MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

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

June 10, 2013
10:00 A.M.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:

DR. DEBORAH SPITALNIK, PH.D.
MARY BOLLWAGE
SHERL BRAND
MARY COOGAN
THERESA EDELSTEIN
DENNIS LAFER
DOROTHEA LIBMAN
BEVERLY ROBERTS
WAYNE VIVIAN
DR. SIDNEY WHITMAN

MEMBERS NOT PRESENT AND EXCUSED:

EILEEN COYNE
JAY JIMENEZ

STATE REPRESENTATIVE:

VALERIE HARR, Director
Division of Medical Assistance and Health Services

Transcriber, Lisa C. Bradley

ATTENDEES:

Dan Keating	Alliance for the Betterment of Citizens with Disabilities
Michael Rooney	Alkermes, Inc.
Cathy Chin	Alman Group LLC
Eric Uderitz	Boehringer Ingelheim Pharmaceuticals, Inc.
Barbara Geiger-Parker	Brain Injury Alliance of New Jersey
Andrea Cotton	Healthfirst Plan of NJ
Frank DiGiovanni	Healthplex, Inc.
Karen Clark	Horizon NJ Health
John Covello	Independent Pharmacy Alliance
Josh Spielberg	Legal Services of New Jersey
Christine Fares-Walley	LIFE St. Francis
Nicole McIntyre	LIFE St. Francis
Lisa Zavorski	LIFE St. Francis
Mark Anderson	Medicaid Fraud Division
Mark Moskovitz	Medicaid Fraud Division
Michele Jaker	MJ Strategies, LLC
Ward Sanders	New Jersey Association of Health Plans
Debra Wentz	New Jersey Assoc. of Mental Health Addiction Agencies
Maureen Shea	New Jersey Association of Community Providers
Ray Castro	New Jersey Policy Prospective
Dean Gianarkis	Pfizer, Inc.
Mary Kay Roberts	Riker Danzig
Steven Vernikoff	The Center for Family Support
Kim Todd	The Innovations Collaborative
Bill Cahill	United Healthcare Community Plan
Zinke McGeady	Values into Action
Chris Santarsiero	VITAS Innovative Hospice Care
Elizabeth Manley	Department of Children and Families
Dawn Apgar	Department of Human Services
Lowell Arye	Department of Human Services
Freida Phillips	Department of Human Services
Dr. Martin Zanna	Department of Human Services
Nancy Day	Division of Aging Services
Lou Ortiz	Division of Aging Services
Maribeth Robenolt	Division of Developmental Disabilities
Karen Kasick	Division of Family Development

ATTENDEES:

Candice Singer	National Council on Alcoholism and Drug Dependency New Jersey
Meghan Davey	Division of Medical Assistance and Health Services
Robert Durborow	Division of Medical Assistance and Health Services
Marla Golden	Division of Medical Assistance and Health Services
Mollie Greene	Division of Mental Health andAddiction Services
Lynn Kovich	Division of Mental Health and Addiction Services
Karen Brodsky	Division of Medical Assistance and Health Services
Carol Grant	Division of Medical Assistance and Health Services
Kim Hatch	Division of Medical Assistance and Health Services
Richard Hurd	Division of Medical Assistance and Health Services
Roxanne Kennedy	Division of Medical Assistance and Health Services
Dr. Tom Lind	Division of Medical Assistance and Health Services
Bob Popkin	Division of Medical Assistance and Health Services
Heidi Smith	Division of Medical Assistance and Health Services
Irina Stuchinsky	Division of Medical Assistance and Health Services

DR. SPITALNIK: The Medical Assistance Advisory Council (MAAC), in accordance with the Public Open Meetings Act, has filed appropriate notice of this meeting with the New Jersey Secretary of State, published on the Department of Human Services website, and Public Notice was also posted in the Medical Assistance Customer Centers, County Boards of Social Services, and filed with the appropriate newspapers, as well as the New Jersey Register. I am delighted and grateful to the Governor's Office that we now have a new complement of members.

In terms of order of the agenda, we're moving up the update about the Comprehensive Medicaid Waiver (CMW) before the approval of the Minutes, and then the agenda will flow as written.

I need to remind all the members of the public, if you have not already done so, before you leave, to please sign the sign-in sheet so we can reflect your presence.

We are going to first have the Managed Long Term Services and Supports(MLTSS) update by Deputy Commissioner Lowell Arye.

MR. ARYE: Good morning. Thank you for allowing the reorganization of the agenda. I appreciate it. I'm going to provide an explanation as

to where we are with MLTSS, specifically on the communications plan.

We discussed that we are planning to move forward with MLTSS and home community-based services beginning in January of 2014. Nursing homes are planned to move to MLTSS in July of 2014.

We have been working towards a communication plan, and we're on schedule with the plan so that we can move forward on MLTSS implementation.

Our strategy is based upon getting out information to all of the stakeholders, both the community providers, as well as the advocacy community so that everyone will have as much information as possible before the conversion happens, and before beneficiaries actually receive information.

As you know, in March of this year, the federal Centers for Medicare and Medicaid Services (CMS) required us to send a letter to all of our Medicaid beneficiaries who are on the home and community-based waiver informing them that the federal authority for their services are changing from a 1915(c) Waiver, to a 1115 Demonstration Waiver.

Next, we would inform beneficiaries of the implementation of MLTSS ninety days prior to the start

date of MLTSS. So we would expect that on October 1, 2013, beneficiaries will receive a formal letter to share the changes.

Right before that, about mid-September, we plan to send letters to the Assisted Living facilities, as well as to the community residential services administrators, informing them so that if there are any questions that their residents have, they'll already have knowledge about it. We'll also be getting information out to care managers.

Letters to nursing homes wouldn't happen for another six months, basically mid-March of 2014. And then ninety days prior to that date, which is April 1st, nursing home residents would receive a similar letter and packet of information.

We have developed a slide presentation specifically on what Medicaid Long Term Services and Supports means. "The Choice is Yours," is what we are calling the slide deck. We have a training plan and web postings that will be prepared to deliver information.

We have also put together a Frequently Asked Questions (FAQs) document that we have started to work on.

All materials are shared with the MLTSS

Steering Committee, and we got a lot of input and included changes that we thought appropriate based upon that input.

We are having meetings with providers and beneficiaries so that people will learn and understand what we're doing.

We have a meeting with our MLTSS Steering Committee on Friday where we are going to be going through a lot more detail. If you don't know, you should know that three members of the MLTSS Steering Committee actually sit on the MAAC; Chairperson, Dr. Spitalnik, Sherl Brand and Theresa Edelstein.

And there's been a lot of work going on internally, as well. We've had some quality assurance meetings both internally and externally, and that will be presented at the Steering Committee meeting on Friday.

The last thing I really want to say -- Division of Aging Services (DoAS) Director, Kathy Mason, is retiring. Literally her last day on is Friday. She's retiring after 33-plus years of service to the State. She has truly been an amazing person to work with, both externally when I was on the advocacy side, as well as internally as I've served the last two years in the administration. So I just want to say and

express that it's really been a pleasure to work with her. She has an expertise that we will sorely miss both in DoAS, but also in leading us on MLTSS.

So with that, I think I'm going to end. And if there are any questions, I can take them.

DR. SPITALNIK: Thank you very much, Lowell. I just want to take one second here to propose that the MAAC formally recognize Director Mason for her contributions and wish her a successful and happy retirement. Can we convey that as the consensus of the MAAC?

MAAC MEMBERS: Yes.

DR. SPITALNIK: Are there questions for Mr. Arye from the members of the MAAC?

Beverly.

MS. ROBERTS: Thank you, Lowell.

A couple of questions. To what extent are families going to be involved in knowing what's going on?

MR. ARYE: That's one of the reasons why we're doing the website specifically so we can inform families. I don't have the specifics of how we will set up the live trainings yet.

MS. ROBERTS: If the families find out about it, fine. But are there specific plans to outreach

families?

MR. ARYE: Well, the letters are going out to beneficiaries, as well as to guardians. We plan to put out as much information to everybody as possible, which is one of the reasons why we're giving the MAAC and the public all the information so you can get the words out to the families, as well. We're doing as broad a spectrum of outreach as we have ever done.

MS. ROBERTS: If you could keep in mind to try to think about the older population -- because there are a lot of older people who don't have a legal guardian.

MR. AYRE: Yes, I understand.

MS. ROBERTS: This population will depend on someone to help them understand the letters.

MR. ARYE: Right. Part of the problem is we don't have family members' addresses. That's an issue. But certainly, through care managers, as well as through the variety of ways that we have to reach people, we'll get the information out. So, if somebody called the Aging and Disability Resource Center (ADRC) there's going to be as much information and assistance available as possible. Unfortunately, we can't mail every person or family member affected in the State of New Jersey.

DR. SPITALNIK: One of the things that we've done in the past with different initiatives is to rely on the advocacy community to get the word out. I think Lowell's point is very well taken that the individual is the beneficiary, although there may be a caregiver involved. So if we could have dates and plans available and then fanned out to the advocacy community, I think that would be an appropriate advocacy and outreach role.

MR. ARYE: And that is why we have FAQs, so that everybody will have as much information as possible.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Other questions? Theresa.

MS. EDELSTEIN: Not a question so much as a follow-up comment on Beverly's question. I think the Steering Committee members as well as the nursing home associations can help spread the information to families.

MR. ARYE: Absolutely.

MS. EDELSTEIN: I'm sure the facility administrators will find it in their best interest to invite families to participate in the process.

MR. ARYE: And that's why we've made sure that the providers will absolutely receive all

information prior to the letters going out for exactly that reason, so that they will be able to both assist their residents and beneficiaries, but also so that they can talk to family members as well.

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

I will very briefly open it up to any comments.

SPEAKER: Will all the letters and also the schedule of trainings be on the website?

MR. ARYE: Absolutely. Yes.

SPEAKER: And when do you anticipate that?

MR. ARYE: According to the current plan, in the next few months.

DR. SPITALNIK: Anyone else?

SPEAKER: Will you be publicizing the results of the readiness review? Is that something that the public will see?

MR. ARYE: Well, I don't know if we will publicize the readiness review information, but we will be making implementation decisions based upon the readiness review. If the state or the health plans are not ready, then that information will absolutely be publicized.

SPEAKER: How about the areas you're going

to look at for the readiness review, will that criterion be public?

MS. HARR: I think at the MAAC meeting we could present a overview of the areas that would be reviewed.

DR. SPITALNIK: Thank you, Lowell. And, of course, we'll put an MLTSS update on the October 7th agenda. Thank you very much.

I'd now like to call Assistant Commissioner Lynn Kovich from the Division of Mental Health and Addiction Services (DMHAS) to give us an update on The Administrative Services Organization (ASO), Managed Behavioral Health Organization (MBHO) and Behavioral Health Home (BHH). The Assistant Commissioner's slide deck as well as all presentations will be posted on the MAAC website.

MS. KOVICH: Thanks, Dr. Spitalnik. I'm here to give you a couple of updates. They are all about the ASO/MBHO. So there's really four updates I will go through relatively quickly.

One is the work that our mental illness substance use disorder work group has been working on since the fall. Another, a Behavioral Health Home update, which is something we've been keeping this group updated on. I will give you an update on the

Request for Proposal (RFP) timeline. And then lastly, I will give you an update on our rate setting process.

(Assistant Commissioner Kovich conducts a slide presentation.)

DR. SPITALNIK: Thank you so much.

Are there questions from members of the MAAC?

MAAC MEMBER: Thanks Lynn. The BHHs that you mentioned that are going to be available for children and adults, will individuals with intellectual and developmental disabilities be able to be included in the population for BHHs?

MS. KOVICH: As long as their primary diagnosis is one of serious mental illness. And as long as they do, then yes.

MAAC MEMBER: Thank you.

MAAC MEMBER: You mentioned that there's going to be an evaluation process for BHHs once they begin. Have there been any evaluation of how they've been operating over the last few years.

MS. KOVICH: We have some data, but we don't have a time yet. We're working on the outcomes data that we're going to be developing. In fact, I think that we're asking for some technical assistance from Dr. Cantor from Rutgers.

MAAC MEMBER: Another question is that in all the presentations it always says ASO/MBHO. I assume there's a distinction between going from non-risk to a risk-based entity. But I don't think there's really been a full conversation about the benefits or liabilities of going to full risk. I'm wondering maybe the next time you come talk with us, we can actually have a conversation about how beneficial that will be. And maybe at the same time we could hear from the other ASO in the state that's a non-risk entity and how that's doing so we have a sense of how this is unfolding.

MS. KOVICH: I don't want to get into this right now because it's complicated. Our ASO even though it's an ASO is really a little different than the kids ASO. And I think that if you wanted to just have a conversation about that, we could.

DR. SPITALNIK: Other comments?

MR. MANGER: Joe Manger from Horizon NJ Health. So the RFP would be issued between 4Q 2013 and 1Q 2014; is that correct? I'm looking at your slide 7.

MS. KOVICH: We operate on a fiscal calendar, so that would be second quarter of 2014.

The only other thing I would like to say is that once the RFP leaves the Department of Human

Services (DHS) and goes to Treasury, we don't really have control over the process of public posting, etc. We'll stay updated and we will stay on top of it, but it will truly sit with Treasury. So, we may have to allow a little bit more time.

DR. SPITALNIK: Thank you so much. We'll now look at the Minutes and then have a Director's Report. We're also going to present the Dual Diagnosis (DD) and Pervasive Developmental Disorders (PDD) Pilot after the Director's Report and then the Quality Strategy presentation.

I'm going to turn to the Minutes of the April 8th meeting of this year and ask the members of the MAAC if there are any comments or questions. We have a sufficient number of members to vote. If new members feel uncomfortable about not having been here, they're free to abstain, of course, as is other members. Any comments or questions.

MAAC MEMBER: On page 16, there's reference to the Division preparing a standard paragraph that could be sent to the members of the MAAC and other advocacy groups related to the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey so that we can collectively generate perhaps a better response rate. My question is whether that was

provided?

DR. SPITALNIK: Can anyone speak to that?

RICHARD HURD: I understood that the actual postcards were sent to MAAC members from staff on the CAHPS®. The message on the post cards is the outreach message to responders.

DR. SPITALNIK: Okay. Any other corrections?

Seeing none, do I have a motion to approve? Sherl Brand.

Second, Beverly Roberts.

All those in favor?

MAAC MEMBERS: Aye.

DR. SPITALNIK: Opposed?

Abstentions?

Hearing none, the Minutes of April 8, 2013 meeting are accepted.

Thank you so much.

We're going to have a presentation on the Dual Diagnosis and Pervasive Development Disorder Pilot from Liz Manley, who is the Director of the Division of Children's System of Care (CSOC).

MS. MANLEY: Thank you. There are CMW waiver pilots that the CSOC is involved in.

I'm going to speak about two, the DD and the PDD pilots. But before I do that, I want to give you a quick overview on Department of Children and Families (DCF).

(Director Manley conducts a slide presentation.)

DR. SPITALNIK: Thank you so much, Liz. Questions?

MAAC MEMBER: Just one clarification on the time frame.

MS. MANLEY: Sure. Two new services are going to be coming when we actually go live with the waiver. And we're working on getting the timeframe down, but we haven't had a solid date on that. So we're still working to make sure it's a really good transition.

MAAC MEMBER: Thanks.

MS. ROBERTS: Thank you, Liz. Two quick questions. How many people can be served in each one of those pilots?

MS. MANLEY: In the PDD pilots there are two hundred people to start in the pilot. In actuality, there will be a ramp-up. So we're thinking there will be fifty in the first round.

MS. ROBERTS: And the other?

DR. SPITALNIK: In the CMW document, it's two hundred.

MS. ROBERTS: You said the CSOC would be working with the managed care organizations (MCOs), which is a wonderful thing. If somebody has private health insurance, and is not part of either NJ FamilyCare (NJFC) or Medicaid, would they be eligible for this or not?

MS. MANLEY: No, because the first eligibility criteria is they have to be diagnosed.

DR. SPITALNIK: Did you want to speak to that?

SPEAKER: The PDD program was designed to try to provide equity among what is already a state mandate on the commercial side.

MS. MANLEY: Thank you.

DR. SPITALNIK: Anything else from the MAAC? From the public, questions?

Thanks so much, Liz. And implementation in October 2013?

MS. MANLEY: I don't have a date yet. We're still working on the integration. All of the things that we're doing must go through our fiscal agent, which requires time. And a lot of it is just allowing sufficient timeframes for systems modifications because

we already have so many competing priorities for system modifications. Much of the timeframe depends on when the systems modifications can get done.

DR. SPITALNIK: Thank you. Of course, we'll add an update to our October 7, 2013 meeting agenda. And now the Director's Report.

MS. HARR: It's so nice to have such great leadership in our Department and other Departments that I just wanted to make sure that they got the opportunity to speak before Medicaid.

Budget Hearings. We had an Assembly budget hearing on April 16, 2013, and Senate hearing on May 1, 2013. We received a few follow-up questions from the Assembly and Senate, which we've responded to. And there are really no lingering outstanding issues from my perspective with respect to the budget. So now they will go through deliberations and we will look for a budget to be struck and have an Appropriations Act July 1, 2013.

Accountable Care Organization (ACO) update. The regulations for Medicaid ACO demonstration were issued on May 6, 2013. They are now open for public comment. The deadline for public comment is July 8, 2013. We will then review and build consensus around our response to the comments we've received. We are

anticipating that those regulations would be adopted in October 2013 and we would be able to start our demonstration in early calendar year 2014 perhaps January or February of 2014.

Provider rate increase update. Under the Affordable Care Act (ACA) we are required to increase our reimbursement to primary care providers up to one hundred percent of the Medicare rate, subject to approval of our State Plan Amendments (SPAs). Our SPAs were submitted after we received the coding from CMS. There are two SPAs. One is our methodology on how we will pay our MCOs, because then the MCOs will be paying their primary care providers. That SPA was approved. We will be amending our contract with the MCOs. Once the contract language is approved by CMS, the health plans will be in a position to be able to make those increased primary care rate increase bump-ups. And it would be retroactive to January 1, 2013. We did also submit a SPA for our rate increase on the fee-for-service side. That SPA is still pending with CMS. So subject to approval of the SPA and the system changes, we also would be reprocessing claims back to January 1, 2013, for the primary care rate increase.

So it's with regret that we don't have those rate increases in the system yet, but they will be

retroactive. But every state, maybe with an exemption of one, every state is in the same position. And, all states were late in receiving the coding from CMS in order to make systems changes. So we're very anxious to get those rates into the system, with the hope that we'll be able to attract more providers into the Medicaid program.

Grievance and appeals. I'm going to give you a little bit of information. And then what I'd like to do going forward is to have a template, because I don't want to get into all the numbers. I'd like to have a recurring report, with all the statistics, so you have them in front you and you're not just hearing them.

So the Office of Quality Assurance (OQA) under Carol Grant and Cindy Rogers, who are with me, do review the reports received by the MCOs. They are required to report to us the status of grievances and appeals within the MCOs. And it's a contractual requirement that the MCOs allow members a timeframe of no less than sixty days and no greater than ninety days to file stage 1 or stage 2 appeals, and four months for a stage 3 appeal. The grievance and appeals report lists each appeal or grievance by the categories mandated by the Department of Banking and Insurance, as

well as whether the grievance and/or appeal was upheld, overturned, or partially upheld.

I'm going to tell you that the top three categories of member utilization complaints, grievance, and appeals that's received and then reported by each of the MCOs. The top three areas are denial of inpatient hospital days, services considered not medically necessary, and pharmacy. So that is consistent through essentially all of the quarters and the three largest areas of grievance and appeals.

I am now going to the podium and go through a slide presentation of the status of our Medicaid Expansion, and I want to provide you with quite a bit of information on our thinking about the benefit package that we are proposing for the Expansion population which will be eligible beginning January 2014.

DR. SPITALNIK: While Director Harr is going up to the podium, let me use this opportunity to thank her and the staff of the Division, Phyllis Melendez and Kim Hatch, for their support of this meeting. I'd also like to thank Commissioner Velez and staff of the Department for their support and persistence with helping us to achieve a broader membership. So thank you all.

MS. HARR: Just as background, Governor Christie announced in his budget address in February 2013 that New Jersey would elect to take the Medicaid Expansion. We're estimating that about 100,000 childless adults will become newly eligible for Medicaid in 2014, as well as the low income parents that we've been covering will be converted from Title 21 and will be newly eligible under Medicaid. So when I'm focusing in the presentation on the Alternative Benefit Package (ABP) in the Expansion, it will be the benefit package for those that are truly new to the system, single adults and childless couples, as well as the parents that had previously been receiving the NJFC Plan D benefit package and will be newly eligible for Medicaid.

With respect to ABP recommendations, we do have an internal group that's been working on the ABP. Again, that ABP benefit package will be for the Expansion population as well as a number of other areas of the ACA. A lot of the recommendations are being finalized right now. But one of the most critical ones was, again, what the benefit package will be for the newly eligible population. We were fortunate to have the Center For Health Care Strategies facilitate several work groups for us and bring in some expert

consultation and resources to the table to help us get to this point. So I definitely want to thank them.

(Director Harr conducted a slide presentation.)

DR. SPITALNIK: Thank you so much.

Questions from the MAAC?

MAAC MEMBER: It's really fantastic to hear your plan with the ABP. We see what's going on in other states. Your proposal is really remarkable. Speaking for myself -- we'll hear from the rest of the MAAC -- it's fantastic. You should congratulated.

I do have a question about parity. I see with the Expansion population you're going to bring parity. I wonder if that's going to extend to the entire Medicaid population?

And the second question is, how are we going to define parity? There's a lot of debate about what that means. I'm wondering if there is some thinking in Medicaid about how you're going to define parity.

MS. HARR: I'm going to ask Roxanne Kennedy to answer that.

ROXANNE KENNEDY: Currently, we have parity for mental health in the basic State Plan. And as Valerie Harr said, we're doing a fiscal analysis with DMAHS to see if we can apply the same parity for the

basic Medicaid Plan A that we have currently.

We did have a meeting with federal and state partners to talk about parity and really get an understanding from the federal level as to what they expect. And we understand it's the no limit and equal access to services as the primary characteristics of parity. For example, in the commercial world there is a cost share of $20 to see a specialist. A psychiatrist is considered a specialist, and they can't charge no more than $20 on the behavioral health side. That's how we will equate parity in the state. It won't be anything less than the current standard medical benefit that's equal to that benefit. So that's how we will apply it.

And at this point, services will be determined based on medical necessity as opposed to, particularly on the substance use side, working with assessment tools to justify level of care in the area of service. Once we have an ASO, it will be much easier to know that we're meeting medical necessity.

MAAC MEMBER: I can understand the benefit part of that, but I'd also like to look at the access part of that, as well. Particularly, if there's a long wait time to get in for mental health services and there's not a comparable wait to get into physical

health services -- that's kind of an issue in many states. I don't know if we're going to address it, but it's something we should also look at as we're expanding parity.

ROXANNE KENNEDY: Absolutely.

DR. SPITALNIK: Thank you.

MS. HARR: I wasn't thinking of parity in terms of that, but it's something we should think about.

I just want to also say I'm not proposing any cost share. We have no cost share for our Medicaid recipients under Medicaid. So I'm not proposing any cost share under the ABP.

MAAC MEMBER: Thanks, Valerie. I have a Medicaid Expansion comment/question and then one on grievance and appeals.

I want to clarify my understanding on Medicaid expansion. As you know, the Division of Developmental Disabilities (DDD) has a requirement that people 21 and over have to have Medicaid to get DDD services. So if there are people right now who don't have Medicaid but they have Social Security Disability and Medicare based on mom or dad's work history but they don't have Medicaid, would they be able to be considered for Medicaid Expansion if they have Medicare

currently?

MS. HARR: I think the answer is no. I think if you have Medicare, you're not eligible for the newly eligible expansion population.

MS. JOSEPHICK: That's my understanding also.

MS. HARR: That was what I understood.

MS. ROBERTS: Now, on the grievance and appeals that you had talked about, at the last MAAC meeting, we were able to hear how many appeals there were for that quarter and also a breakdown by MCO. Can you provide that at this time?

MS. HARR: I have it, but last time it was so confusing between the numbers of grievances and appeals reported by the MCOs versus fair hearings. I prefer to provide it in writing and follow-up at future meetings.

MS. ROBERTS: You mean a follow-up that we would get after the meeting?

MS. HARR: Yes.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Anyone else from the MAAC?

MR. CASTRO: Ray Castro, New Jersey Policy Perspective. As you know, New Jersey is fortunate in that we're one of the few states that determine whether

someone is insured or not insured through State income tax information. I'm wondering if you're thinking of using that as a vehicle for outreach, as well, since we know their income.

MS. HARR: Heidi, do you want to comment on that? We do include material about NJ FamilyCare in the 1040 tax packet instructions.

MS. SMITH: Thank you, Ray, for that question. The authority actually expires, but we've learned a lot through that process of using other vehicles to get information about the uninsured.

In regard to income, we're going to be using information from the federal hub, which will have their federal income tax information, but we're allowed to use other sources for the information, if it's not available through the federal hub.

MS. HARR: I think Ray is asking for an outreach strategy.

MR. CASTRO: Yes.

MS. HARR: I don't know if we could do targeted mailings based on a data review of people that we know are eligible now.

MS. SMITH: With outreach for the free and reduced lunch program, we anticipate adding some messaging so that parents know there could be insurance

for them, and we would do that same thing with the tax form. In the messaging we do now, we talk about insurance only for the children. We can change some messaging to let the parents know that it could be available to them also.

MR. CASTRO: And the single adults?

MS. SMITH: And the single adults too, absolutely.

MS. SINGER: Candice Singer, National Council on Alcoholism and Drug Dependence New Jersey.

I also want to congratulate you on the plan that you developed. We really, really appreciate that. But I was wondering, although that covers most people, there will be a few people that will need long-term residential care. What will happen with those people?

MS. KENNEDY: We have worked with Mental Health and Addiction Services, also with our colleagues on the federal level. We specifically leave long-term residential out. We have operated halfway house services for short-term residential as opposed to the long-term residential for this service. We do recognize there will still be some State funds for people who are uninsured and potentially for people who meet that level of care and absolutely need that. But at this point, we chose not to cover it in the Medicaid

State Plan and opted more for the halfway house and working toward getting people back into their communities and into their lives and supportive housing, focusing our efforts on those recovery supports as opposed to long-term residential.

MS. SINGER: Thank you.

MS. WENTZ: Deborah Wentz, New Jersey Association of Mental Health and Addiction Agencies. When you're saying that you're going to follow the medical necessity model for habilitative services in mental health, I think that would apply to substance use, too, but in substance use, and I do applaud the services that you listed, but on the mental health side, how will that cover our recovery-oriented services? Because I've had a lot of discussions over at the Department of Banking and Insurance (DOBI). And they were open. We really need to perhaps clarify or expand on the commercial side so it would be applied in terms of their understanding of the habilitative services. DOBI interprets the mental health parity currently, which is in the largest small employer plan, as strictly a medical necessity that doesn't include some of the habilitative services that even the National Association of Insurance Commissioners cover. Now is the time to bring it forward. Would that

be possible?

SPEAKER: The recovery support services that are available on the mental health and addiction side are not going to be in the Medicaid State Plan, they're going to remain State-only funded services, i.e., the self-help centers, and Eva's Village. I'm not sure if there's more substance abuse recovery peer life supports. And what Deborah Wentz is referring to is what DOBI had met with us about six or seven months ago when we were looking at the essential health benefit for the recommendation for the Health Insurance Exchange, and we brought this topic up -- about true parity in the commercial side. And it is something that Molly Greene and I have on our agenda to schedule with DOBI and work internally to really help DOBI and us understand what the commercial plans are providing -- it's not just medical necessity, but it's plan of care for that consumer who may benefit from the supports that are outside the MCO and available through State-only funding and other supports in the community.

SPEAKER: Somebody might have an opinion about this. For mental health consumers, their primary access to any kind of treatment whether it's physical or mental health is through what would probably eventually become the ASO or MBHO. Will there be good

communication between the MCO and the MBHO eventually? Because usually the ASO or MBHO is their [the consumer's] primary access to any kind of care. And I just wonder how much communication there will be between those two entities?

MS. HARR: That's a good question. What I left out, when I said that the Expansion population would be under managed care, was to clarify that behavioral health is carved out of managed care. It's fee-for-service and it would be moving under the same track as the ASO for behavioral health services.

So, yes, everybody can set the goal and stipulate, through requirements, and coordination, to build those lines of communication. And we've been working to make improvements in the communication. And that goes back to certainly our same goal that we would do the same thing with the Medicaid MCOs and the ASO/MBHO.

SPEAKER: I think the reason I asked that question was because it seemed like the Behavioral Health Homes are going to take a while to roll out.

DR. SPITALNIK: Thank you so much, Valerie.

MS. LIEBMAN: Evelyn Liebman, AARP. We also want to commend you for the work that you and your

staff have been doing. It's very exciting. I just wanted to know if you could elaborate a little bit on what additional education and outreach you will do if you're successful in getting the Round 3 CHIP grant?

MS. HARR: I'll ask Heidi to answer that because she wrote the grant proposal. I think it's pretty exciting.

MS. SMITH: Thank you. I want to stress that the outreach and enrollment grant's primary intent is to outreach coverage for children. We all know that children come with parents. We plan to explain Medicaid's new federal health care law, the new Expansion group, the role of the application assistors, and the new eligibility guidelines for Medicaid.

We intend to use the training grant to do State-wide training at the local community colleges, because the local community colleges are within a 20-minute distance of everybody in the State. So we will have access to professors that will select and train. We will follow a train-the-trainer model. The college professors will deliver a curriculum to the attendees. And, they can train about 5,000 people. We're encouraging people to apply online. The whole intent of training in the community colleges is to give the

public an opportunity to go through the online application so that they can help families submit online applications.

DR. SPITALNIK: Thank you. And now we're going to turn to the New Jersey Medicaid Quality Strategy Plan from Carol Grant who is Chief of Operations for the Division.

MS. GRANT: This may be the first official presentation of the Quality Strategy to the MAAC. But, in fact, the Quality Strategy Plan is a living document, and this is not the beginning nor the end. It's part of the journey under the CMW. We've always had a quality strategy at DMAHS. Many of its tenets are captured in the MCO contracts and, therefore, they are requirements of the program and we do monitoring and tracking of those requirements.

Ongoing, the quality strategy will be subject to public review and input and amendment. It's not just a set of measures. It is an integrated document that functions to assure that the model of care that we propose is actually working for our beneficiaries.

So in compliance with federal law, the quality strategy incorporates the required activities for a comprehensive strategy for monitoring, assessing,

and proving the quality of managed care services offered in the following programs: New Jersey Family Care/Medicaid, the new MLTSS, and Dual Eligible Special Needs Plans (D-SNP). D-SNP and MLTSS are new additions to the quality strategy.

The State conducts periodic reviews to evaluate the effectiveness of our quality strategy and to update it as needed, or whenever a significant change has been made, as well as providing regular reports on the implementation and effectiveness of the quality strategy. Ultimately, we will be doing an annual review of all elements of the quality strategy with a minimum expectation of annually updating it. We will
be monitoring routine reporting and we will definitely seek stakeholder input.

(Carol Grant conducts a slide presentation.)

DR. SPITALNIK: Thank you so much. I will open this up now to the MAAC for questions about the quality strategy.

MS. ROBERTS: Thank you, Carol. That was really, really very helpful to have detailed. It was a very comprehensive report. There have been discussions at past meetings. So thank you.

I'm wondering if we could think about having

a subcommittee about consumer satisfaction surveys. Our next meeting is in October. And the months go by and we still, I feel, aren't where we need to be with regard to improvements in looking at the consumer satisfaction piece of this. So do you think that it would be reasonable to have a subcommittee to look at that before the next meeting in October?

MS. GRANT: To think about MLTSS?

MS. ROBERTS: Well, no, not specifically. Remember, we had had that meeting before awhile back? And then the thought had been that there was going to be a comprehensive approach to consumer satisfaction. I'm just wondering how to get at that specifically for individuals that have developmental disabilities and other special health care needs.

DR. SPITALNIK: Well, I just want to clarify what you're asking. Are you asking for a subcommittee related to the CAHPS® or to the issue of consumer satisfaction?

You are advocating on behalf of consumer satisfaction measures for people with developmental disabilities. There's the challenge of consumer satisfaction in MLTSS. I just want to make sure what you're asking for and whether that comports with the comprehensive approach and that whatever structures

get set-up support the comprehensive approach.

MS. ROBERTS: The meeting we had a while back was not related to MLTSS. It was looking at the population that was already in Medicaid managed care and the concerns that had been reported about durable medical equipment and personal care assistant services. There are certain areas that I've heard anecdotally that people are talking about.

But yet, the way we
have the consumer satisfaction modeled under CAHPS® currently doesn't seem to get at those types of issues and concerns, so we had been told let's wait, let's see what the comprehensive quality strategy looks like and then we could come back and discuss. I think you said with CAHPS® itself the way it's set-up, we can't necessarily add questions that I might like to add, so we might have to look at other ways to survey consumers.

SPEAKER: I'm just wondering if it's really with respect to consumer satisfaction. Is it the quality of life survey where you would be capturing the consumer perspective?

MS. GRANT: We started this conversation in the quality and monitoring workgroup around MLTSS in terms of what's the best way of getting at consumer

satisfaction across the board. And, yes, it would be quality of life and personal experience and those kinds of things. And I think we really have to do some thinking about it. The reason CAHPS® is good is because it's used as a national benchmark. And you have the ability to say how are we doing related to other things. Overall I think it's a subject that needs some thought and perhaps some recommendations that could be presented and then go from there.

MS. ROBERTS: And again, we can start setting something up now, before the next meeting so that we could come back with some thoughts before we have our meeting in October, is my thinking.

SPEAKER: I'm wondering if you could meet independent of the agency and come back with recommendations. I think that's different from just looking at the CAHPS® and going through and adding questions. If the goal is to try to get better consumer satisfaction information in particular areas, I think that Carol said we would take your recommendations.

MS. ROBERTS: Just another point, CAHPS® also has a health version that's already in use. There's also a nursing home version that is a draft and may be tested. My recommendation would be to look at

it and to see if it's applicable.

SPEAKER: I'd also like to caution us to not overly rely on the concept of satisfaction, which by its very construct doesn't really measure access or quality of service for quality of life. And I think there's some danger here in making the assumption of satisfaction equaling quality of life. So I'm not sure what the next steps are. Would it make sense to try to collect from MAAC members the concerns that you bring around quality and then see whether those are being addressed in the strategy? But I think we're a little bound by this concept of satisfaction. And I'm not advocating for people being dissatisfied with services, but there really is a history of quality evaluation, particularly in developmental disabilities and that satisfaction doesn't necessarily equate with quality. So I don't know. Would it make sense to conduct some information gathering about concerns before we attach ourselves to a particular strategy? Would that seem viable?

MS. ROBERTS: I think it would be helpful to have a timeframe so that we know we're moving forward. For example, like for children with special health care needs, there are questions already out there that could be utilized, but I know it wasn't part

of CAHPS®. This is going back to the meeting we had awhile back. I was not aware that there's a home health version of CAHPS®, for example. So I would love to see what that looks like. That's not what everybody utilizes, is that correct.

SPEAKER: It's being utilized.

SPEAKER: But, no; not within New Jersey Medicaid.

SPEAKER: Not with Medicaid, but within Medicare it's a federal requirement.

SPEAKER: I think taking a look at that would be very helpful.

SPEAKER: Beverly, is your focus exclusively on CAHPS®? Because I appreciate the history and frustration that the CAHPS® survey has gone out and we've labored with that. But I think one of the things that we had talked about in committee was that the Division is launching a much broader much more elaborate quality strategy and that's being built upon and expanded under the CMW. But what I'm hearing you talk about is the relationship to CAHPS®.

SPEAKER: Because I think, that is what has been used. That has been the gold standard of the way in which this information has been elicited. And I think the feeling had been that for people that have

developmental disabilities and other special health care needs there are a lot more areas of concern. So I think we just have to figure out how we can get the best handle on what really is happening, not just anecdotal information. And I know we've had discussions before.

DIRECTOR HARR: Looking at CAHPS® is one thing. But it may be providing you some of the reports and statistics Medicaid collects. So Carol talked a lot about what we are measuring as we are moving toward MLTSS, but we can provide the MAAC with actual reports of what we already have. And there are focus studies that we do, so we can go back and take a look at what we have and we can maybe start there, because I think what Carol was trying to show is the broad canvass of all the quality strategies. The CAHPS® is one component, but we do have a significant amount of information I think we can provide to you that may answer some of the questions.

SPEAKER: That would be great. Thank you.

DR. SPITALNIK: So the first step is really a communications step and providing information.

SPEAKER: Carol, just quickly. I really like the addition of other indicators that are going to get added. Will these indicators be put online and

reflected in the MCO Performance Report, or something similar?

MS. GRANT: Some of the them will be in the MCO Performance Report. The goal is to have the quality strategy plan online. And then as we start collecting measures, the measures will be online. That's what I'm trying to get to. That's the vision. Here, at the starting point, we're updating the quality strategy plan to be broader, to look at the entire Medicaid enterprise, including MLTSS, and including some of the pilot programs. And when it's final, it becomes public so everyone knows how we are measuring ourselves.

MAAC MEMBER: Just a point of clarification. Under the Special Terms and Conditions where you say that the state must develop a comprehensive quality strategy with measures related to behavioral health and managed care for all the programs including primary care and MLTSS, is this the plan that you're talking about?

MS. GRANT: Yes.

MAAC MEMBER: I only saw one or two questions on behavioral health. Is this the extent of the questions for behavioral health for adults and children?

MS. GRANT: We're actually working with Roxanne Kennedy and the Division of Mental Health and Addiction Services to create a set of quality metrics for behavioral health and substance abuse. They're not all reflected today because they're really under construction.

MAAC MEMBER: Because it says that this would be submitted 90 days before the program goes live, does that mean October?

SPEAKER: Let me answer. The quality strategy plan is required only for managed care. Behavioral health is carved out. So that's why you wouldn't see it. But we are trying to have a quality strategy plan that is, again, like I said, is broad and covers all areas of the program. But the 90 days is to have the quality strategy plan updated for MLTSS because it is required for the move to managed care.

MAAC MEMBER: And behavioral health is included under MLTSS, it's not carved out?

SPEAKER: Right. Behavioral health is included MLTSS.

MAAC MEMBER: So we'll be seeing that prior to the October submission?

MS. GRANT: We're already working on the metrics. This is a living document that will grow and

evolve and change. There will be discussions at future meetings.

DR. SPITALNIK: Other questions from MAAC? Thank you.

Questions from the public around the quality strategy?

Yes. Tell us your name, please.

LISA ZAVORSKI: Lisa Zavorski, Director of Quality from Life St. Francis. Is there any possibility that there might be representation from any of the State Program of All-Inclusive Care for the Elderly (PACE) organizations on the quality steering committee?

And secondly, for your critical indicators, will that be open to public comment?

SPEAKER: There is a representative from PACE on the quality committee. There's also material shared with the representative through the quality committee.

MS. GRANT: This is all part of our goal of alignment. We've looked at PACE. We've tried to look across the board so we're not reinventing the wheel. We are capturing the best thinking wherever it exists in the system.

DR. SPITALNIK: Thank you. Other final

questions?

Thank you so much, Carol.

MS. GRANT: Thank you.

DR. SPITALNIK: Our next meeting is October 7, 2013 in this same location. So far the agenda items that I have include -- this is more of a follow-up -- a standard paragraph given out to agencies about CAHPS® to encourage participation, an ACO update, Valerie committed to developing a template for grievances and appeals so we'll see the empirical data in a standardized format, an MLTSS update, quality update, and an update on the children's pilots. Please keep in mind that the slide presentations will be available online for viewing after the meeting at: http://www.state.nj.us/humanservices/dmahs/boards/maac/.

MS. ROBERTS: Just something that was not on today's agenda, which I hope could be included would be an update from the credentialing task force.

DR. SPITALNIK: Thank you. Other items?

Hearing none. Do I have a motion to adjourn?

MAAC MEMBER: So moved.

DR. SPITALNIK: Second?

MAAC MEMBER: Second.

DR. SPITALNIK: All in favor?
MAAC MEMBERS: Aye.
DR. SPITALNIK: We are adjourned.
Thank you. Thank you all. Have a great summer.
(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 transcript of the proceedings as recorded.

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