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 11, 2014
10:00 a.m.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:

SHERL BRAND
MARY COOGAN
EILEEN COYNE
THERESA EDELSTEIN
DOT LIBMAN
BEVERLY ROBERTS
WAYNE VIVIAN
SIDNEY WHITMAN, DDS

MEMBERS EXCUSED:

MARY BOLLWAGE
JOSE JIMINEZ
DENNIS LAFER
DEBORAH SPITALNIK, PHD

STATE REPRESENTATIVE:

VALERIE HARR, Director
Division of Medical Assistance and Health Services

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ATTENDEES:

IRMA Camaligan	Accredited Health Services
Mark M. Stephen	Alkermes, Inc.
Dan Keating	Alliance for the Betterment of Citizens with Disabilities
Cathy Chin	Alman Group
Mary Coogan	Association for Children of New Jersey
Jennifer Jacobs	Amerigroup
Deb Charette	Autism New Jersey
Thomas Grady	Brain Injury Alliance of New Jersey
Dean Roth	Burlin Consulting
Judy Potter	Children's Specialized Hospital
Mary-Catherine Bohan	Community Care
Lowell Arye	Department of Human Services
John Indyk	Health Care Association of New Jersey
Andrea Cotton	Healthfirst of NJ
Karen Brodsky	Health Management Association
Chrissy Buteas	Home Care Association of New Jersey
Jean Bestafka	Home Health Services & Staffing Association
Karen Clark	Horizon New Jersey Health
Lillie Evans	Horizon New Jersey Health
Lewis Kudgis	Horizon New Jersey Health
Joseph Manger	Horizon New Jersey Health
Christine Carlson-Glazer	Hospital Alliance
John Covello	Independent Pharmacy Alliance
Phillip Lachaga	Johnson & Johnson
Carol Katz	Katz Government Affairs
Christine Fares Walley	LIFE St. Francis
Lori Price Abramms	MWW
Mark Moskovitz	Medicaid Fraud Division
Alison Gibson	New Jersey Department of Health
Michele Jaker	MJ Strategies, LLC
Randy Thompson	New Jersey Association of Mental Health & Addiction Agencies
Debra Wentz	New Jersey Association of Mental Health & Addiction Agencies
Pauline Lisciotto	New Jersey Department of Health
Melissa Chalker	New Jersey Foundation for Aging
Linda Schwimmer	New Jersey Healthcare Quality Institute
Theresa Edelstein	New Jersey Hospital Association
Colleen Picklo	New Jersey Hospital Association
Selina Haq	New Jersey Personal Care Assistance

ATTENDEES:

David Drescher	Office of Legislative Services
Audrey Anderson	Ombudsman
Matthew D'Oria	Perform Care NJ
Mary Kay Roberts	Riker Danzig
Deepa Srinivasavaradan	Statewide Parent Advocacy Network & Family Voices NJ
Beverly Roberts	The ARC of NJ
Vincent Ceglia	United Healthcare
Zinke McGeady	Values Into Action
Sherl Brand	VNA Health Group
John Kirchner	Wellcare
Lisa Knowles	Wellcare
Valerie Harr	Department of Human Services
Freida Phillips	Department of Human Services
Martin Zanna	Department of Human Services
Andrew Robertson	Department of Human Services
Meghan Davey	Department of Medical Assistance and Human Services
Carol Grant	Department of Medical Assistance and Human Services
Kim Hatch	Department of Medical Assistance and Human Services
Andrea Large	Department of Medical Assistance and Human Services
Phyllis Melendez	Department of Medical Assistance and Human Services
Maribeth Robenolt	Department of Medical Assistance and Human Services
Louis Ortiz	Division of Aging Services
April Baeani	Division of Developmental Disabilities
Darlene Yannetta	Division of Developmental Disabilities
Joseph Amoroso	Division of Disability Services
Karen Kasick	Division of Family Development

MS. HARR: Good morning, everybody.

Dr. Spitalnik is not available to join us today. I know she sends her regrets. She is faithful and always in attendance, so this is rare for her to not be with us today. But Dr. Whitman has generously agreed to chair the meeting, although he's a little under the weather, so whatever I can do to help you, I will.

DR. WHITMAN: I appreciate it. Thank you. Good morning. I'd like to welcome you all here to this lovely facility. In opening the meeting, a notification has to be done.

Pursuant to the New Jersey Open Public Meetings Act, the public notice and invitation to attend the 2014 meetings of Medical Assistance Advisory Council (MAAC), was transmitted to the Medical Assistance Customer Centers and County Boards of Social Services. It was posted on the Department of Human Services(DHS) website. It was published in the newspapers. And it was filed with the Office of Secretary of State and published in the New Jersey Federal Register.

First, I would like to tell you something about someone at this table who is going to be hornored at an event shortly, and that's Bev Roberts. She's

done a tremendous amount of work for the Arc of New Jersey and so many other organizations.

(Applause.)

DR. WHITMAN: On June 5th at the New Jersey Law Center in New Brunswick, there's going to be a festivity in her honor. And any of those that are in this audience that would to attend, I'm sure you'll be more than welcome. Thank you.

I'd like to start the meeting by having everyone introduce themselves. Let's start at the MAAC table.

(Attendees introduced themselves.)

DR. WHITMAN: Thank you. Did the members of the MAAC Committee get an opportunity to review the January Meeting Summary?

Any additions or revisions?

May I have a motion to approve them?

MS. COOGAN: I'll make the motion.

DR. WHITMAN: A second.

MS. ROBERTS: Second.

DR. WHITMAN: Approved.

Informational update. The first one is the State Fiscal Year 2015 budget, and that will be conducted by Valerie Harr.

MS. HARR: Good morning again. I'm going to

give you just a high level update on the Division of Medical Assistance and Health Services' (DMAHS) State Fiscal Year 2014 Governor's proposed Budget. So in the Governor's Budget with respect to the Division's Medicaid Program, we have essentially fully funded the cost of covering the medical services and enrollment growth that is anticipated as we move into State Fiscal Year 2015. There are savings from the NJ FamilyCare (NJFC) expansion that helped offset our expected or unanticipated growth and funding needed to cover more individuals and more services. And we have increased funding in both our Division and the Division of Aging Services to support the implementation of Managed Long Term Services and Supports (MLTSS).

I just want to highlight, unless you are reading -- and some of you may -- all the details of the budget and the budget language. The Commissioner of Human Services has the option, beginning January 2015, to expand the service package for Medicaid population to add the additional substance abuse benefits that we have in the Alternative Benefit Plan (ABP).

So, again, just to make sure I'm clear, in the Alternative Benefit Plan, we did add five or six additional substance abuse treatment services that are

not currently in the Medicaid State Plan, so the option is there for the Commissioner of Human Services to add those services for the entire Medicaid program.

There is also an option that's specified in budget language that would give the Commissioner of the Department of Human Services the ability to transition Medicaid eligibility determination out of one or more County Welfare Agencies to privatize or centralize eligibility information. Again, it's an option that would not happen before January 2015.

One other thing that I wanted to highlight, because it has been raised here in the past, is that the Governor's Budget does not include a continuation of the primary care rate bump-up that was 100 percent federally funded for calendar year 2013 and 2014. That federal program expires, and it's the State's option to continue to support that with state funds and federal matching funds. It is not included in the Governor's recommended budget to continue that program.

So the next steps, as we move forward with the Governor's proposed budget, is we have budget hearings. The Department of Human Services had its Senate budget hearing yesterday. And we will go before the Assembly Budget Committee on May 12th. And then the Legislature weighs-in and there are negotiations

and discussions that occur between the Legislature and the Executive Branch, and we anticipate the Legislature passing the Appropriations Act by June 30th. And then when we meet again later in the year, I would be able to update you on what changes may or may not have occurred from the time of the Governor's recommended budget to what is signed into law on June 30th.

I'm just going to go right into the NJ FamilyCare Expansion Update. Starting in October 2013, we started taking applications for the expansion population, and the benefits began on January 1, 2014, again, for the Medicaid expansion. So, with the expansion option for the states, New Jersey did elect to expand Medicaid to adults earning up to 133 percent of poverty. And those previously eligible were also expected to enroll.

We anticipated not only the expansion population to enroll, but also people previously eligible that had not would also enroll.

So for the expansion population, the federal government pays 100 percent of the cost of services for the expansion population through 2016. And then it phases down to a 90 percent federal match through 2020, and then it stops at a 90 percent federal match, unless Congress makes any change to that Law.

(Director Harr conducts a NJ FamilyCare Expansion Enrollment update.)

MS. HARR: So I will stop there.

Dr. Whitman, maybe take any questions at this time, and then we can go to the next agenda.

DR. WHITMAN: Are there any questions for Valerie?

MS. ROBERTS: Hi, Valerie. First, thank you very much for that information.

With the Call Center volume being so high, is it well known what the hours are of operation? And I don't remember exactly what it was. But I do know that in the past there were some evening hours. Part of what I was wondering is if there's a message that would indicate what the expanded hours might be?

MS. HARR: Monday and Thursday are expanded hours to 8 o'clock. I'd have to go check what the message says in terms of calls that are coming in after hours. The hours are posted on NJFamilyCare.org.

MS. ROBERTS: I just think it's helpful for people to know, in general, that there is this -- I don't know what the call volume is on those evenings, but I'm guessing that people assume it ends at 5 o'clock, so they might not even be trying.

MS. HARR: And I know that Xerox has -- I

think they were taking calls even over the weekend.

DR. WHITMAN: Are there any other questions?

MS. COOGAN: I was wondering if you could talk a little bit about the backlog. We get calls from time to time from people who are waiting for months. And I know I've called a couple of the county offices and not been able to reach people. But I've also heard recently where there's thousands and thousands of people waiting to have their application processed. So if you might give us some information about that, and maybe there's something we can do to address that. I mean, I understand people are working very hard. I'm not trying to minimize the effort. But I just I think at this point the frustration of applicants must be pretty high, as well as people who are trying to process them.

MS. HARR: There are a number of things. The application volume is great at the county welfare agencies (CWAs) and at Xerox. What we're finding, though, that there are a lot of duplicate applications. People that have applied multiple times at HealthCare.gov, multiple applications through the website. So we really have discouraged that, because that is just adding to the backlog. So that is one thing that we're finding. So we met with the

CWAs. They are all doing everything that they can to process applications. Truthfully, we had a very streamlined application. Our streamlined application was 2 pages. We now have a streamlined application that is 12 pages. It's difficult. And the rules have changed. We've now moved to Modified Adjusted Gross Income (MAGI) for parents and children and adults. And there's a steep learning curve around the new MAGI rules. So it's taking some time with respect to making those determinations.

We have done a few things to try to assist the CWAs. When you apply to NJFamilyCare.org there's a whole system that sits behind it. The CWAs pull down the applications. So we've done little things to try to assist in making that more streamlined for them. We are working through things. We have been in discussion with CMS about continuing our waiver of redeterminations through the entire calendar year so that they would not do redeterminations for recipients for the calendar year 2014 and would be able to focus on new enrollment only.

We have also made Xerox a presumptive eligibility entity, which would allow them to more expeditiously take and process applications so that they can process them and the person can get onto the

program. And then our State, it's a federal requirement, we must have merit system workers do the final determination. But the person is enrolled. And then the State coming in behind can do the final review. But it will and it has helped to improve the rate of applications processed.

Xerox is also making some other changes so that they're doing web interfaces with the NJFamilyCare.org applications so they can take it more immediately into their system.

So there are a number of things that are in motion to try to alleviate that backlog. I think in my conversations with CMS, now that the open enrollment period and HealthCare.gov is closed, even though people can continue to apply to Medicaid, we do expect the volume to decrease somewhat.

So we've been through this with FamilyCare before. We want to get through and process applications as quickly as possible. I think the great news is that we've expanded Medicaid, and people are interested, and we've successfully enrolled a hundred thousand people and kept over 200,000 people that could have otherwise lost coverage.

So we really just continue to ask for people's patience. Their effective date, if they're

determined eligible, does go back to the date of application. And we've said if there's an urgent need, there is presumptive eligibility (PE). And we did expand presumptive eligibility to the new adult population.

So I think CMS has agreed we've taken up every opportunity to try to get folks enrolled as quickly as possible, and taken every sort of streamlined thing that we could.

DR. WHITMAN: Are there any other questions?

MS. ROBERTS: One quick question. When you just said if there's urgent need, you could get presumptive eligibility. How would that work? Would the person have to say, "This is really urgent." I mean, they might not know to ask for presumptive eligibility when they apply. How would that work?

MS. HARR: This isn't new. So we've been doing presumptive eligibility for pregnant women and children for years. And it's primarily been Federally Qualified Health Centers (FQHCs) and hospitals that are PE entities that all go through training and get, essentially, certified. And when someone shows up at the emergency room or a FQHC that's uninsured and appears to be -- through the intake, they know that the person appears to be Medicaid eligible,

they're filling out the PE, the shortened application with self-attestation and taking the application so that the person can be treated and that the provider can get paid. All the FQHCs and the hospitals are aware of the presumptive eligibility program, and we do trainings for all of those organizations.

DR. WHITMAN: Yes?

UNIDENTIFIED SPEAKER: The presumptive eligibility is for what period of time? Is it 30 days?

MS. HARR: So its PE lasts for 30 days, but we have extended it longer if the full application is still in process or the PE application is still in process and there's not a full -- Medicaid eligibility determination that has not been completed.

UNIDENTIFIED SPEAKER: And given your current volume, what is the average time it's taking to process the application?

MS. HARR: Which applications?

UNIDENTIFIED SPEAKER: The presumptive eligibility applications.

MS. HARR: I don't think I can give you an estimate right now. There's the backlog. We have our staff working overtime, as well, on the PE applications. And we'll see the numbers going down one day, and then they have a flood of new applications, so

I don't know the average time for a PE application.

DR. WHITMAN: Are there any other questions?

Thank, you Valerie.

Lowell, Managed Long Term Services and Supports (MLTSS).

MR. ARYE: Good morning, everyone. This is a standing agenda item, which I think shows the importance of MLTSS and the move to MLTSS. Certainly, other than the Medicaid expansion, I think MLTSS is probably the next largest service delivery change that we're making, along with the closure of the Development Centers. So this is clearly an important piece, so I'm happy to talk about this.

What I'd like to do and what I'm going to do to -- and for our two members of the MAAC who sit on the MLTSS Steering Committee, as well as some of the other folks in the room who go to the Steering Committee, it's really a much broader overview than what we provided to the Steering Committee. What we did was in just last month, the end of March, we actually had a Steering Committee meeting. And we have another Steering Committee meeting the end of April to discuss our next steps.

What I'm going to do is lay out some of the things that we've done. But what I also want to do --

and I just reiterate and I'll talk more about this as we talk about our communication -- We have made very clear that it is imperative that everyone speak to everyone about MLTSS. It's not just our role as the State nor the managed care organization's (MCO's) role to ensure that everybody knows about MLTSS. We take ownership of it as the MCOs have taken the ownership of it. But we also urge everyone to speak to people about MLTSS and let them know about it. It's important and there's such major service delivery changes happening that this is something that we ask you all to do.

(Deputy Commissioner Arye conducted an MLTSS presentation).

MR. ARYE: I'll stop and answer any questions right now.

DR. WHITMAN: Sherl.

MS. BRAND: We're one of the case management entities right now, as you know. And as was expected, we're starting to see resignations of case managers because, obviously, they need jobs. And the ones we know about now are going to the MCOs. So I have a few questions.

I'm wondering is there an opportunity to get some sort of a fact sheet so the current case management entities know what they need to do

specifically and what information will be helpful for you to receive for the transition purposes, but also, what we should communicate to the beneficiary. We want to send a communication to them explaining that effective a certain date they will no longer have this particular case manager and is there a phone number or something to give so that they would feel comfortable knowing they've got ability to access someone?

Second, I don't know if the MCOs have given any thought to or if there's been any discussion with Medicaid, because since some of these case managers are going to MCOs that the beneficiary is already connected to, maybe there's a way to maintain that continuity, because the case managers have worked with these folks for, some of them, decades. And that's a great opportunity for the MCOs to maintain that relationship, which is so important. So those are my two questions.

MR. ARYE: Nancy Day is in the audience, and she can respond to the issues of the fact sheets and the like.

MS. DAY: In fact, thank you, Sherl, because all of the requirements for the transitioning of the cases from the current care management agency to the MCO is a policy and it is on the Department's website. But as Kevin Murphy, who is the lead person, he is

making personal calls to each of those care management agencies. As you call us to say, we've been notified that X number of care managers were hired and are leaving, there is a requirement of one year for all of the records to be copied and transitioned over to the MCO.

We know that it's difficult now that it's more centralized as opposed to before we were asking care managers to meet one-on-one. And that's not really going to be feasible, but we're really recommending that you set up conference calls to go over a higher level of the cases.

In addition to the files, all of our data now is on our Home and Community Based Services (HCBS) database, and so the MCOs will have access to that well. So they'll see who the provider agency is that's been approved, they'll see the number of hours. They'll get basic demographic information that will be readily available to them when you transfer these cases.

In addition, we just tested, and we were successful in our first test of data going over to the MCOs so that July 1 -- well, starting really in May, we'll begin sending all of the electronic information over to the MCOs.

In terms of your second question, what we have been doing in all of our trainings -- our quarterly meeting, with our care coordinators, as well as our most recent meetings with the care managers at the end of March, is to inform them about using their Frequently Asked Questions (FAQs) for their current care managers. Really, they are the front line individuals. And the assurances that they have to say to that Waiver client is that this is going to be a smooth transition, you're going to continue those services until you have a face-to-face.

So I think those are the types of information that we have put into place.

Your third point about MCOs, suggesting that the current care manager who is seeing that person continues, I think that MCOs have indicated they are trying to do that, but it may not be possible and they may have to shift. But I think their intention is at least to make that as smooth a transition as possible with the current care manager.

Just as an FYI, for those of you doing the CRPDs and TBI waivers, we're beginning to see some of those care managers leave, as well. And so we've been meeting and we will be issuing those transition practices, as well.

DR. WHITMAN: Thank you.

Wayne.

MR. VIVIAN: Are personal care assistance (PCA) services part of the MLTSS?

MR. ARYE: PCA is actually a State Plan service and was rolled into managed care in July of 2011.

MR. VIVIAN: So it is part of --

MR. ARYE: Well, it's part of the State Plan. What I like about MLTSS is that we are actually integrating, truly integrating, the acute health care side, which is including PCA, the State Plan services, as well as the long-term services. With PCA services, you don't have to have nursing facility level of care to get PCA services, but certainly for someone who needs assistance with activities of daily living, PCA services is part of the puzzle. So it's not part of MLTSS, but it's certainly a part because to get MLTSS, you have to be functionally eligible for nursing facility level of care. But it's certainly a part of it. And I think that's what's so great about the integration is that we're going to see differences of the way in which services are provided to people because the MCOs will be able to manage both their PCA services, as well as all the other different services,

not just in their current waiver, but under -- now that the waiver walls are being knocked down, they can pick and choose, basically.

MR. VIVIAN: Okay. The reason I ask is because I really have not been familiar with people with developmental disabilities and their needs of services. And I recently joined a supported housing group that is more focused on people with developmental disabilities (DD). And I hear from the family members that there's all kinds of concerns about what they used to get in personal care services not being available like it was, and might be limited in the future. There's a great concern out there.

MR. ARYE: Well, let me say that PCA Services are State Plan services. If a person is in Medicaid, indeed a person with DD currently is in NJ FamilyCare under managed care, then they will continue, based upon the planned care that's been developed with their MCO, to receive it.

On the MLTSS side of this, though, if a person has a developmental disability and receives services through the Community Care Waiver (CCW) or when the Supports Program rolls in, currently, they will not be eligible to get MLTSS services because those two programs have been rolled out of MLTSS.

MR. VIVIAN: They're part of the CCW, the Community Care Waiver.

MR. ARYE: If they're part of the CCW and they receive PCA services, it's State Plan services.

Any more questions?

(Presentation continued by Deputy Commissioner Arye)

MS. ROBERTS: I have a few questions. Just on what you were saying about the Office of Community Choice Options (OCCO), if you could just reiterate that a little bit.

MR. ARYE: So basically what happens, it's Not OCCO first, it's the Aging and Disability Resources Center (ADRC) or the Divsion of Disability Services (DDS) information and referral staff who do an initial screening -- what we call level 1 screening. And that basically makes a determination whether or not we think they could be functionally eligible for Nursing Facility (NF) level of care. And so at that point, once that level 1 screening is done and we think that they may be potentially NF level of care, what then happens is that they are then referred to the Office of Community Choice Options who will actually do a functional eligibility using the New Jersey Choice Tool face-to-face. And that is a determination. The New

Jersey Choice Tool, as we've said, is actually a nationally-based tool with validity and reliability, national as well as some international countries actually use them, but a number of other states use this tool. It was created by the University of Michigan initially. So at that point the OCCO staff will also do options counseling for those individuals and assist them in determining and choosing the MCO.

MS. ROBERTS: So let's say we have a child aging out of CRPD and has been getting private duty nursing, a lot of complexity, they have private duty nursing. At the time point that they're going to be aging out, does the family have to request it or is DDS automatically going to do that initial screening?

MR. ARYE: Joe, can you answer that?

JOE: Sure. We're trying to query people right now so we can find out when people are going to age out. We're going to do some reaching out to make sure nobody falls through the cracks. But there are families that are calling us months and months ahead of time. We're happy to talk to them, too, and get them on the radar and get them walking in the process.

MR. ARYE: But if they are currently receiving CRPD through the MCO and they're getting private duty nursing, then the MCO -- after July 1st,

the MCO is then responsible and will be doing similar to what they do now -- rather than going through DDS, it will go to the MCO which will look at the person, and will then assess their service needs through the New Jersey Choice tool, on which we've said they've been trained on. They will then say the person's NF level of care or not. Either way, that then goes to the Office of Community Choice Options for final determination. OCCO is the final determiner, not the MCOs.

Again, if there's a plan of care that the individual or their family doesn't agree with, they can appeal. And we'll continue those services until such time as the appeal is complete.

MS. ROBERTS: So they can go up to a Medicaid fair hearing if they choose to do that and continue their level of service?

MR. ARYE: Exactly. Until the fair hearing is completed, just like it is now. So there's no difference. The only difference is that the MCO will be doing the assessment for the NF level of care rather than State folks. But the State ends up being the final arbiter on NF level of care. This is something CMS is actually touted that we have done better than any other state when we put this in place.

MS. ROBERTS: So the FAQs that are posted there's a question on them -- a lot of the FAQs on MLTSS are aging related. There is a question, No. 33, that talks about private duty nursing services. And there's a second sentence there that says, "If you are receiving private duty nursing service under your current NJ FamilyCare waiver, these services may continue based upon your needs as assessed by your managed care plan."

So what I heard you say was there's going to be the continuity of care, you have the additional things that you said. But that's not in the FAQ, and I'm wondering if it could be added.

MR. ARYE: We can certainly put it in. And as we always said, the FAQs are a running document. It is a live document. And certainly, we can figure out how we can put that in.

We do have, if I remember correctly, it's been a while since I've read through the FAQs even though I've probably read them 25 or 40 times, but I thought we had some pieces about continuity of care. I think we can probably put something in addition on that for this.

MS. ROBERTS: This is my last question for now. With regard to new applicants -- so before, when

it was a CRPD waiver, there was a process for somebody new. So I'm thinking about somebody -- you know, a baby that's born, a lot of need, the family's getting private health insurance, so were it not for the very significant need that this child has, the family would not be considered eligible for Medicaid. And I'm just wondering how that's going to work going forward for somebody who would need to be applying for what used to be the CRPD waiver but no longer will be called that, because it won't be a waiver anymore.

MR. ARYE: It would be the same thing. The nursing facility level of care, the determination is done initially by the MCO. Certainly, if the child is getting those private duty nursing through CRPD, that process will continue.

MS. ROBERTS: But that would be a Medicaid eligible child. I'm talking about a child who otherwise would not be considered Medicaid eligible because the family income is more middle income, but the needs are very, very extensive. So I'm just wondering is something still going to be called CRPD?

MR. ARYE: No, there will not be any such thing as CRPD. CRPD goes away. All waivers go away as of July 1. CRPD, ACAP, TBI, GO waiver, it now is one broad breadth of services, MLTSS.

MS. ROBERTS: So how will -- let's say a family has a child or in terms of going to your pediatrician, a child with very significant needs. There is no more CRPD? How is this going to be known, especially because MLTSS broadly is serving a huge number --

MR. ARYE: As I said to you earlier, we are doing trainings with Special Child Health Services. And that's why I said from the get-go, everyon is responsible in this room and everywhere else to tell everybody what's out there. We are taking full responsibility and doing all the training. So Special Child Health Service is being talked to, the Office of Disabilities, everyone is being told. So this process will continue. There's really no difference between how they find out now versus how they're going to find out on July 1st.

MS. ROBERTS: Is it going to have a name?

MR. ARYE: MLTSS. That's the name, Managed Long Term Services and Supports.

MS. ROBERTS: Okay. I think it might be helpful if there was some other little subtitle for this very small group of children.

MR. ARYE: If we do subtitles, then we're going to do subtitles for everybody. And the problem

with subtitles is the reason why we're moving MLTSS is so that we're knocking down waiver walls. These children may not necessarily just need private duty nursing. They may need home modifications. They may need some other types of services that they have been able to get under CRPD, but they could not have gotten it if it was under the GO Waiver. Now they're going to be able to get these services regardless of whether or not where they are in the waiver rules. There's no waiver rules anymore. So once the person, when we get in -- and I'm sure you get calls all the time and you'll say MLTSS, you need to get in contact and apply for Medicaid, for MLTSS. And then they will go through the process and do what they need to do, and that will be the way it's going to be. It's really not different.

MS. ROBERTS: I don't want to take a whole lot of time now. We will have additional conversations, but I appreciate this very much. Thank you.

DR. WHITMAN: Thank you. Thank you for a thorough presentation.

Are there any questions out there?

Valerie.

MS. HARR: So we're going to talk about the

Administrative Services Organization (ASO) and the Managed Behavioral Health Organization (MBHO). And you're not going to get a thorough presentation from me on this topic because, as Molly Green has reported in the past, we really can't say much because this is open competitive procurement and we don't want to put any applicants, any bidder or the State in any bad position in terms of disclosing information that we shouldn't. So I'm not going to go through the entire slide deck. You have it.

(Director Harr conducts an ASO/MBHO Presentation).

MS. HARR: So, Dr. Lind has been with us in the past. He has a conflict today. I have not been part of the Credentialing Task Force. So I'm going to take Dr. Lind's notes at face value. And then hopefully, he'll be able to join us at the next MAAC meeting.

He has indicated that there's agreement between our Medicaid health plans, that credentials providers moving between existing offices within the same participating practice, that they will be able to see and bill for services within 30 days, thereby improving patient access. I really can't go into detail. Again, I'm going to share what Dr. Lind has

provided. And then if there are questions, certainly please ask and then I'll probably have to go back and consult with Dr. Lind.

(Ms. Harr presents update on Provider Credentialing.)

DR. WHITMAN: Thank you. Are there any questions?

MR. VIVIAN: I hope some consumer providers will also be on this Task Force, because there's a lot of issues about rate setting and credentialing. It's all based on credentialing. So there are issues about all of this.

DR. WHITMAN: I've had the privilege of being in some of those meetings. They have the right players at the table. We're tying to get some agreement, and I think they are moving in the right direction. I really do.

MS. HARR: Wayne, the organizations you're talking about, are they also contracted with our Medicaid MCOs?

MR. VIVIAN: (Nods.)

MS. HARR: So we want to make sure if there are other representatives that -- and if those providers are also frustrated or want to see improvements with credentialing, we'll make sure that

we --

MR. VIVIAN: All the rates are being based on credentials, who provides the services is how agencies will be reimbursed.

DR. WHITMAN: That's not quite the same thing. The meetings that I've attended are in order to streamline the process to improve the amount of doctors that are participating.

MR. VIVIAN: Different goal.

MS. HARR: All right. I'm glad we clarified that.

MR. VIVIAN: Sorry.

DR. WHITMAN: No problem.

Any questions?

Personal Care Assistance Tool, Carol.

MS. GRANT: We kind of committed to keeping you updated on our progress in developing and implementing and new PCA tool. I have up here with me Maribeth Robenolt, who is one of the two staff most principally involved in developing the new tool. But it has been something that has been a joint endeavor between aging services, disability services, and Medicaid. I want to especially thank Steve, Tony and Maribeth Robenolt, as well as the nurses from DDS who are early testers of the tool to give us a flavor of

it. We really have something that was useable out there, and I want to publicly thank them.

(Ms. Grant and Ms. Robenolt conduct the PCA Tool Update).

DR. WHITMAN: Questions?

MS. BRAND: First, I want to applaud you for all the work that obviously has been put into this. I know this has been a discussion for many years. And I've been someone who's been out in the field using the current tool. So it's really fabulous what you've pulled together here. And I'm pleased to know that there's a provision for using that timeline as a guideline and not a hard fast rule, because we don't have cookie cutter people out there. And 30 minutes for a bath, and I can visualize some of the folks that I worked with, that that would be nowhere near enough. So kudos to you and the folks that have been working on it. I'm exited to see the tool when it's ready to go public.

One of the questions I have is, what would be the method on the plan side? So, let's say, a nurse makes a recommendation, but there are those instances where the family will say, but it really takes so much longer than that. How is that going to work its way through? Or will it be purely the nurse who does the

assessment and makes a determination in one day? So if you can answer that.

MS. GRANT: I think some of that we're going to really be seeing as the beta test goes forward is that the nurse will assess what the nurse will assess. There's lots of observations and things like that. That's going to be all part of our analysis as we take a look at to see what other questions we have to answer or what other procedures we have to answer. And we're going to be sitting down with the plans to make sure we're hearing what's actually happening out there in the field, so that we can be sure about how it will work.

The thing is that this is going to be a critical service for everyone. Certainly for MLTSS. It's a lynchpin service, and we wanted to make sure that we're assessing properly, that we're following our Medicaid regulations with relationship to PCA, what's in, what's not, who can get served, who can't. It's lessons learned, but it is certainly a question that has also come up in some of our discussions as well. I don't know that we have answers for everything at this point.

MS. HARR: I imagine there could be cases where the nurse may note the family. And then the

nurse can then -- they would consult with a supervisor or the medical director. I imagine that could happen. I also just want to say if it's the nurse making the assessment, is it reflecting the family, what they're saying and if there's disagreement, there's still the grievance and appeal process.

MS. GRANT: That's right. I think that's a good answer. That's why the summary area was included and there's also a line for justification. And I think that certainly is something that we can note.

MS. ROBENOLT: One of the things that's slightly different, this is not getting a score, per se. One of the things we emphasize with the nurses is that you're not going in asking close-ended questions. You're going in, describe for me how you do such-and-such. You know, when you're doing this, how long does it take you to obtain these things?

Again, asking those questions. Bathing is a real critical area. It's not just to sit there and say, "Well, how long does it take you to take a bath today?" It's a "Can you show me where your bathroom is? And can you describe for me how you take a bath?"

So you get to see what's in the environment of that room. You're also getting a sense of that person ambulating, can they transfer, et cetera. So

it's, again, trying to get the big picture, as well.

MS. BRAND: And certainly, anything that can be observed as opposed to a Q and A is better.

Carol, your comment leads to part two of my question. That is, currently, we've got the PCA tool requirement for the agencies. And so they continue to do it even though it bears no relevance to what's happening in the plans determination, because the plans are now doing it. So is there an opportunity to eliminate that requirement because it's duplicative and, again, an unnecessary burden, really.

MS. GRANT: That's true. And it's in the regs, so --

MS. BRAND: It's the regulations under personal care.

MS. GRANT: The thing is that we know that there's going to have to be some re-tooling, which is not a short process. So it's something we're trying to deal with with our legal folks. I don't know whether we've got the ability to waive it.

MS. BRAND: Could it be, like -- I don't know if a memo -- if there's the ability to take that.

MS. GRANT: We have to look. It's an issue that has come up, and we acknowledge it.

MS. ROBERTS: I also want to thank you very

much for all the work you're doing and for this really helpful presentation, so thank you for that. Just a couple of questions.

It was really helpful to see these examples. Thinking about both my population as well as the older adult population, assistance with feeding, I think, could be something that could be very, very time consuming. Aspiration.

MS. GRANT: Absolutely.

MS. ROBENOLT: That's a separate category.

MS. GRANT: We didn't give all of the elements that were in the tool. All of the ones that are in your packet that talk about the IADLs and ADLs are things that are going to have the same kinds of questions. And I think that's what we emphasize, is that you really have to understand the needs of that person.

You could have six-year-old or a seven-year-old with serious issues, for example, with dysphagia who cannot swallow. That's going to take much more time. So the tool will allow for that.

MS. ROBERTS: And in terms of frequency to reassess, I think on the DD side, it is what it is. But in terms of the elderly population, things could improve, things could worsen. How is it going to be

triggered when somebody either needs more care or now has improved and needs less care than what they previously received?

MS. GRANT: This is a question that's been raised by our plans, as well. I think the regulations require a level of care reassessment, but the PCA tool, unless there's a change of condition, you know, could extend beyond that. We had talked about perhaps doing that for the year. Under regulations, you still have to do a six-month reassessment on level of care.

MS. ROBERTS: For example, let's say for an elderly person there's a spouse who's helping. And then the spouse becomes ill or goes into hospital. Now all of a sudden overnight, that level of assistance is gone.

MS. ROBENOLT: There's nothing to prohibit someone from saying that they need more and going back to the plan and say I need to change my condition. And that will then trigger somebody to go back out.

MS. GRANT: Because change of condition is a factor here. People do have disease states that progress and become worse, so that has to be built into the process of the tool.

The one thing we also took a look at as we were doing this tool is the New Jersey Choice

Assessment System, because ultimately we would like to have greater consistency of tools across the board. And this begins to sort of build in a conceptual sort of context for that person and how you're looking at them or how you're going to serve them. So that's another sort of goal with this.

MS. ROBERTS: Thank you.

DR. WHITMAN: Yes.

MS. EDELSTEIN: Just going back to the change of condition part, doesn't the provider agency have a role in notifying the MCO if there's change that they're observing.

MS. GRANT: Absolutely.

MS. ROBENOLT: That's part of a nursing assessment. When you have a PCA out there, they still have a nurse who has to provide supervision. So it should be a part of that nursing supervision. If they're seeing a change in condition, they should be coming back to the MCO, absolutely, making them aware.

DR. WHITMAN: Questions?

UNIDENTIFIED SPEAKER: Yes. First, I don't often take exceptions to something that Bev says, so I do this with great trepidation. But when Bev said that people with development disabilities, it is what it is, I take exception because their conditions can very much

change. They progress, they regress. So I just wanted to say that for the record that we need to pay attention to that.

MS. ROBERTS: You're right.

UNIDENTIFIED SPEAKER: I do want, from an advocacy perspective, to just raise a question or an issue. It's not a question, it's more an observation.

I applaud the dynamic explanation that you're talking about in terms of the process. When you put up a slide about decision-making or use terms like -- and I don't remember because I didn't write it down -- moderately impaired, severely impaired, I wonder if we couldn't look at a more positive way of saying that. Because when we devalue people by being impaired -- the World Health Organization, for more than a decade, wanted us to focus on what people can do, not what they can't do. And so, yes, they have limitations, they have challenges, but I'm wondering if we couldn't look at the language throughout, but most particularly in that decision-making and not look at people as being impaired, but as having challenges. That's just an overall observation, and I'm sure there are folks who could help us from the advocacy community to look at the language that we're using to make it more affirming of people and their needs, thank you.

DR. WHITMAN: Well put.

Any other questions or comments?

UNIDENTIFIED SPEAKER: Just a quick comment.

Thank you for your efforts on the PCA tool. You did reference as a point in Sherl's comment that the regs may be looked at. Do you have any sense of a timeline?

MS. GRANT: We're working on it.

UNIDENTIFIED SPEAKER: Okay. Thank you.

DR. WHITMAN: Any other questions?

Our next meeting is June 11th in this building at 10 o'clock. And I'd like to thank all the people that attended.

Can I have a motion to adjourn?

MS. LIBMAN: Motion.

DR. WHITMAN: Thank you. Second.

MS. ROBERTS: Second.

DR. WHITMAN: Thank you. I appreciate it.

(MAAC Meeting adjourned.)

CERTIFICATION

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

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Lisa C. Bradley, CCR
The Scribe

Date:_____