered in a
4 Marketplace product.
5 So regarding the coordination with the
6 Marketplace, we continue to have conversations and we
7 are working with the Robert Wood Johnson Foundation and
8 having conversations with HHS on that. I know the
9 topic of outreach has come up previously. Again, I'm
10 talking to the Robert Wood Johnson Foundation and HHS
11 about outreach opportunities. I think some of the most
12 success we've had is around in-reach so we want to
13 continue to look at other divisions and departments in
14 the State to make sure that they're getting the word
15 out and that we continue to make sure that people know
16 that we continue to cover children in NJFC, that people
17 know that all of the Medicaid and NJFC programs that we
18 have are available. We're talking about putting things
19 on our website and preparing material in coordination,
20 hopefully, with HHS, that we will make available to you
21 so that you can share as well. We're going to try to
22 maximize, again, on those relationships and notices and
23 programs that we have in place so that people
24 understand and know about the Medicaid Expansion and
25 other existing programs.

29

1 program with the adjusted rule. So do you have an
2 estimate of how many of that group that lost coverage
3 will regain coverage under the Expansion?
4 MS. HARR: No, I don't have an estimate of
5 that. But you're right. That's why I said 14,000
6 parents that I have sort lumped into that group that
7 will do a renewal because we will not have disregards
8 like we do today. Some of those parents are newly
9 eligible and some will go into the Marketplace.
10 The 45,000 that you're talking about, to the
11 extent that they are newly eligible will be because of
12 the way income has changed in terms of the MAGI, I'm
13 assuming they are part of my estimate of about 200,000
14 people that would become eligible. When Rutgers did
15 their analysis, they didn't differentiate between with
16 those disregards. I'm expecting that in that 200,000
17 includes individuals that currently are not qualifying
18 because they don't have the enhanced earned income
19 disregard, but many of them will be eligible under
20 MAGI.
21 Does that answer?
22 MR. SPIELBERG: I think so. You're talking
23 about the 192,000 that were eligible but not enrolled?
24 MS. HARR: Yes, because Rutgers didn't know
25 the distinction. They assumed that those individuals

30

1 MR. VIVIAN: In the future, the adults now,
2 the parent, their eligibility for Medicaid will no
3 longer be dependent on if their child gets Medicaid?
4 In the past it was that the parent was only eligible
5 because the child was eligible.
6 MS. HARR: Right. So all non-Aged, Blind
7 and Disabled adults would be eligible up to 133 percent
8 poverty regardless of the child. Now, we would
9 continue to cover children up to 350 percent of
10 poverty. So under the Affordable Care Act, you could
11 have a parent eligible for a subsidy and getting
12 something through the federal Marketplace and the child
13 would still be eligible for NJFC.
14 MR. SPIELBERG: Josh Spielberg with Legal
15 Services of New Jersey.
16 Valerie, when you were going through the
17 list of populations that would now be covered, I didn't
18 hear you mention the parents who had lost coverage as a
19 result of the 2010 change in eligibility.
20 Now, I think that category which is now
21 14,000, they're lumped into that category, it used to
22 be at 60,000. So they're about 45,000 parents who lost
23 coverage, some of them may be between 133 and 200
24 percent, but many of them are under 133 because they
25 have unearned income that made them ineligible for the
which then offsets the additional cost of the 192,000
that will be reimbursed?

MS. HARR: Right. So of the 145,000 parents
and 44,000 childless adults that will be transitioned
from either the NJFC match or the 50 percent match
under our current 1115 Waiver to 100 percent federal
funding for the first three years, and then it drops
down over the course of another three years to 90
percent federal match indefinitely.

So your other question. We had previously
in 2000 covered childless adults up to 100 percent of
poverty with 100 percent State funds. We reexamined
our claims information from that population, and we do
expect that the newly eligible population will have
greater costs and greater health needs than, say, some
other populations. I don't have an exact percent of
how many will have a psychiatric illness or a mental
health need, but we are expecting that it will be
significant which is why I've been working with the
Division of Mental Health and Addiction Services to
make sure that we have really what we think would be an
appropriate mental health and substance abuse benefit
to meet the needs of the expanded population.

MS. ORLOWSKI: Hi. I'm Gwen Orlowski from
Legal Services of New Jersey.

My question goes to screening people for
programs that they might be eligible for under the
Expansion. And these numbers may well be small, but
people who are currently on Waivers or in nursing
homes, that have income between a hundred percent of
poverty and three times the federal SSI level, who lose
clinical eligibility, but their incomes now may be
between 100 and 133, are there plans to screen those
people before terminating them from Medicaid?

MS. HARR: Yes. There should be screening
happening now before anybody loses eligibility to see
if they would be eligible for any other Medicaid
program.

MS. ORLOWSKI: With all due respect, this is
not always happening. I have people who are eligible
for Global Options who are terminated at the county
level without being screened for Global Options.

MS. HARR: So we'll take that back, but
certainly my expectation is that everybody would be
screened at our redetermination or renewal to see if
they are eligible for any other Medicaid program. The
County Welfare Agencies will be trained on the
Expansion and how to do the new MAGI calculation.

MS. ORLOWSKI: But the termination comes out
of the Division of Aging Services; it doesn't come out
of the CWA.

MS. MASON: One may have the clinical
eligibility determination, but then it should go back
to the Board of Social Services for financial
eligibility determination.

MS. HARR: And at that point, if they no
longer meet that nursing home level of care, they
should be screened for other Medicaid programs. So
we'll take that back as something to make sure we
recognize.

DR. SPIITALNIK: Thank you.

Valerie, the next item is the Accountable
Care Organization (ACO) update.

MS. HARR: The State statute was passed that
requires the Medicaid agency to do an Accountable Care
Organization demonstration. Prior to us implementing
this demonstration, we need to promulgate regulations.
The originator of this has been the Camden Coalition,
on drafting these regulations. But one obstacle that
we had is that this demonstration allows that if the
ACO demonstrates success and saves Medicaid dollars,
that some of that savings goes back to the ACO
physicians and they can share it with the members of
their ACO and providers. That shared savings really
sets off red flags with other federal partners. So it

requires several conversations with the Department of
Justice and other federal regulators. So it's taken
some time to tease out the regulations, but they are
with our Office of Administrative Law. They sent back
many, many questions that we've responded to. Now,
this is just a target date, but we're hoping that they
get published in the New Jersey Register for public
comment in May 2013.

In addition, we have submitted a concept
paper to CMS on the Accountable Care Organization.
We're going to have a conversation about to what extent
do we need a State Plan Amendment to do this
demonstration.

So our planned timeline, again, subject to
change, the public comment May 2013 on the regulations.
Regulations finalized in August or September 2013, our
deadline on receiving applications to be an Accountable
Care Organization will be 30 days after the Regulations
are finalized. So if they're finalized in August or
September, our application deadline would be September
or October 2013 and we would have a project start date
of January 2014. So that's the timeline.

We do already have one application that we
received, so that applicant isn't waiting for the
Regulations. They may need to change based on review
DR. SPITALNIK: Any questions about the ACO demonstration?

Seeing none, from the MAAC, any questions from the public about the ACO demonstration?

Thank you. Let's move on.

MS. HARR: You heard Dr. Lind introduce himself. He's been leading a Credentialing Task Force. The goal is to try to provide streamlined unified credentialing process for medical, dental, and mental health, and non-traditional providers in New Jersey. That's the goal. I think we probably will start small just within the Medicaid program, but there's a vision that will be unified credentialing, maybe even with commercial insurance. The Credentialing Task Force was formed and a series of goals developed at the February 26, 2013 medical and dental directors meeting -- the medical and dental directors of our Managed Care Organizations (MCOs), as well as our staff and it also includes representatives from the Department of Banking and Insurance, other folks from the Department of Human Services, the Medicaid Fraud Division, and the provider community.

The next meeting of that Credentialing Task Force is being scheduled to meet in April 2013, and we will continue to meet every one to two months until such time that there is a formal recommendation on how to work with the streamlining or credentialing between our health plans.

DR. SPITALNIK: Any questions?

MS. ROBERTS: Thank you for this. Is there a target time when this might be finalized?

DR. LIND: Beverly, I'm hoping that we're going to get a recommendation within six to seven months.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Okay. Thank you. And thank you Dr. Lind.

Grievances and appeal reporting update.

MS. HARR: We have over 90 percent of our 1.3 million Medicaid recipients now in managed care. In order to ensure that members of Managed Care Organizations have their rights to file complaints, appeals, and grievances, our managed care contract requires that that MCOs submit quarterly reports to us on the status of complaints, appeals, and grievances. It contractually requires that the MCO allow the members a time frame of no less than 60 days and no greater than 90 days to file Stage 1 or Stage 2 appeal, and four months for Stage 3.

Now, the Affordable Care Act (ACA) changes the complaints and grievances process with commercial insurance. We have historically tried to align the Medicaid rules with Department of Banking and Insurance rules so with that, there was a change effective January 2013, we amended the managed care contract to reflect Department of Banking and Insurance regulation, also because I think the Stage 3 appeals go to the Department of Banking and Insurance, so we have to make sure that we're consistent and aligned there. But that change no longer requires a member to request a continuation of benefits during the appeal process. So previously, if a member requested an appeal, they had to elect if they wanted a continuation of benefits; you had to check-off a box. With the Affordable Care Act changes, the member no longer has to request; it's automatic.

This is under the scope of our Office of Quality Assurance. And Carol Grant, our Chief of Operations, is here in the audience.

So at the request of the MAAC, we're trying to gather, compile our fair hearing statistics. I do have some and will continue to refine them and present them to you in MAAC meetings. A member has an opportunity to file a grievance or appeal through the managed care organization (MCO). A Medicare recipient also has the opportunity to file for fair hearings through the Medicaid agency. So here are our statistics on the fair hearings filed with the Medicaid agency, 76 cases are related to United and they are in various stages of the appeal process. We have eight that are with Horizon and three with Amerigroup.

So with respect to the third quarter of 2012, the majority of the top five categories of member utilization complaints and grievances were for denial of inpatient hospital stays, denial of home health services considered not medically necessary, denial of Durable Medical Equipment (DME), and the remainder fall under "other."

Most of our complaints, appeals, and grievances are resolved internally with the Managed Care Organization at the first or second stage level. Any appeal reaching Stage 3 would require an external review by the Independent Review Organization (IRO). As I said, the Stage 3 appeals do go to the Department of Banking and Insurance.

So let me clarify, are those fair hearings or are those complaints and grievances captured by the MCO, Carol?
MS. GRANT: The 80-some-odd cases are fair hearings. The other numbers are through the internal health maintenance organization (HMO) recording and the complaint database.

MS. HARR: Okay. In addition, the Office of Quality Assurance receives complaints as well. And those complaints are tracked in a database according to the same Banking and Insurance categories.

MR. VIVIAN: The fair hearings are for denials of services generally?

CAROL: Both could be denials of service, but you do have two options.

MR. VIVIAN: Is this annually?

MS. HARR: No, it’s quarterly.

MS. ROBERTS: So that was 80 fair hearings in one quarter?

MS. HARR: Yes. DR. SPITALNIK: Are there questions from the MAAC?

MS. ROBERTS: Thank you. Obviously, this is something that I’m very, very interested in, and I know we have other agenda items so we can’t take an extended amount of time. Would it be possible for this information to be sent out electronically?

MS. HARR: Yes. So those 80 are fair hearings. So we said in October, hopefully we’ll have more information for you on the complaints and grievances that are coming from the HMO quarterly reports, as well as what’s going to the Office of Quality Assurance.

MS. ROBERTS: Quarterly is fine, but can we get an annual picture?

MS. HARR: Yes.

MS. ROBERTS: It appears as though a gigantic number of the group of 80 were from one particular HMO.

MS. HARR: Yes, 76 were United; 8 were Horizon; 3, Amerigroup.

MS. ROBERTS: I’m curious as to when there’s such a huge amount coming from one HMO specifically, does anything happen when you see that volume coming from one particular HMO?

MS. HARR: Yes. The fair hearings will go to the Office of Administrative Law. So it’s not the Medicaid agency that will be a part of that fair hearing. But, yes, we’re aware of those, and so the Office of Quality Assurance (OQA) is looking at the reports that we received from the Managed Care Organization, as well as the complaints and grievances. And, yes, we take administrative action when we think it’s appropriate. OQA meets with clinical staff. Dr.

Lind meets with the medical directors, and we do try to get to the cause, especially if there seems to be some systematic reason that there’s a trend or a high volume.

MR. VIVIAN: That could just be a spike.

You never know. That’s why you would have see it over a duration.

MS. ROBERTS: And I would like to see the annual numbers.

MS. HARR: We did see the numbers increase as we moved different populations to services. So we need to have some time see what the trend is. But certainly, we know about these things based on the calls coming in. Also, we address the issues immediately regardless of what’s happening with the fair hearings.

MR. LAFER: So will we find out how these were adjudicated?

MS. HARR: Yes. Know that the majority of those 9 cases were withdrawn. I don’t know the reason for the withdrawal of the cases, but yes.

This is very new for us to be reporting this type of information. So it’s a work in progress, but we will continue to have this topic and to try to provide information.

More information for you on the complaints and grievances that are coming from the HMO quarterly reports, as well as what’s going to the Office of Quality Assurance.

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with the reductions in hours or the terminations. The Division of Aging Services now, when they do a termination, are sending a copy of the New Jersey Choice Assessment Tool so people know how they've been assessed. And it's really difficult for the consumer to get that PCA Assessment Tool unless I'm involved, and then we can get them. But in our opinion, it should just be rote that the Tool goes out so people see how they were assessed and maybe correct it in the moment.

And the third thing is people are not getting their continued benefits on PCA hours. We have current cases right now where it involved a reduction in hours, and absolutely those folks are getting the reduced amount of hours unless we get on the phone and call and change it.

DR. SPITALNIK: Thank you.

MR. VIVIAN: The other thing I would say I'm concerned about is that United may be too quick to deny, and that can cause a lot of angst. So I would be concerned about that.

MS. ORLOWSKI: I just wanted to point out that they're correcting their mistakes. They recognized in the autumn that they were denying or terminating people and reducing hours, and they were taking corrective measures. I appreciate when they didn't deny so easily.

MR. VIVIAN: But it would be better if they didn't deny so easily.

MS. ORLOWSKI: Agreed.

MS. JACOBS: I'm Jennifer Langer Jacobs from Amerigroup. I just wanted to add on to a couple of the things you were saying. You talked about the continuing hours not being in place. It sounds like an implementation problem maybe of one of the MCOs. Certainly, if it's my MCO, I'd like to know. And then the letters that Gwen mentioned, one of the challenges that we run into is somebody writes a really nice letter, and then somebody else puts it into fifth grade level language, which is required. When you translate from the nice letter that somebody wrote to fifth grade level language some of the nuance and style and, frankly, clarity gets lost because you're trying to take it down several vocabulary levels.

I don't think we all use the same letter, but I'm wondering if it would be helpful for us to have that conversation about the best way to communicate this sort information at the reading level we have to communicate it. It's not something I've heard before, so I'm just really interested in trying to get to the bottom of that.

MR. LUBITZ: Phil Lubitz. So the first thing I think we need to control when we're looking at complaints is the level of understanding of the recipient of the right to complain and the procedure to complain. That's really the first thing you have to understand, that there's equality across all the health plans about the recipient's understanding that they can complain before you really look at the number of complaints per organization.

MR. MANGER: Joe Manger from Horizon NJ Health. Just a quick comment. The Office of Managed Health Care does have templates. And I know Horizon NJ Health is using them, but I know that they're under discussion after revisions for just the same reasons brought up because of continuation of the benefits change that just went into effect January 1, and also the recent issue with PCA not having the right to deny an appeal. So I know those are under review and I know we will continue those discussions. We're right with you. They're not always the clearest things, but unfortunately there's a lot of regulatory and statutory stuff that we have to put in.

DR. SPITALNIK: Thank you.

Also, we wanted to add an item to Valerie's report, on the HMO Performance Report.

MS. HARR: I have hard copies, and we'll make sure we send a link out to the report. We have it listed up here on the overhead.

We do an annual HMO Performance Report, so I have copies of the 2011 Report to share with everybody.

DR. SPITALNIK: Thank you very much.

Our next item: State Fiscal 2014 Budget update. And I'll turn to Vasyl Litkewycz, the Bureau of Budget and Accounting and, DMAHS.

(Mr. Vasyl Litkewycz provided an overview presentation of the proposed 2014 State Fiscal Year Budget).

DR. SPITALNIK: Thank you very much.

Any questions from the MAAC?

MS. COOGAN: So the savings, the $227 million, that will stay a part of the Medicaid budget?

MR. LITKEWYCZ: Yes. Our budget would have gone up, but we will be able to receive a federal match.

MS. COOGAN: Right. So that $227 million is in your total?

MR. LITKEWYCZ: Yes. Out of a $3.5 billion state budget.
MS. HARR: I just want to mention our Department of Human Services budget hearings, we have the Assembly budget hearing on April 16th and the Senate Budget and Appropriations Committee hearing on May 1st.

DR. SPITALNIK: Thank you.

Any questions from the public about the budget?

MS. JACOBS: Please forgive me if you said this, but the $159 million in trend, does that include long-term care?

MR. LITKEWYCZ: Actually, it does a little bit, a piece of it, but not the whole Managed Long Term Care Services and Supports (MLTSS).

MS. JACOBS: The long-term care that's currently fee-for-service is in there?

MR. CASTRO: The $8.5 billion for Medicaid is just for the Department of Human Services (DHS). Do you have the total amount for all departments?

MR. LITKEWYCZ: I believe our federal claim annually is about $12 billion, so the full Medicaid program statewide would be in that $12 billion, state and federal. Probably a little bit above that now.

DR. SPITALNIK: Thank you very much. And we wish you well with the budget hearings.

Our next item is the implementation of the Affordable Care Act initiative. And we have John Guhl who part of CMS Region 2, and former Division of Medical Assistance and Health Services (DMAHS) director.

MR. GUHL: I'm John Guhl. I'm now with CMS. And we are now involved in the outreach and enrollment for the ACA. I would like to engage as many stakeholders to assist with the outreach and enrollment efforts for the Affordable Care Act as possible. So I have a couple of forms if anyone is interested, please fill them out. Have three of the same form. I'll put it in the back. Anyone interested, please fill it out, and we want to help you help us with our outreach and enrollment efforts. As Valerie mentioned, enrollment begins October 1, 2013 so we need as much stakeholder support in the efforts to enroll as many possible as possible.

Thanks for your time.

DR. SPITALNIK: Thank you.

We'll go to other elements of ACA, the Non-Billing Provider Enrollment, the Provider Rate Increase. Valerie Harr and Marcia Harrison is in the Office of Managed Care Finance and Fiscal Reform from DMAHS. So I'll turn to Valerie and Marcia.
any questions the public?

MR. PYLE: Thank you very much for a
detailed and technical presentation.

As a father of man who has a psychiatric
disability, I'm very concerned that the ACA has done a
great social injustice to all who have psychiatric
disabilities by not including psychiatrists and other
non primary care providers in the rate increase from
the current 37 percent of Medicare rate to 100 percent.

I'm also concerned that this is only going to last for
two years for the primary care providers.

So my question is then to maybe the Medicaid
department. What is the State going to do to equalize
the payments for psychiatrists that are not being
covered by the federal top upgrade? And who is going
to decide what these rates are going to be so that we,
parents and family members who feel very strongly about
this injustice, may I say, note to where we could
direct our advocacy?

MS. HARR: In terms of the Affordable Care
Act, you could direct your advocacy to CMS, those
providers were excluded from this rate increase.

This leads me into the next topic of
discussion, because as part of our movement to a
managed behavior health system, we are doing a rate
analysis.

Actually, Ms. Fresolone, can you comment on
the status of the rate study for providers?

MS. FRESOLONE: I'm not sure we can talk
about who it's going to be yet, but there is an Request
for Proposal (RFP) for an actuarial firm to look at the
behavior health rates. There will be a contract to
look at behavioral health services rates, including the
psychiatric service. There's a whole list of our rates
and we'll look at it through an actuarial firm.

They'll be making some recommendations for rate
balancing for on all our services.

MR. PYLE: I appreciate the direction to
CMS. I'm interested in somebody in the State because
I'm interested to see if the State will then do what is
necessary, even if CMS is not.

DR. SPITALNIK: I think what Vicki Fresolone
was describing is a State action. And may I ask that
we wait until we discuss the Administrative Service
Organization (ASO) under the CMW and engage the issue
there.

MR. PYLE: Who is going to make decisions
about rates? I appreciate that the consultant firm is
going make the proposal, but who is going to be the
final decider as to what those rates are going to be?

program is only for two years. And it sounds like
there's some things between the Division and CMS that
are still going forward I wondered if you could speak
to that and what you think the deadlines are as to when
current providers will actually be getting
reimbursement, how you're going to move that forward?

And secondly, a part of this is really to
increase provider participation. And I don't think
you're going to get new providers until the
reimbursements are actually flowing. But I'm wondering
what the procedures are on that.

And then the other thing I would request is
that at the next MAAC meeting that this be on the
agenda again so we can get updates.

MS. HARR: CMS has our State Plan Amendments
(SPAs) to review. SPAs need to be submitted before the
last day of the quarter. So we did that. So that
would have been March 31, 2013 Assuming it's approved,
it would be retroactive to January 1, 2013. And those
payments would be reprocessed back to January 1, 2013
so the providers would see the rates back to that day.

MR. SPIELBERG: But in terms of new
providers, in terms of getting current reimbursement at
the Medicare rate, which will be a concern both to
existing providers and to new providers, when will that
fee-for-service basis. So there is fragmentation and services are provided to those in managed care but on a carve-out. So mental health and substance abuse disabilities. Currently, behavioral health is a carve-out. So mental health and substance abuse services are provided to those in managed care but on a fee-for-service basis. So there is fragmentation and lack of coordination.

MS. HARR: That's what we hope, that more providers will be willing to accept Medicaid. It would be upon their enrollment either into the managed care organizations network or in fee-for-service. So it wouldn't be until they were an active provider. It's something that we are discussing internally, is there something that the MAAC could do or members of the public can do to try to attract, through communications, more providers to accept Medicaid and get that word out about the provider rate increase?

MS. ROBERTS: Again, for us all to be consistent, if there could be something that you put together about that and then get it out to everybody on the MAAC as well as everyone who's in attendance here, I know I would be happy to distribute it, and I think other people would as well.

DR. SPITALNIK: Thank you. Anything else about the rate increase at this point?

MR. PYLE: Can I ask a quick question? Does the rate increase apply to all who are coming into the Medicaid system? It doesn't apply only, let's say, to the newly eligibles?

MS. HARR: It applies to all Medicaid recipients, new or existing.

DR. SPITALNIK: Marcia, thank you so much, and we'll put this on the Agenda for our next meeting. Our last topic is our Comprehensive Medicaid Waiver update. We're going to move the third item, Dual Diagnosis and Pervasive Developmental Disorder Pilot Updates to our June 2013 meeting. And I'll turn to Valerie Harr for an update on the ASO and the Behavioral Health Home and also the Managed Long Term Services and Supports (MLTSS) update. I'll turn to Valerie.

MS. HARR: So unfortunately given our time constraint, I don't think I can take you back in time and get you through our whole CMW process. But I think, Dr. Spitalnik may address that in an orientation for the new MAAC membership. We can certainly make sure you understand the whole CMW.

As I mentioned, we have 90 percent of our Medicaid beneficiaries enrolled in one of four HMOs, with the exception of people with developmental disabilities. Currently, behavioral health is a service provided to those in managed care but on a fee-for-service basis. So there is fragmentation and lack of coordination.

The RFP for that vendor has been drafted and is under review. And it's a coordination between DMHAS and the Medicaid agency. I would say these are still optimistic timeframes but RFPs need to go through Purchase and Property in many cases, and the Office of Management and Budget needs to approve it. It's not solely within my authority. So optimistically, the RFP or Request for Proposal, will be issued in summer 2013.

We hope to award a vendor in late fall or winter 2013. We would go live after January 2014 because we will allow ourselves a 4 to 6 month readiness review to make sure that the State's organizations and systems, as well as the vendor and providers, are ready to move into this new system.

The ASO is non-risk. It's a managed behavioral organization but it's financed in a way that is different from MCOs?

DR. SPITALNIK: Questions?

MS. HARR: We are looking to doing a pilot of a Behavioral Health Home for individuals with severe mental illness. So we have a concept paper that has been sent to CMS, and we will begin to have conversations with CMS. It will result with a formal statement amendment and the selection of a region to do a pilot of a Behavioral Health Home. And we're targeting individuals with severe mental illness where they are receiving ongoing behavioral health services, and we want to try to physical health and mental services onsite and co-located or at least have strong coordination with physical health. It's really an attempt to coordinate physical health and mental health and substance abuse services.

Now, Managed Long Term Services and Supports, we do have a Steering Committee that was established as part of the CMW for Managed Long Term Services and Supports. While there's tremendous opportunity for long-term savings to the state and federal government, as well as improved quality of life, there are a lot of start-up costs and there's a lot start-up and systems and implementation that has to
happen, and we have so many on-going priorities that we've taken a step back and said, how can we start Managed Long Term Services and Supports in a way that we can administratively handle and in a way that is financially doable?

What we are proposing to do is have a staged implementation for Managed Long Term Services and Supports, beginning with home and community-based services, individuals receiving long-term home and community-based services and moving that into managed care, effective January 2014. The major reason that we did that is because approximately 12,000 individuals, are already enrolled in an HMO for their acute care services. So this would be an expansion so that HMOs would be responsible for their services and supports. And then we are proposing that six months following, July 2014, the managed care organizations would be responsible for the nursing home population, which is another 28,000. This is a partnership between the Medicaid agency and our Division of Aging Services. So we still working through a lot of the details. We are drafting revised contract language, because it's in contract what the MCOs will be responsible for managing when we have a Managed Long Term Services and Supports program. We're looking at our care management program for this population. We are developing a set of Frequently Asked Questions that I know the Steering Committee will be receiving and commenting on. Dr. Spitalnik, I would offer that the MAAC review those materials and provide feedback. In the documents, We try to include questions that providers would have, as well as consumers about this movement to MLTSS.

We were hoping people are able to age while in their homes, in the community and delay, not that they won't need it, but delay their need to move to a nursing home setting.

DR. SPITALNIK: Thank you so much. Questions from the MAAC about either the ASO or MLTSS?

MS. EDELSTEIN: Very quickly, I would like as part of the MAAC to be able to review the FAQs. You had mentioned that that was possibility?

DR. SPITALNIK: Yes, we will.

MS. EDELSTEIN: And also the communications issue, I know we've talked about a little in the past, but I would love to see if we could review that information and have that on the agenda for the next meeting. Thank you.

DR. SPITALNIK: Other comments or questions?
the capitation rate.

MS. MASON: They still have to have their assets down to the Medicaid income level. The hypothetical eligibility is based on the private pay nursing home rate of about $7,000 month. That will make you categorically eligible for Medicaid. Then your deduction from your income to get back down to Medicaid eligibility will be based on the capitation amount.

MS. ORLOWSKI: Thank you.

MS. HARR: On the attestation, just so everybody knows, that one of the concerns is the amount of time it takes for applications to be reviewed and processed and approved with the County Welfare Agencies. So one of the things we thought we could do to try to expedite that is -- for applicants that have income less than 100 percent of property that are applying for institutional Medicaid, the likelihood that they transferred any assets is very small. So we said in our CMW proposal we would like to waive the five-year look-back period for someone who is applying for Medicaid benefits with income less than 100 percent property, we would take an attestation that they did not transfer assets during that period. To us, it's a program integrity issue. There must be a sampling and a review of these cases. If during that process or some other process it is found that one of the individuals who attested that they had not transferred their assets is found to have done so, we are not waving that. There will be the normal course of process to resolve that issue. So again, we think the likelihood of that is very small. We don't think that's a huge risk for the state or federal government.

It's not waiving the penalty. It's allowing for the self-attestation, but we have to do a post-audit and that will be something we report on. And CMS is eager to see what the results of this are in our CMW. I think it's a demonstration that we're really pleased about and eager to launch.

So, Gwen, number three, can you clarify your question.

MS. ORLOWSKI: There are people who need nursing facility level of care but they're being told under the Global Options (GO) Waiver that they're not in the target population because they have chronic mental illness. When you look at the GO Waiver that phrase is used in two different places. One is the CMS requirement, so if the person otherwise would need to be in a psychiatric hospital, the State can't divert them to a home and community-based placement for,

historical reasons. This has to do with reimbursement rates and federal matches, etc. But, then also in the CMW itself, the State limits it and said people with chronic mental illness or developmental disabilities or intellectual disabilities can't be on the GO Waiver.

However, I've been told that that will no longer be the case when we move to Managed Long Term Services and Supports, that there won't be a prohibition on getting Managed Long Term Services and Supports. So I have clients right now who absolutely meet level of care, who absolutely need services, recognized as such, but because they're in their own homes and they are unwilling to receive those services in a nursing home, are in their own homes without services.

MS. HARR: So in general, I'm going to say you're correct. We have home and community-based Waivers right now, and we very much see them as silos and some of them have slots. When we move to Managed Long Term Services and Supports, that silo approach goes away. But, there will be a requirement for an assessment to be done, a plan of care to be developed, but you would not have that restriction. If someone is financially eligible for Medicaid and meets the nursing home level of care and a plan of care is developed and it's determined that home and community-based placement

and services are appropriate, that's what we would do.

MS. MASON: And, the only thing I would add is that Behavioral Health is part MLTSS, so hopefully that will provide a more holistic approach to that population.

MS. HARR: So that hopefully will be one of our great successes and accomplishments when we move to Managed Long Term Services and Supports.

DR. SPITALNIK: Thank you. Thank you all.

This was a both a very full meeting and highly technical meeting, and I thank everyone for our presentations and their forbearance.

(Review of the meeting conducted by Dr. Spitalnik.)

DR. SPITALNIK: Do I have a motion to adjourn?

MS. COGAN: Yes. Motion to adjourn.

MS. CORNE: Second.

DR. SPITALNIK: All those in favor.

MEMBERS: Aye.

DR. SPITALNIK: Any opposed?

Thank you all. We look to forward seeing you in June.

(Meeting adjourned at 12:30 p.m.)