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

April 25, 2019
10:15 A.M.

FINAL
MEETING SUMMARY

DR. SPITALNIK: I want to welcome both the members of the MAAC and the members of the public.

We have had a strong tradition in the Medical Assistance Advisory Council (MAAC), which we take great pride in, of being able to have interaction on a substantive basis issue-by-issue. Many councils resort to restricting public input to a particular time. What our practice has been is that after a presentation, we ask if the members of the MAAC have any questions or comments. After those are concluded, I'll turn to the members of the public. This is a time to raise questions or make brief comments. We reserve the right to have to restrict the timing of comments. We've never had to resort to that, and I'm sure we never will.

So welcome, everyone. First, I think I will review the agenda, and then we'll ask people to

introduce themselves. So, after introductions, we have a series of presentations on the New Jersey ABLE Accounts, on Office Based Addiction Treatment (OBAT) and Medicaid Assisted Treatment (MAT), a presentation on Any Willing Qualified Provider Initiative (AWQP), then we'll have a series of informational updates from Division of Medical Assistance and Health Services (DMAHS) Office of Innovation, Managed Long Term Services and Supports (MLTSS), and NJ FamilyCare.

So with that, we'll proceed to introductions.

(MAAC members introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Welcome, everyone. We are always so appreciative of everyone's attendance. I think it makes for a robust discussion.

We are going to waive the approval of the minutes. I don't think we have a quorum, and we'll move right now to presentations. And we'll start with New Jersey ABLE Accounts, and I'll welcome Ursula Baker and Dianna Maurone of the New Jersey Division of Disability Services (DDS), which is part of the Department of Human Services.

Welcome, Ursula, and thank you for being with us.

MS. BAKER: Thank you, Deborah. Good morning

again.

I'm Ursula Baker. I serve as the Information and Referral Unit Supervisor at the Division of Disability Services, and I also serve as the representative for ABLE for the State of New Jersey.

I just want to mention that the Division's mission is to provide a single point of entry for those seeking disability-related information. And we're responsible for sharing that information that promotes maximum independence and a full participation with those with disabilities within all aspects of community life. Today, I'm here to share with you about the ABLE Program and its valuable benefits.

(Slide presentation by Ms. Baker.)

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

DR. SPITALNIK: Thank you.

Any questions from the MAAC?

Beverly.

MS. ROBERTS: First of all, thank you very much. That was a great presentation.

MS. BAKER: Thank you.

MS. ROBERTS: I do have a couple questions.

First, on Slide 26, the example that you gave with Katy, you talked about the Medicaid Buy-in Program, NJ WorkAbility. Now, this is just a sidepoint because that's not what your presentation is about, but I never viewed NJ WorkAbility as a Medicaid buy-in. Right?

MS. DAVEY: Right. It's not.

MS. ROBERTS: Is there a buy-in program through Medicaid?

MS. DAVEY: Just the Medicare Buy-in Program. And then we have the Payment of Premium and Premium Support Program where we buy-in for employer and individual coverage --

MS. ROBERTS: So the reason I was asking -- totally unrelated to this -- but someone had called me with regard to a child, a little child, like 14-months-old, with a very, very severe disability who I think is probably eligible for Private Duty Nursing (PDN) through MLTSS, but the parents were very concerned what happens if they're not approved and they asked about Medicaid buy-in for an infant. And I just didn't know.

MS. DAVEY: We should talk about that separately.

MS. ROBERTS: Okay, so we can talk separately.

So now back to the couple very specific questions that I have about your presentation. On Slide No. 9 where it says, "No impact on current benefits. ABLE assets will be disregarded or receive favorable treatment."

Disregarded is what I had thought. What does "receive favorable treatment" mean? Does that mean something different from "disregarded?"

MS. BAKER: It means the same. It's not going to be looked at. And if you have an ABLE account, it's a good thing.

MS. ROBERTS: I get that, but I just wasn't sure if "receive favorable treatment" meant something different from "disregarded."

DR. SPITALNIK: It is confusing. Is that part of authorizing legislation, the favorable treatment comment?

MS. MAURONE: It's how it's written, but if it makes it less confusing, we can leave that piece out, because essentially it's disregarded.

MS. ROBERTS: Right. That's sounds better to me. That's what I always thought. When I talked about it, I just said disregarded.

And then my very last question on Slide No. 10 where it says NJ ABLE is subject to the Medicaid payback provision, could you just talk a little bit

about that?

MS. BAKER: So when someone has Medicaid and either they're receiving benefits while they're living and they pass away, they are required to file a claim and pay back all the benefits that they used with those funds. They would have to use New Jersey ABLE funds to pay back.

MS. MAURONE: So if I could just jump in. So before any of the money that remains in the ABLE accounts would go on to the individual's estate, Medicaid could file to receive payback for any money that they paid during that person's life for services. So they have the option to go ahead and recoup that money, as they do anytime you're enrolled in a Medicaid program.

MS. ROBERTS: There's different between they could, they have the option, and this is what will happen.

MS. BAKER: It will happen. There is a form that needs to be filed. We are working with New Jersey ABLE to manage to keep account, do quality control to make sure that when someone passes away, if it's the account owner, the authorized representative or someone is required to let New Jersey ABLE know, who then lets Medicaid know, and then there's a formal process that we

do not get involved with. That's through Medicaid.

MS. ROBERTS: Just because I talk a lot to families with young children. So let's just say somebody would open an ABLE account, somebody is 20 or 21 years old. Years down the road, they have $50,000 in their ABLE account. They pass away. The likelihood is that for all of those years with the payback provision that money would probably be taken back.

MS. MAURONE: Medicaid is going to recoup first. And then whatever is left can go to the estate.

MS. ROBERTS: Thank you.

MS. LIBMAN: My question is referring to no impact on current benefits. So people that are in the Division of Developmental Disabilities (DDD) world and the Supports Program and getting funding and things like that, I see here that you could use your ABLE account for employment training and support, a lot of things that you could use the Supports Program for. Can they use this in addition to the Supports Program, once they back stamp their two-year budget?

MS. MAURONE: I don't see why they couldn't because you can always private pay for any service that you want, and that would be absolutely considered a disability-related expense. So I don't see why they couldn't use their own funding. So once your budget is

maximized, you can put in whatever -- and it doesn't affect your eligibility for DDD because, in fact, this is really one of the main benefits is that it's going to allow you to maintain that Medicaid so you can continue to receive the services that you need.

MS. LIBMAN: But you wouldn't be penalized the reverse, well, if you're paying for it privately why should we --

MS. MAURONE: I would ask DDD that question, but I don't believe so. I can certainly look into that and get the answer back to Meghan and Deborah.

MS. EVANS: But your language is similar to the Special Needs Trust. It's supposed to supplement benefits, not replace them.

MS. MAURONE: That's right.

MS. EVANS: Or not duplicate them.

MS. MAURONE: Right. So it shouldn't penalize them is what you're saying, right?

MS. EVANS: Well, you shouldn't be duplicating services you're eligible for because of your eligibility. This should be supplementing it.

MS. MAURONE: Okay. I'll check with DDD.

DR. SPITALNIK: When you make a comment, can you please give us your name?

MS. EVANS: Lily Evans.

DR. SPITALNIK: Thank you.

MR. VIVIAN: When you say all benefits, does that include housing subsidies, as well?

MS. MAURONE: That's a tricky one. No, not yet.

MS. BAKER: They are working on legislation. Some of the housing on the table right now is with HUD.

MR. VIVIAN: What about like a voucher?

MS. MAURONE: I don't know the answer to that question, actually. I'd have to look into that further. I know that Housing and Urban Development (HUD) is not on board yet. They don't overlook it. And it is a problem currently for people who have a HUD voucher or other Section 8 or something. I could ask about the Division of Mental Health and Addiction Service (DMHAS) with that type of voucher and get back to you on that as well.

MR. VIVIAN: Because we have a couple of people that are going to inherit money. They don't know it will affect them.

MS. MAURONE: The other thing you need to think about, depending on the amount they're inheriting, so there's $15,000 annual maximum for NJ ABLE. So if it's more than that, they're going to go with a Special Needs Trust (SNT)first, just to accommodate all of that

money. And an important thing is that you can have both. So we're here to talk NJ ABLE because it's a great program for individuals with disabilities who meet criteria, but we're not trying to say it's the only program or the best. I think people really have the opportunity to open both things, depending on their circumstances.

MR. VIVIAN: Well, it may only be like that amount, but if they have to open up a Special Needs Trust, it will cost a lot. It will eat up a lot of that 15,000.

MS. MAURONE: It does, I know. And that's kind of disadvantage. But these folks are receiving some type of housing subsidy or voucher?

MR. VIVIAN: Yes.

MS. MAURONE: Okay. I will definitely ask that question and get back to you.

DR. SPITALNIK: Thank you.

Any other questions from MAAC?

Paul.

MR. BLAUSTEIN: Paul Blaunstein, Chairperson of Developmental Disabilities Council. This isn't a question. I think the answer to Beverly's last question was misleading. Medicaid does not recover, it's the State. It's not the Centers for Medicare and Medicaid

Services (CMS). It's up to the individual State whether it wants to recover. It's not a federal recovery. So New Jersey right now allows recovery. Not every state does.

MS. MAURONE: Thank you for clarifying that.

DR. SPITALNIK: Questions?

MS. ORLOWSKI: Gwen Orlowski, Disability Rights New Jersey. I have a question about who are the legal representatives who can assist in establishing the ABLE account, if that's clearly defined and if that's anywhere that people can find it.

I ask that because I had a client last autumn who came to me in the situation that the mom was the guardian of the person but not the guardian of the property, and they needed to do this quickly to get Medicaid eligibility. That guardianship of the person documentation did not suffice in New Jersey. It did in Ohio. I don't know if Ohio is as scrupulous as New Jersey. But I'm wondering if there is a concrete answer to that and a list of what constitutes an authorized person to help set up a trust, especially if the person lacks capacity.

MS. MAURONE: That's a good question. We don't have a list, but we have a reach out to a Census. That's something that they'll have. I would assume

that, as you mentioned, anyone that has control over money, so a power of attorney or a guardianship of property, that seems to make sense with our typical rules and regulations. But I'll follow up with a Census and get that answer out to you as well.

MS. ORLOWSKI: So to the extent that it's not the other one, just maybe having Frequently Asked Questions (FAQs) that clarifies that for people, because when they come and they say, "But I am the guardian," and they show me the paperwork, I'm like, you are the guardian of the person. That would be really helpful.

MS. MAURONE: Thank you.

DR. SPITALNIK: Thank you.

MS. ABRAMS: Mary Abrams, New Jersey Association of Mental health and Addictions Agencies (NJAMHAA).

You say disability-related expenses, and then you have quite a long, broad list of areas that it could fall within. And I think you specifically mentioned rent?

MS. BAKER: Yes. You can use it to pay the rent.

MS. ABRAMS: And I'm wondering how that qualifies as a disability-related expense. Of course, moving out, you had the one example, or if you needed

ramps or equipment or specialty things.

MS. BAKER: The beauty of that is it's not limited to medical necessities. So someone who is disabled and they're living on their own and they're able to rent, that's maximizing their independence and quality of life. It is very broad, which is a good thing. So they would not be penalized. And there is a penalty for someone who uses the funds outside of that scope. You could use it for mass transportation. It's a long list, so I don't know how you could go wrong.

MS. ABRAMS: A simple justification of independence supports the rent?

MS. MAURONE: Right. And I think that in addition to that, you want to think about meeting basic needs. So ABLE recognizes that an individual with a disability needs more money because of the things that they require. And so this is allowing them that savings account to spend. So it is still an expense that other people have, but recognizing that other expenses that they incur that others don't kind of leave them with less, which is why they're able to leave it for that.

Now, I think if you were trying to make an argument about vacation, that would be tricky. Unless it's a specific type of guided tour or something that would meet your needs, I think that could be an

argument. But here's the thing; it's up to the individual to make these choices on how they use the money. That person can be audited, so we definitely don't recommend that they use the expenses for anything that's not disability-related, but it is established in a way that it is broad on purpose. So that's really the benefit of this program. So we don't want any more rules.

DR. SPITALNIK: Wayne.

MR. VIVIAN: I have a question regarding the investment options. So any money that's in this account will be invested? I see you have more aggressive approaches. You have more conservative approaches. So is all the money invested? Is there a set amount where the person gets a 6 percent return or a 4 percent return?

MS. BAKER: What we recommend, we're doing the marketing and outreach. If you have an investor or someone that you hire to do your taxes or show you how to invest, we would recommend that you reach out to them. We are not here to say how to invest.

MR. VIVIAN: Is the money automatically invested?

MS. BAKER: That's a question for a census.

DR. SPITALNIK: I'm making a list of

questions that have been raised. And at our next MAAC meeting either with a sheet answering those questions, we'll make sure that they're communicated.

MR. VIVIAN: I guess what I'm asking is can you opt-out of investing or is the money automatically invested?

MS. MAURONE: I'll look into it. How many people in here have 529s for their kids? Anyone?

This is really a 529 for people with disabilities. Do you know if your plans allow you to have sort of a bank option?

MR. BLAUNSTEIN: Yes, there's a cash option.

MS. MAURONE: And I think there is the same with NJ ABLE, but I want to verify it with a census before I get back to you.

MS. BAKER: I believe there is a banking option. It's through Fifth Third Bank.

MS. MAURONE: I think that's correct. In fact, I'm pretty sure it's in the handout that's on the table that you grab on your way out.

MR. VIVIAN: Paul, may I ask you a question?

MR. BLAUSTEIN: Sure.

MR. VIVIAN: Regarding the Medicaid Payback, since it's only the State that does it, does that mean you're only responsible for half the amount?

MR. BLAUSTEIN: I would think so.

MR. VIVIAN: Because the other half, the federal government doesn’t require it.

MR. BLAUSTEIN: They do not recapture.

MR. VIVIAN: So then technically no matter how much Medicaid has laid out on your behalf, they could only take half of it back?

MR. BLAUSTEIN: I would assume that's the case.

MS. DAVEY: No, we take it all and then we reimburse the Federal.

MR. VIVIAN: Even though they don't require it?

MS. DAVEY: Right.

MS. MAURONE: I just want to jump in. Someone was so kind to bring the brochure to me. So the Able brochure actually says that you can contribute to an FDIC-insured checking account through Fifth Third Bank, as Ursula mentioned, that lets you withdraw money using a debit card or by writing a check.

MR. VIVIAN: So you have the option, so you could put directly in a checking account?

MS. MAURONE: Yes. Through this, though, not any other kind of checking account.

DR. SPITALNIK: One last question.

MS. TODD: Dennie Todd with the New Jersey Council on Developmental Disabilities. I'm also an advocate.

I just need clarification. When you guys are saying duplicating services, is it also known as double-dipping? I'm curious. I don't know.

MS. MAURONE: I mean, in this regard, it would not be because these are your funds. These are not Medicaid dollars, so no.

MS. TODD: For recreational purposes, if it was therapeutic, would it be covered?

MS. MAURONE: I think you could make the argument, yes.

DR. SPITALNIK: Thank you very much.

I also want to make a reference. On the Boggs Center website, there is a presentation by Michael Morris who is the head of the National ABLE Association that explains a lot of background of ABLE of trying to provide equity for family members with disabilities comparable to a 529. So as you're introducing this to people you serve or colleagues, that may be a useful resource to everyone.

Thank you both, and thank you for your willingness to research these questions.

(Applause.)

DR. SPITALNIK: We will now turn to Steve Tunney, who is Chief of Behavioral Health and Customer Service at the Division of Medical Assistance and Health Services, who is going to give us a presentation on Office Based Addiction Treatment and Medication Assisted Treatment.

Steve, welcome back.

MR. TUNNEY: Thank you.

Good morning, everybody. I'm just going to run through the New Jersey Medication Addiction Treatment (MATrx) Office Based Addiction Treatment (OBAT) Program quickly.

(Slide presentation by Mr. Tunney.)

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

DR. SPITALNIK: Thank you so much, as always.

Questions from the MAAC?

Hearing none, questions from the public?

MS. ABRAMS: Mary Abrams, NJAMHAA. If I may, I do have two.

On the counseling, you did note on one slide that navigators are required to track outcomes. I'm wondering what kind of monitoring or reporting is there

to ensure that they're actually getting the counseling services in particular that are so important to success.

MR. TUNNEY: So a navigator's treatment plan, for lack of a better term, is going to be, for example, they're experiencing anxiety and they need counseling. So then the intervention would be making a referral to Joe's OTP program. They go through the program. The navigator is going follow-up with that individual to see what progress they're making, did it meet their needs, are they feel better based on the treatment that they're getting. It's going to be that simple for the navigator.

The actual treatment provider, Joe's OTP, is going to have more of the official quality type things that we would measure, like the stays and things of that nature that we do.

There's going to be some -- I don't have a definitive answer yet because we haven't gotten it from CMS, but there's going to be some quality measures that we have to report under OTP that will be associated with the actual physician practice.

But, again, I'm just trying to recognize these individuals that are the navigators are not really clinicians, per se. They have experience with this and they can provide a great service, but they're not a

clinician providing an actual counseling service.

MS. ABRAMS: Right. And my concern is if that if they're not monitored or reporting on making those connections or ensuring that, you have people just being prescribed and you have no clue how many are only getting that prescription and not getting the other services.

MR. TUNNEY: Like any other Medicaid-covered service, they've got to do the who, what, where, when, how. So if they're making a referral, that's got to be documented, I referred them to this person for this reason on this date. And then the E in the PIE is the evaluations. Now you're going to follow up. Hopefully, there will be agreements between providers. You're going to have that established relationship of who you're making these referrals to. And it's just on a basis of are they showing up? Are they getting the services? Now it's up to a provider to determine, okay, they need to go to another provider, and we'll go that way. It won't be lost.

DR. SPITALNIK: Thank you, Steve.

Phil Lubitz.

MR. LUBITZ, Mental Health Alliance: Sort of a follow-up question. So I'm hearing that it's a requirement that the physician practice has a navigator.

Is it a requirement that the patient take advantage of the services recommended by the navigator?

MR. TUNNEY: No. We're following ASAM guidelines. A big part of ASAM is individual choice. Not everybody would benefit from having counseling.

MR. LUBITZ: Benefit or want.

MR. TUNNEY: Or want, correct. That's what I'm saying, not everybody will go to counseling. But the person's role will still be to continue to make attempts to connect them with services that are identified as a need.

MR. LUBITZ: That's going to affect your quality measure.

MR. TUNNEY: Okay.

DR. SPITALNIK: Dennie.

MS. TODD: Dennie Todd, New Jersey Council on Developmental Disabilities.

I'm going to piggyback on what you had just said. How many of the addicted personalities in the State of New Jersey come to ask for assistance from you?

MR. TUNNEY: I missed the last part.

MS. TODD: How many of the addicted personalities in the State of New Jersey come to ask you for assistance, for help?

MR. TUNNEY: Me, being Medicaid?

MS. TODD: Medicaid.

My question is how many people with an addicted personality come and ask for the help? Because you know they're not going to get the help unless they ask for it.

MR. TUNNEY: Most of the people go through the IMA or through the other channels that are available. They can go directly to an OTP clinic. They can go directly to an FQHC. There's no wrong door to get into this service. We're just saying that we're opening up another piece of this puzzle where people can choose to go. And that's it.

DR. SPITALNIK: Thank you. One more.

MS. ABRAMS: So the navigators are only available to the primary care physicians? There were a couple slides there that led me to believe some of the other ambulatory care and whatnot under fee-for-service (FFS) could also be --

MR. TUNNEY: So the navigator has to be to a practice that cannot provide counseling. Or if you're counseling practice, it can't provide physical medicine. So there's that need to connect them up with the half that's missing. That's what that's going to be. So an FQHC ambulatory care clinic, the groups that have both sides coming separately outside of all that, there's

going to be SUD peers and they'll be able to utilize those services to assist people with many of the same things, connecting them with services out in the community.

MS. ABRAMS: So the outpatient clinic that don't have primary medical care generally but might have a psychiatrist, they are or aren't eligible?

MR. TUNNEY: I don't want to get into the licensing part of this. They have a psychiatrist, but they're not allowed to provide primary medical help in those clinics unless they have a separate license. If they do, then they become an ambulatory care clinic. So it's going to depend on what group you actually are. And it could come even down to a case by case.

MS. ABRAMS: For them to be able to do that case management piece would be great.

MR. TUNNEY: Agreed. I don't want to leave anybody out, if we can.

DR. SPITALNIK: Thank you.

MS. ANGELINI: Will you be keeping a database of the navigators? How would the outpatient programs want to connect? Because I think that would be a good opportunity.

MR. TUNNEY: The managed care organizations (MCOs)are responsible for certifying, and they're going

to put onto their providers' list that they keep online, and they will be identified as an MAT provider with navigators. So we'll have them that way if somebody's searching or wants to look. Otherwise, I'm pretty much relying on relationships that will get built between individual practitioners and whoever the OTP providers are in their community and go from there.

On the Medicaid side, it's going to be harder because you come into Medicaid and in a month now you're in an MCO. Most of the people that come through the door, they need the service today, are going to be those fee-for-service (FFS) people. So we're going to get that going. When a provider says that they have the navigator, then we'll go with that until so we can set something up.

MS. ABRAMS: Thank you.

DR. SPITALNIK: Steve, thank you so much for this presentation and for what you're doing.

(Applause.)

DR. SPITALNIK: Leah Rogers, who is the Quality Assurance Coordinator in the Division of Aging Services (DoAS), a presentation on Any Willing Qualified Provider Initiative.

Leah, welcome.

MS. ROGERS: Thank you. Good morning.

So the AWQP Initiative was developed in collaboration with the MLTSS Steering Quality Workgroup, which includes the NF providers, the MCOs, and other long-term stakeholders and advocates.

(Slide presentation by Ms. Rogers.)

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

MS. DAVEY: Any questions from MAAC members? Questions from the public?

MS. LIEBMAN: Hi. Evelyn Liebman from AARP.

AARP was a member of the quality workgroup that was part of the collaborative process that developed the Any Willing Qualified Provider Program, and I would note that one of the goals of the program, at least as part of that collaborative process, was to more fully extend the goal of Managed Long Term Services and Supports to not only improve quality, but to bring the institutional facilities fully into a more market-based approach and give some flexibility to the MCOs to consider whether or not any nursing facility that did not meet the collaboratively established quality measures to be excluded from the network.

I raised this at the MLTSS Steering Committee

meeting, but I want to raise it here as well. We are concerned that as a member of the workgroup, we were not involved in any discussions to change the program. Clearly, decisions have been made to fundamentally alter the program. And at least as far as the information we've received thus far, it does appear to us that the program has been weakened in terms of the types of quality outcomes that we are looking for.

I would respectfully request that the workgroup be pulled together as quickly as possible so that we actually have an opportunity for input into the design and changes of the program.

Many of us worked very long and hard over many months to reach consensus over the design of the program. It is one of our earliest forays into pay for performance, which, certainly, we at AARP support. And we know that there are some serious quality concerns among our institutional facilities. So we are concerned that the program has been changed without that collaborative input particularly from consumers. And we believe that waiting until June and once the program is up and running certainly isn't in the spirit of that collaboration. And we believe the design of the program and any changes to the program would benefit from bringing that collaboration to the table more quickly.

DR. SPITALNIK: Thank you.

Other comments?

Thank you, very much, Leah.

We now move to a series of informational updates, and I'm pleased to welcome back Greg Woods who's Chief of the Office of Innovation and who is going to present about the Office of Innovation.

MR. WOODS: Thank you. I wanted to say hello to everyone, introduce myself. I'm new to Medicaid and not ultimately new to New Jersey, but I'm returning to New Jersey. So I'm Gregory Woods. I'm the Chief Innovation Officer and the Director of the new Office of Medicaid Innovation, which is an office that we're very excited about.

(Slide presentation by Mr. Woods.)

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

DR. SPITALNIK: Thank you so much. And we're delighted you're here. I see many people writing down, get in touch with Greg.

Are there questions?

Beverly.

MS. ROBERTS: It's a comment. Hi. Welcome.

You will be hearing from me. I just wanted to tell you that.

DR. SPITALNIK: We had no doubt.

MS. ROBERTS: When I send you my e-mail, it's Beverly Roberts at the Arc of New Jersey. I just wanted to let you know.

DR. SPITALNIK: Any other questions from the MAAC?

Thank you so much. And thank you for making the commitment to work at the State level and bring your experience.

MR. WOODS: Thank you.

DR. SPITALNIK: Welcome. We look forward to seeing you again.

(Applause.)

DR. SPITALNIK: I now move to an update on Managed Long Term Services and Supports and welcome Carol Grant, the Deputy Director of the Division.

MS. GRANT: Hello, everyone. Good to see you all. I'm actually stepping for Elizabeth Brennan who is not here with you today. She left a couple of her notes. I'm sure I will not probably do as comprehensive a job as she will, but I'll do my best.

(Slide presentation by Ms. Grant.)

(Slide presentations conducted at Medical

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

DR. SPITALNIK: Carol, is this individuals over 21, or is it based on the DDD code or is it DD diagnosis?

MS. GRANT: I don't see any qualifier by age, but that is something we can take back to our researcher at the Division and see. I would suspect these are adults, but I don't want to make that claim.

DR. SPITALNIK: Carol, thank you. And I'll take questions, but I do really want to reflect back to the Division, our appreciation that this issue was raised, it's of concern, and the data both about people with traumatic brain injury and intellectual developmental disabilities. So I really thank you for your responsiveness.

Questions?

Beverly.

MS. ROBERTS: First of all, thank you. Again, I want to echo what Deborah just said. We really appreciate this information. I don't know if you can answer this question now, but perhaps for the next meeting.

Of the individuals with IDD in a nursing

facility, do we know how many of them actually have MLTSS versus -- what I'm hearing is sometimes a person is in a nursing facility, not because that's where they need to be, but there isn't the proper housing for them, like a medical group home or something like that in the community so they're sort of not MLTSS, but they are in a nursing facility waiting for the proper kind of housing, in which case they could certainly leave.

MS. DAVEY: We definitely can see if they're on MLTSS. We just don't have it with us, but we can get that for the next meeting.

MS. ROBERTS: Because I think there's housing that we need to have developed. And so knowing about this number would be good.

DR. SPITALNIK: That's also an issue with people with traumatic brain injury.

Thank you.

MS. LIEBMAN: Evelyn Liebman, AARP.

Carol, thank you for the presentation.

One of the things that we look at within the context of rebalancing is certainly the number of beneficiaries who are in HCBS versus institutional settings, but we also pay attention to the amount of dollars and how they are being rebalanced. And I'm wondering if at the next meeting we could get some

figures on how we've done with rebalancing the dollars through MLTSS.

MS. GRANT: I think we can certainly get back to you with that.

MS. LIEBMAN: I know Department of Health keeps track of this, but I think their numbers are a little not so up-to-date.

MS. GRANT: Okay. We'll get back to you.

DR. SPITALNIK: Thank you.

MS. JOHNSTON: Hi. Barb Johnston.

Previously you reported on the behavioral health utilization services for this population. I didn't see it in this presentation, but if we could do that for next time, it would be appreciated.

MS. GRANT: Sure.

DR. SPITALNIK: I've noted that.

Gwen.

MS. ORLOWSKI: Thank you so much. I have three questions.

The first is thank you so much for the IDD EEI information. Facility rights, in particular, are going to start for our next fiscal year really focusing on that as a priority project in nursing homes. So I really do appreciate that information. I'm sure we're going to be following up.

Secondly, I also appreciate all of the data. So I'll just say on behalf of Disability Rights New Jersey -- I won't identify the other groups right now. I didn't ask them permission to do that. But several of us did file this week a proposal for the enhancement grant. I think we have a brilliant idea. I really hope it gets taken seriously. We relied a lot on your data to be able to show the need for our project, so that was invaluable. Thank you.

One aspect that they asked about that wasn't in your data that was great going forward, you should have some breakdown of individuals by race and by Limited English Proficiency (LEP) status. So we're really looking to try and target the most isolated adults by economic and social factors, and that's something that isn't in your information. I'm not being critical. Your information is wonderful, but that would be really great for the future if that's possible to do.

The third thing I just want to raise right now, and maybe this is for future discussion, as we're coming up on the five-year anniversary of MLTSS, there are those of us in the advocacy community who do see some systemic issues, and we would like to be able to sit down. We appreciate the improvements in the Personal Care Assistance (PCA) pool, but we think it's

time to revisit that, how it's being used. We are looking also on the fact we're not really clear how PDN is determined. It seems to be individualized. And we have some other issues. If we can have an opportunity to meet and bring some of those to you. And, as part of that, we need to get information about appeals and fair hearings. We're not getting that anymore. We still think that's an issue. And that ties in with some of those other issues. We're looking forward to trying to solve those not through the fair hearing process, but under other creative ideas.

DR. SPITALNIK: Thank you.

Thank you so much for the data, and thank you for stepping in for Liz Brennan.

(Applause.)

DR. SPITALNIK: I turn to our final update. Meghan Dave, Division Director, will now present an update on NJ FamilyCare.

MS. DAVEY: Good morning. This is kind of my general update. I know you see these slides all the time, but it always is good to see where we are.

(Slide presentation by Ms. Davey.)

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

/humanservices/dmahs/boards/maac/.)

DR. SPITALNIK: Thank you.

I'll take questions, but I remind members of the MAAC and the public that no one in the administration at this point can comment on any of the budget proposals. That was clarified by Commissioner Johnson at our last meeting, and we appreciate your role vis-a-vis that.

Are there other questions?

Beverly.

MS. ROBERTS: So the point on the very last slide, default enrollment into DSNP. This had come up in the past a couple years back. There's enormous amount of concern about that in the IDD community, and I just wanted to reemphasize that concern is still there.

MS. DAVEY: We understand, and that's why we're doing our due diligence to see how it's working in other states. We'll keep you in the loop on that.

DR. SPITALNIK: Other comments or questions from the MAAC?

From the members of the public?

MR. LUBITZ: Phil Lubitz.

Thank you so much for your presentation. I was wondering do you have any comments to make about an application for a waiver for the Institutions for Mental

Disease (IMD) exclusion for mental health?

MS. DAVEY: For SMI, yes. Similar to what we did for SUD so that got around that IMD exclusion.

DR. SPITALNIK: I'm going to ask you to define the acronyms.

MS. DAVEY: Institutional mental disease. So, yes, we are going to be applying for that waiver. We have our waiver folks here. They're actively in discussions with our Division of Mental Health and Addiction Services to prepare a waiver. So, on the horizon.

MR. LUBITZ: Thanks.

DR. SPITALNIK: Other questions or comments?

Thank you.

As we always do at the end, I will review the items that came up, thinking about our next agenda.

There were a series of queries and questions that were made to the Division of Disability Services (DDS) to clarify some aspects of ABLE.

There was a concern raised about the Any Willing Qualified Provider, and I will, as we have in the past, bring that formally to the attention of the Department.

There were questions raised about trying to go deeper into the data about individuals with

developmental disabilities and people with traumatic brain injury; a question about trying to look at the data, not only in terms of the population numbers in rebalancing, but the fiscal note; the behavioral health utilization in Managed Long Term Services and Supports, as well as data not only by age, but race and social factors in the MLTSS data. An opportunity to use the hallmark of the fifth anniversary of the implementation of MLTSS to have a dialog about systemic issues. And, then, information on appeals.

Anything else that came up that we want to make sure we address in our next meeting?

MS. ROBERTS: So the issue of people with Intellectual Developmental Disabilities (I/DD) in a nursing facility and whether they are MLTSS or not. They're in a nursing facility, but it would be helpful to know how many of them are not in MLTSS.

DR. SPITALNIK: Thank you for that.

MS. ROBERTS: Based on what was just discussed a minute ago -- and my blood pressure is now through the roof over the issue of the possibility of a default enrollment of DSNP -- could you maybe keep us posted?

MS. DAVEY: Honestly, I was showing you where we are.

MS. ROBERTS: Is this being seriously considered?

MS. DAVEY: Not at this moment.

DR. SPITALNIK: Anything else from the members of the MAAC?

So in closing, first of all, thanks to all Meghan Davey, Phyllis Melendez, and everyone else from the DMAHS for these excellent presentations. As always thank you to Lisa Bradley for recording.

Our next two meetings for the calendar year are Thursday, July 25, 2019, and Thursday, October 2019.

Do I have a motion to adjourn?

MS. ANGELINI: So moved.

DR. SPITALNIK: And second?

MS. ROBERTS: Second.

DR. SPITALNIK: And we are adjourned.

A good, safe summer, everyone. And we look forward to seeing you in July. Thank you.

(Meeting adjourned at 12:09 p.m.)

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