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

June 15, 2016
10:06 A.M.
FINAL
MEETING SUMMARY

MEMBERS PRESENT:
Deborah Spitalnik, PhD, Chair
Theresa Edelstein
Beverly Roberts
Mary Coogan
Dennis Lafer
Dot Libman
Wayne Vivian
Sidney Whitman

MEMBERS EXCUSED:

STATE REPRESENTATIVES:
Valerie Harr, Deputy Commissioner,
Department of Human Services

Meghan Davey Director
Division of Medical Assistance and Health Services

Transcriber, Lisa C. Bradley
THE SCRIBE
6 David Drive
Ewing, New Jersey 08638
(609) 203-1871
the1scribe@gmail.com

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

ATTENDEES:

Thomas Papa	AdoSew
Christopher Bruette	Aetna Better Health
Cheryl Reid, M.D.	Aetna Better Health
Cathy Chin	Alman Group
Jenn Jacobs	Amerigroup
Kati Brilhart	Amerihealth
Matthew Minnella	Association of New Jersey Chiropractors
Susan Buchanan	Autism New Jersey
Elena Graziosi	Autism New Jersey
Claire Wieczenak	Autism New Jersey
Colleen McLaughlin	Boggs Center Rutgers
Rita Steindlberger	Brian Injury Alliance of New Jersey
Hillary Pearsall	Camden Coalition of Healthcare Providers
Whitney Wilson	Cerner Population Health
Mary-Catherine Bohan	Community Care Behavioral Health Organization
Valery Bailey	Consultant
Jill Hoegel	Disability Rights of New Jersey
August Pozgay	Disability Rights of New Jersey
Kate Clark	Family Planning Association of New Jersey
Tom Dorner	Health Care Association of New Jersey
Karen Brodsky	Health Management Associates
Frank DiGiovanni	Healthplex, Inc.
Lillie Evans	Horizon NJ Health
Jeff Brown	Hospital Alliance
Joshua Spielberg	Legal Services of New Jersey
Gwen Orlowski	Legal Services of Central New Jersey
Barbara Dunn	Magellan Healthcare
Mia Morse	Matheny
Ilesha Sevah	Medical Society of New Jersey
Taylor Johns	Medical Transportation Association of New Jersey
Brady O'Conor	Medical Transportation Association of New Jersey
Sarah Adelman	NJ Association of Health Plans
Wardell Sanders	NJ Association of Health Plans
Mary Abrams	NJ Association of Mental Health and Addiction Agencies
Kevin Casey	NJ Council for Developmental Disabilities
Paul Blaustein	NJ Council for Developmental Disabilities
Grace Egan	NJ Foundation for Aging

ATTENDEES:

Tyla Housman	New Jersey Health Care Quality Institute
Kim Higgs	New Jersey Psychiatric Rehabilitation Association
Raquel Jeffers	Nicholson Foundation
Karen Shablin	Optum, Inc.
Liz Homan	Otonomy
Sal Anderton	Porzio Government Affairs
Sonia Delgado	Princeton Public Affairs Group, Inc.
Mary Kay Roberts	Riker, Danzig, Scherer, Hyland & Perretti, LLP
Jennifer Farnham	Rutgers Center for State Health Policy
Marie Verna	Rutgers University Behavioral Health Care
Ron Poppel	Sunovion Pharmaceuticals
Julie Caliwan	The Innovation Collaborative
Vincent Ceglia	UnitedHealthcare
Susan Hazen	UnitedHealthcare Community Plan
Zinke McGeady	Values Into Action NJ
Cort Adelman	WellCare
Lisa Knowles	WellCare
David Weber	Xerox Government Health
Doretha Howard	Centers for Medicaire & Medicaid Services
Dominique Mathurin	Centers for Medicare & Medicaid Services
Nicole McKnight	Centers for Medicare & Medicaid Services
Michael Kahnowitz	Centers for Medicare & Medicaid Services
Tara Porcher	Centers for Medicare & Medicaid Services
Chris Gabbett	NJ Department of Human Services
Frieda Phillips	NJ Department of Human Services
Brian Francz	NJ Department of Treasury
David Drescher	NJ Office of Legislative Services
Robin Ford	NJ Office of Legislative Services
Rosemary Browne	NJ Department of Children & Families, Children's System of Care
Elizabeth Manley	NJ Department of Children & Families, Children's System of Care
Stacy Reh	NJ Department of Children & Families, Children's System of Care
Michelle Schwartz	NJ Department of Children & Families, Children's System of Care
Laura Otterbourg	NJ Division of Aging Services

ATTENDEES:

Stu Dubin	NJ Division of Medical Assistance and Health Services
Alison Gibson	NJ Department of Health
Laurie Brewer	NJ Office of the Ombudsman for the Institutional Elderly
Chris Czvornyek	NJ Division of Medical Assistance and Health Services
Jodie Flandinette	NJ Division of Medical Assistance and Health Services
Elizabeth Fortunato	NJ Division of Medical Assistance and Health Services
Carol Grant	NJ Division of Medical Assistance and Health Services
Phyllis Melendez	NJ Division of Medical Assistance and Health Services
Stephanie Myers	NJ Division of Medical Assistance and Health Services
Valerie Mietke	NJ Division of Mental Health and Addiction Services
Maribeth Robenolt	NJ Division of Medical Assistance and Health Services
Stacy Shanfeld	NJ Division of Medical Assistance and Health Services
Heidi Smith	NJ Division of Medical Assistance and Health Services
Terrie Whitfield	NJ Division of Medical Assistance and Health Services
Joshua Lichtblau	NJ Medicaid Fraud Division

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, and I'm delighted to welcome you to the June 15th meeting of the Medical Assistance Advisory Council (MAAC). Pursuant to the New Jersey Open Public Meetings Act, adequate notice of the schedule of quarterly meetings for Calendar Year 2016 of the Medical Assistance Advisory Council, the MAAC, was issued by the New Jersey Department of Human Services, comporting with all the requirements of the meeting notification.

I am also required to tell you as a condition of using this space that in case of emergency, please exit through the back, exit through the front doors, and meet in the parking lot where the meeting organizers can make sure that everyone has, on the unlikely event, exited the building.

Having done that, I want to call the meeting to order. And this is a meeting that has a very specialized purpose, so let me review the agenda. We will do introductions, as we typically do, starting with the members of the MAAC and then the members of the public. We will then proceed to approval of the minutes of our last meeting. We will then have a presentation of New Jersey Comprehensive Medicaid Waiver (CMW) Renewal. And after that -- and I will ask

people to hold comments and questions until the end of the presentation -- as is our practice, the members of the MAAC will have the opportunity to make comments and raise questions. We will then turn to all of you as members of the public.

Unlike our usual mode of operation where there's more of a dialog, this will be New Jersey's main public opportunity for making stakeholder comments on the Waiver Renewal. And as such, I will ask that people limit their comments to two to three minutes.

The purpose of this meeting is both informational and also to give the Department of Human Services (Department) and Medicaid and the members of the MAAC the chance to listen. If there's any factual misinformation, that will be clarified, but it will not be a conversation, it will not be a dialog. And you will hear in the course of the presentation other opportunities for comment upon the Waiver Renewal, both in writing and other occasions when leadership in the Department is meeting with the community. And also there will be a separate session for the developmental disabilities community to be scheduled, I believe, at the end of the month for public comment. After that and with time permitting, with our 1 o'clock stop, we will proceed to brief updates, which will be slide

presentations on NJ FamilyCare, Managed Long Term Services and Supports (MLTSS), and the National Core Indicators (NCI-AD). Those slide decks will be posted on the MAAC website at: http://www.state.nj.us/humanservices/dmahs/boards/maac/.

So with that information and those caveats, I turn to our first agenda item, which is calling for review and approval of the minutes of our April 20th meeting. And as always, our thanks to Lisa Bradley for her fine transcription.

Members of the MAAC, are there any changes or amendments to the minutes of April 20th?

Do I have a motion for approval of the minutes?

MS. EDELSTEIN: So moved.

MS. ROBERTS: Second.

DR. SPITALNIK: Edelstein moved, and I want to give Bev the second for that.

All those in favor?

MAAC MEMBERS: Aye.

DR. SPITALNIK: The minutes of April 20th are accepted, with thanks.

So with that, I will now turn to Allison Hamblin. Allison is Vice President for Strategic Planning at the Center for Health Care Strategies

(Center). Many of you are familiar with this Center which has been an incredible support to the Department and the Medicaid Program in the planning of a variety of initiatives. Allison brings us a long history of technical assistance and support of the CMW.

Allison, I apologize. I didn't do introductions, and so I'm going to do that first so that you will be able to know with whom you are speaking, and we'll all have an understanding of that. So begin with the MAAC.

(Members of the MAAC introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Welcome, everyone. We're delighted and grateful that so many people are here today.

Allison, please.

MS. HAMBLIN: Thank you so much.

Good morning, everyone. I am going to do my best to go slowly, which his not my natural tendency. So if I'm going too fast, I hope you will make sort of visual signals to me to slow down so I know to keep the pace at a manageable level. There's a lot of really exciting concepts to talk through and to preview for you all, and so I'm privileged to be here have the opportunity to do so on behalf our colleagues at the

Division.

For those of you who don't know the Center for Health Care Strategies, we are a national non-profit policy organization based here in New Jersey. We work very closely with the State on a broad array of technical assistance support around various Medicaid initiatives, but we also work nationally with states across the country. We've been doing so for 20 years. And so where possible, I will try and inject a little national perspective in various places throughout the presentation to provide that context.

Before we get into the details, on behalf of the Division, I wanted to lay out the vision that really is grounding and guiding the development of the renewal application, and that is to create a fully integrated continuum of care that seamlessly addresses individual's physical, behavioral health, and long-term care needs. As we go through both the accomplishments under the Comprehensive Waiver and the platform that the State is building from with this renewal and go into each of the concepts, it's really important to keep that vision in mind, because it's that vision that is really guiding the State in its efforts here. And I think you'll hopefully note that all of the proposals that are included in this renewal application really do

come back to this vision.

So before we dive into the new and exciting concepts in the renewal application, I wanted to take a moment to just walk through these two slides some of the key accomplishments that the State has achieved since the approval of the first 1115 Comprehensive Waiver back in 2012.

(Presentation by Ms. Hamblin)

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

DR. SPITALNIK: Thank you so much, Allison, for such a comprehensive and clear presentation.

So as Allison said, I will turn to the MAAC first, and the MAAC can also comment during the public period. I have a timer, and I will keep track of time in order to maximize participation.

And let me also clarify that we will only have responses from the Department or the Division of Medical Assistance as clarification. This is not meant to be a period of dialog, but rather the opportunity for both the MAAC and State officials to listen to the comments that people bring. So we will correct any confusion or misinformation, but not go beyond that.

So with that, I open the comment period to members of the MAAC.

I'm going to turn to Mary first.

MS. COOGAN: Just as a clarification, on the expansions of the pilots regarding autism program and the children's program, is there any goal in terms of numbers of children we want to expand it to?

DR. SPITALNIK: Let me repeat Ms. Manly's response, that there's no number that's presently envisioned.

MS. COOGAN: Thank you.

MS. HARR: Because it would be moving under a State Plan and under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) would be any child meeting the medical necessity in the requirements, so it wouldn't be a cap number or a slot based.

MS. COOGAN: Okay. Thank you.

DR. SPITALNIK: So the shift is from no longer a pilot for autism services, but is directed by Centers for Medicare and Medicaid Services (CMS), part of the State Plan under EPSDT.

MS. COOGAN: Thank you.

DR. SPITALNIK: Beverly.

MS. ROBERTS: So I have two main concerns right now, recognizing time constraints and the fact

that I'm very pleased there's going to be meeting, you said, at the end of June to discuss some of the Division of Developmental Disabilities (DDD) specific aspects of the proposal.

So having said that, in the expansion of the services, as were just clarified for all youth under age 21 who have autism sounds wonderful, but that brings up the concern of will those services continue when they turn 21 and in large part get services from DDD?

It has been a concern for some time that the DDD population who have intellectual disabilities (ID) and a significant behavioral health challenge have had their behavioral health from the Medicaid HMOs. I noticed that wasn't mentioned as a success because I don't think that it has been a success, so we have long asked for more integration for improvement, specifically for this population in terms of access to providers. So I'll keep that short, but I am really very concerned about the continuation of that. While I'm pleased to see that it's going to be expanded for under 21, again, very concerned about 21 and over and their access.

My other area of concern is the requirement of the Fully Integrated Dual Eligible Special Needs

Plans (FIDE-SNP) group that are going to be required to be FIDE-SNPs. I guess I should have said that differently. That the dual eligibles will then be required to be in a FIDE-SNP. Right now, it's voluntary. I would like to see it, especially for my population, individuals who have dual eligibility who have an intellectual disability, I would very much like to see that continue to be a voluntarily FIDE-SNP enrollment. For many of our folks, they also have private health insurance under their parents, so when you say, well, you'll just take the HMO that they're in for Medicaid and that's going to become their Medicare Special Needs Plan (SNP), for many people, they're not even using the Medicaid HMO. They've got their private health insurance from their parents, that's primary, that's what they use. At some point later typically they don't have that private health insurance anymore and then Medicare and choice become important for them. So I want to emphasize the importance of choice.

DR. SPITALNIK: Thank you so much. Anyone else from the MAAC have any comments at this point?

Okay. That option still, of course, remains.

And I'll turn to the members of the public. For the purpose of the transcript, please indicate your

name. And, again, we're going to have a time limit of two to three minutes. So thank you.

Raquel. Please stand, if you can, and state your name thank you.

MS. JEFFERS: I think my primary question is really have you given thought to the vehicle that you want to use to drive the behavioral health integration? I know that for the D-SNPs and for the MLTSS population, integration has included a full at-risk pardon to Managed Care Organizations, so I don't know if you've given any more thought to that or what the vehicle will be.

And I guess the other question that kind of goes with it but I think you might have answered a little bit, do you see this behavioral health integration just to include a benefit for the SMI population? Or will you also be looking at individuals with mild to moderate mental illness and substance use issues and including an array of services in different service settings, like primary care settings, for that population, as well?

DR. SPITALNIK: Thank you. And that was Raquel Jeffers from the Nicholson Foundation.

MS. HARR: Raquel, so you posed those as questions, but I think we're looking for what are your

thoughts around those particular issues. Of course, we have discussed and are looking at all of those things.

So I don't know if you want to comment now, but that's what we're looking for public comment.

MS. JEFFERS: Well, I'll just say the Foundation would love to be a part of that conversation and in a way to bring different models to the table. I think there's a full at-risk carve-in. There's a carve-in that potentially is not at risk but is just managed by the behavioral health plan. I think Allison is completely -- her overview of how there are different models around the country was fantastic. I think we should learn from them. I think we should also learn, as Bev sort of tried to indicate, some of the lessons that we've learned here. I think some of the things about integrating Behavioral Health and Managed Long-Term Services and Support and in the D-SNPs, some things that worked and some haven't. So I think there are some lessons here in New Jersey that we could also learn from the two carve-ins that are already underway here.

DR. SPITALNIK: So may I reiterate Deputy Commissioner Harr's point of asking for substantive comment and input and suggestions to address that issue. Thank you.

Josh.

MR. SPIELBERG: Josh Spielberg with Legal Services of New Jersey.

So first I have an overall conceptual point, which is separating out what a waiver is needed for from the blueprint for Medicaid. So a lot of the ideas that are presented today are great ideas, excellent, the vision is excellent. But for a lot of those, I don't think you need to go through a waiver. There may be -- and a waiver, again, what a waiver does is it waives existing Medicaid requirements. As alluded to here, you can make changes in the Medicaid Program through State Plan amendments or there may be existing authority under the State Plan to make those changes. So I think it would be very helpful to separate out those things, the accomplishments of Medicaid, the plans for the future, and then what exactly is a CMW needed for. For example, the idea to extend presumptive eligibility to behavioral health providers, I think, is a great idea. I don't know that you need a waiver to do that. You may be able to do that through a State Plan amendment or under existing authority.

MS. DAVEY: I agree. I think when we're total incarceration, we're saying we need waiver authority to increase the eligibility limits. And I

was just saying all these things go along with doing something like that. So they kind of go hand in hand. Right, we don't need waiver authority, but it goes with the overarching how do they get in door quickly and how do we keep their eligible going longer, which we need CMS waiver authority for. Stuff like autism, it could be done through the State Plan, but there may be other services that are more waiver-type services that we would ask for as part of that benefit package. So on top of the State Plan benefits, we'd also need waiver authority to give something additional.

So it is a little muddy; I would agree with that, but they do kind of weave together.

MR. SPIELBERG: Right. So I think to the extent you can be specific about what you need waiver authority for and what you don't -- again, great ideas in here, but CMS has to approve whether they're going to grant a waiver for additional Medicaid requirements, and specifics will be very helpful on that.

MS. HARR: I want to interject there. So just like the original waiver, this is the five-year strategic plan for the Medicaid enterprise, so that's a continuation of this. We don't always know what needs waiver and what doesn't until you start to have the discussion with CMS. But I don't know what purpose it

really serves to put the things in the bucket. I mean, we're just looking for it's one authority, it may even just be an e-mail of approval for something from CMS. So I guess I'm sort of not in agreement that we need to parse out the bucket that everything falls in because then I think you lose the objective of having all of us understanding the broader vision, because I think you get bogged down into the bureaucratic mess of authorities and so forth. So, of course, through the ongoing discussion, you'll see what initiatives we continue to pursue in advance, but if we only have this waiver saying, well, we only need waiver authority for X, Y, and Z, you are all missing out on the bigger picture of the agenda that the State is moving forward for its Medicaid Program.

MR. SPIELBERG: Just to clarify, I think it's right that you have an agenda, a strategic plan, but the waiver is a specific legal requirement. So within that strategic plan, I think you need to identify. It will be very helpful to identify what needs to be what.

MS. HARR: You get there with the special terms and conditions. That's where you would see -- and I don't know if it's in the renewal, but you see the actual regulatory citation that you would need to

request waiver authority for.

MR. SPIELBERG: So the terms and conditions come once there's approval, but I think it's helpful for people commenting to see what you're asking for in terms of specifics.

MS. HARR: Well, I think in the document there is what we're asking for waiver authority and expenditure authority. It is spelled out.

MR. SPIELBERG: At the end, there's a very limited part of that. Like on page 23, one of the things you talk about is -- let's see. Just looking at page 14 and 15, required new managed care enrollees to choose MCO upon application or be auto assigned. So that is something you need a specific waiver for and you address that on page 23, because that's waiver of freedom of choice. To put those together though, would be helpful. The first part of this section where you talk about the really good accomplishments and New Jersey FamilyCare in terms of the cloud, et cetera, that's an accomplishment, you don't need waiver authority for that. So I think putting those things together would be very helpful.

Let me just comment on one other specific in that section, which is on this requirement that individuals who could but choose not to enroll in

Medicare to do so.

Again, I think it makes sense in terms of cost setting have everybody who is eligible for Medicare is enrolled in Medicare. The problem comes up sometimes because Medicare has specific enrollment periods, so if somebody misses the enrollment period for Part B in January through March and then they're told in April they have to be enrolled in Medicare, they can't actually enroll until the next January period. That's when they sign up; they don't get enrolled until the following July. So a person could lose all coverage during that period. So it should be sign up or enroll at the first opportunity to do so and not lose Medicaid eligibility during interim.

DR. SPITALNIK: Thanks very much.

Kevin.

MR. CASEY: Kevin Casey, New Jersey Council on Developmental Disabilities.

A couple of things. One, in terms of the comment period, the 30-day comment period is a minimum requirement, it's not a maximum requirement. I would strongly suggest to you that you cannot have an adequate dialog in a 30-day comment period and that it is much more important to work on this crucial development and get it done right as opposed to getting

it done quickly. I strongly suggest you expand the comment period. I strongly suggest you put parts into the comment period that specifically allow families and self-advocates and consumers to have time to have dialog about this and have time to get their input in.

A couple of specific things, care management supports coordination, in my experience, is what these systems live and die on. If you have a good care management, good support coordination system, the system does well; if you don't, it does not. The key to that is not only allowing but requiring the supports coordination case manager to be an advocate for the consumer and the family. If they don't have that responsibility, it's very difficult for them to do their job.

I want to support Beverly's comments on the behavioral services for people with developmental disabilities. This is not just a New Jersey problem; it's a national problem. It is incredibly difficult for people with developmental disabilities to get behavioral health services, and we really need to work on that.

Last, I strongly encourage the State to tread very carefully in looking at the issue of gradually moving Developmental Disabilities into

Managed Care. You need to look at what has happened in other states. You need to look very carefully as to what has happened in other states. There have been states where it has been an absolute disaster. And there are very few states -- in fact, the only one I'm aware of is Arizona, where that movement has been relatively trouble-free. And the reason it was relatively trouble-free is because the State DD Division was made the managed care entity; it was not primed out. So I think it's crucial that that be looked at very, very carefully. But I'm going to repeat what I said first, this comment period has got to be much more dynamic, much longer, and have much more dialog. Thank you.

MS. HARR: I just want to clarify. We're not proposing to put the CCW services into managed care. That is not a proposal.

MR. CASEY: I understand that, but the national movement is very clear there. And if we are going to look at it or even think about looking at it in New Jersey either now or in the future, we need to proceed very carefully.

DR. SPITALNIK: Thank you.

MR. BROWN: Hi. Jeff Brown, Hospital Alliance.

A couple of things. First, I wanted to thank the Department and the Administration for the folks on Behavioral Health. I think you put a lot of thought into this and I look forward to a robust discussion on that. I know they've already been happening. Many of our member hospitals are weighing in directly with the Department, and we will be submitting extensive comments on how we think that can be rolled out, et cetera.

The second thing I wanted to talk is enhancing access portion of this. A lot of our hospitals actually have to subsidize particular specialty groups within their hospitals because of large volumes of Medicaid patients and low Medicaid rates. So I know when the fee-for-service (FFS) list was rolled out, and I assume that enhancing access references the $90 million for fiscal year to improve access to primary and preventative services, some of those were not full based. We commented we really wanted -- we're hoping a lot of that money targeted at hospital based positions specialty physicians in underserved communities, because if it would take some of the burdens off our hospitals that have to subsidize some of those costs to make up for the Medicaid rates.

The third thing, just on a personal basis,

take off my hospital hat, Bev, I wanted to thank you for comments. My sister has an intellectual disability, and she falls into the bucket you talked about. Has managed care company which has been helpful, but at the same time primary insurance is private health insurance from my dad's employer. So just think about that population, and I think that would be great.

Thank you.

DR. SPITALNIK: Thank you very much.

Yes.

MS. ABRAMS: Hi. Mary Abrams, New Jersey Association for Mental Health and Addiction Agencies.

Two areas I wanted to just comment on. One is stakeholder engagement, which I was happy during the presentation. It was stated that you can never have too much stakeholder engagement. There's a couple things in the concept paper, one on children services, one about exploring a pilot for IDD adults, and then also towards the end of the process it was mentioned about 25 listening sessions that were held internally to develop ideas on Medicaid redesign. At NJAMHAA, of course, always promote early at the table from the start inviting all stakeholders, but particularly the providers of services that are out there on the front

lines and really can have very effective input without direction being selected before those people make it to the table. So it was commented specified in here. There were, like, 250 suggestions. I think some give and take, having that broader community at the table is helpful.

The other area to address, clearly, is the Fee For Service transition, the greater access expectation that's in there, we know we've had many, many meetings continue to talk with DMHAS. Both DMHAS on a daily basis. We have great concerns. Looking in the presentation, there was a list of lessons learned from other states. And among them, there are several that we seem headed for. One is the greater access or the continued access and continuity of care for consumers. The other one is investing appropriately in behavioral health service providers. So many of those here present know from our conversations, we have great concerns that imminently there are outpatient programs, in particular mental health programs, that will be closing and reducing and tens of thousands of consumers stand to lose services. So we will continue those conversations, but as we move forward in developing this, there are many current issues on that path that we need.

DR. SPITALNIK: Thank you very much.

Yes?

MS. VERNA: Marie Verna, Rutgers University Behavioral Health Care.

To what extent will be ongoing supports include supported education, supported employment, not just through Council?

DR. SPITALNIK: Do you want to respond or do you want to --

MS. VERNA: Oh, I see. I should have made that a comment. Do you want me to? I can do it with a period at the end.

DR. SPITALNIK: Thank you. Other thoughts? Back to the MAAC, anyone who hasn't spoken yet. I'm happy to cycle back to Raquel.

MS. JEFFERS: Raquel Jeffers. I should have said this before. I'm so happy to see the value-based purchasing. Are you in the same position that you would like take some recommendations during the comment period around ways that you can structure value based purchasing.

MS. SPITALNIK: Thank you.

MS. ROBERTS: What I would love to see is a way within the new waiver for individuals under the age of 18 with profound disabilities but who do not require

private duty nursing -- so that is not the Community Resources for People with Disabilities (CRPD) group that was moved into MLTSS, but individuals with very severe profound disabilities who require personal care assistant services, they need lifting, they need positioning, they are considered nursing home level of care living with their families, those who are not eligible for Medicaid because the family income is such that the family is not Medicaid eligible. What I would like to see is a way for those specific individuals who could be MLTSS if they needed private duty nursing, they would be viewed as family one, they would get MLTSS. At this point, they don't get anything at all. Parents either have to -- Mom has to quit her job to provide the care or pay privately. They cannot get Medicaid services until they're 18 and then they could apply for SSI and Medicaid. Other states have done this. I think I've had something from Pennsylvania that had found a way for those individuals. And it's not a large number, but for those individuals so impacted, it is extremely difficult for the families.

DR. SPITALNIK: We're trying to seek clarification.

MS. DAVEY: That's a good comment. We have to look at how we do it. If you can provide the

Pennsylvania information on how they're doing it, that would be helpful.

MS. ROBERTS: Remember, we had that meeting not long ago and I had information on Pennsylvania? But I will get it for you.

DR. SPITALNIK: Thank you.

Other comments?

Josh.

MR. SPIELBERG: This is really a question. And it follows up on the comment before. There is a Rutgers evaluation that I think is taking place is about to be published which would be helpful to see in terms of evaluating the first period before commenting on the renewal, and I wanted to ask when you expected that to be public, and just state in terms of the comment that the comment period needs to be extended. It would be helpful to keep that in mind.

MS. DAVEY: So the federal government requires that the final evaluation be submitted on July 2017. They do require an interim evaluation to go with our application which is being finalized now. But just so you know, we do report the evaluation in every quarterly report and every annual report, which is public. It's on Medicaid.gov. So you can see the progress of the evaluation over the last four years.

And then once it's submitted to CMS, they'll post all of those documents for comment. So we're finalizing the CMW Renewal application and term evaluation right now.

DR. SPITALNIK: Thank you.

Seeing no other hands or comments, again, I want to thank Allison and everyone and to remind people that renewal application is on the Division's website. This comment period ends July 10th. The Division of Developmental Disabilities will be announcing a stakeholder meeting sometime before the end of June, to be held sometime before the end of June. E-mail comments are preferred but will also be received by mail or fax.

And with that, we will move to the next elements of the agenda, which are informational updates. The first is from Meghan Davey, the Director of the Division of Medical Assistance, and it's an update on New Jersey FamilyCare.

MS. DAVEY: So this is kind of a standing update on NJ FamilyCare.

(Presentation by Ms. Davey)

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

/humanservices/dmahs/boards/maac/).

DR. SPITALNIK: Thank you so much, Meghan.

Any questions from the MAAC for Meghan?

Any questions from the public?

MS. VERNA: Marie Verna, Rutgers University Behavioral Health Care.

Can I ask a question or make a comment?

DR. SPITALNIK: You can ask a question. The distinction was the stakeholder input, so please ask a question.

MS. VERNA: Can you please help me understand? The complaint coming from consumers that for transportation they're being told that under circumstances that they never had to deal with before they're being told they have to take public transportation to partial programs. They're being told they have to use public transportation.

MS. DAVEY: Is that LogistiCare? It's not public transportation.

MS. HARR: Partial care --

MS. VERNA: It really was opposite. We're getting letters.

MS. HARR: Partial Care was not the responsibility of LogistiCare. Initially, they did start to transport individuals and start to negotiate

reimbursement with partial care providers. When everyone discovered LogisitiCare's contract did not include that, they allowed the continuation for people that had been served but said no more. The State increased mileage reimbursement for partial care providers and so now it is the partial care provider's responsibility to transport clients. But we are hearing that some of those providers, they don't believe the millage reimbursement is adequate or the individual transportation is too far. So Steve Tunny and our Office of Customer Services has been working with some providers and NJAMHAA to address any issues around partial care. But there is no requirement that they take public transportation. That really was the change.

MS. VERNA: I guess I'll talk to Mary because letters were shown to me.

MS. DAVEY: If you can share examples with us, I'd be happy to look into it.

DR. SPITALNIK: Thank you.

Other questions or comments about the update on FamilyCare?

Thank you, Meghan.

And we'll now turn to an update on Managed Long Term Services and Supports (MLTSS) with Stu Dubin

who is the Director of Business Intelligence for the Division of Medical Assistance and Health Services.

MR. DUBIN: Good morning, everyone.

Thank you, Dr. Spitalnik.

So this will be the streamlined slide that I presented at the last meeting. We were up to about 15 or 20 slides, so we've consolidated it down to just a few to kind of give everyone the high level picture of MLTSS, how it's doing and how it's performing since it's inception of July of 2014.

(Presentation by Mr. Dubin)

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

DR. SPITALNIK: Thank you.

Any questions for Stu?

Beverly.

MS. ROBERTS: Thank you for that information.

In the past, sometimes there's been a breakout by age, and I'm wondering for next time or whenever you do this again if we could see ages. And I'm specially concerned about those who are not 60 or 65 and older. So I'm concerned about younger people

who are getting private duty nursing, as well as people receiving TBI services. If you have a breakout for TBI, that would be great. But if not, if we know age related, we can sort of get an idea of people who are not there because of their elderly status.

MR. DUBIN: We're trying to balance the slow creep of slide expansion with the great question that you asked. So I think adding one more for age is something we can do for next time.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Thank you.

Yes.

MS. HIGGS: Hi. My name is Kimberly Higgs. I'm with New Jersey Psychiatric Rehabilitation Association.

What percentage of persons receiving MLTSS services are people who have serious mental illness?

MR. DUBIN: That's not something that we do on a regular basis as part of our analysis, but we can look into that.

MS. HIGGS: That would be very interesting.

DR. SPITALNIK: Thank you.

Any other questions?

Hearing none, thank you very much, Stu.

And we turn to our last presentation,

Maribeth Robenolt who is the Director of MLTSS Quality Monitoring Unit to talk about the National Core Indicators, the aging disability update.

Maribeth.

MS. ROBENOLT: It's not quite good afternoon, everyone; it's still good morning.

For some of you, this may be familiar. I gave this information at our last steering committee for MLTSS.

Just to let you know, we have been talking before about the National Core Indicators For Aging Disabilities a survey that we participated and conducted last year. It is now available on the NCI-AD website. The report that's currently available is the national results. This is based upon the survey that is done for an expedited schedule. For year one of the NCI-AD, there were 13 states that participated. Of those, 8 of them were in the expedited schedule. So that meant that they conducted the surveys from June through the end of September with the results coming out mid-year. And the remaining states had until the end of May of this year to complete their survey, so their results will not be out until the end of year.

So when you go onto the website, New Jersey, given that we launched the MLTSS Program, we really

wanted to participate in this project and also to participate on an expedited schedule so we could get a sense of how our MLTSS Program was really starting. This was the baseline for MLTSS Program. And one of the things we decided in here New Jersey to also do is we looked at and surveyed individuals who are receiving all publicly funded long-term services. So when we looked at this, we did not only just look at our MLTSS community based population, we also looked at individuals receive services through PACE, Older Americans Act, which is a different funding stream; it's not Medicaid. We also looked at individuals residing in nursing homes, the four MCOs. So the four MCOs that are active in MLTSS, PACE, Fee for Service nursing home, as well as Older Americans Act.

So when you're looking at the reports, it's also some things to keep in mind. You cannot compare one state to another because not all states looked at all the exact same populations. Only two states looked at the nursing facilities. It was New Jersey and North Carolina. Only a couple states looked at PACE. We looked at all of our programs across the State. Some other states only looked at specific waiver populations, not necessarily all the waiver populations. So I think those are some really key

points to keep in mind when you're looking at it is that you can't compare, but it can give you a sense right now how New Jersey, first year out, how do we look.

We will be getting a state-specific report. That is the one you really want to pay attention to, because that will then give the results by individual program. It will show you how the four health plans and community-based services were doing the first year, as well as how it compares with Program of All-inclusive Care for the Elderly (PACE), the nursing facility, and Older Americans Act. That state-specific report, we anticipate seeing posted within the next couple weeks. I'd say early July at the latest. And that's really something exciting.

We are planning to participate in next year. We've already started working towards that. This year, we'll be increasing and having all five health plans. All five managed care organizations (MCOs) will then be participating. So we'll be increasing our survey size already by an additional 100 individuals.

We completed, just so you get a sense for this project, we used all State staff, and we completed 700 surveys in less than three months. This is face-to-face with the individual. So it was really a

huge undertaking and it's something that we're committed to doing and moving forward. The individuals for HCBS were also those individuals who were the first six months of MLTSS. So also note that's a change and that may also be reflected in the people responses. When we discussed this on a national level, one of the things that was mentioned, look at the states that participated and the personality of the state may also come through in their results; New Jersey from the northeast as opposed to some of your southern states. There is a sense where people felt that northeast people may be a little more blunt responses and more upfront and honest, where the south may be a little bit more gracious and not quite as blunt. And that actually came from the national level. So just keep that in mind when looking at it.

Any questions?

DR. SPITALNIK: Thank you.

Meghan, did you want to clarify?

MS. DAVEY: We saw all publicly funded managed, but we're excluding DDD.

MS. ROBENOLT: We're excluding DDD because actually NCI -- that's a really good point. The National Core Indicators, that survey has already been existence for years for the developmentally disabled

population. They did not have a similar survey or a tool for the aging and disabled. So last year was literally the fist time aging and disabled population. New Jersey has been participating in NCI-AD for the developmentally disabled for several years. And you can also get their information on the website, as well. I don't think it's on the NCI-AD link; I think it's on --

DR. SPITALNIK: I think temporarily New Jersey hasn't participated in the last year with Core Indicators. I thought there was a hiatus with that. But we can clarify that.

Thank you.

Any questions from the MAAC about the data Maribeth presented?

Any questions from the public?

MS. ROBENOLT: To access the report, there's the website. You would want to go to the link that says resources, reports, and then just click on New Jersey.

DR. SPITALNIK: Thank you so much.

Amazingly, we have finished, not only within time, but early. Before you leave, what we do towards the end of our meeting is to make sure that we've identified agenda items for our next meeting. And so

from my notes, there's some additional data that was requested in the presentation on MLTSS. By the time we meet in October, on October 19th, also here, the CMW Renewal will have been submitted. So we will look forward to a presentation on that, as well as the comment.

Any other agenda items that we want to add for the October meeting at this point?

Beverly.

MS. ROBERTS: So to the extent that we don't get everything we want in the renewal of the waiver, I would really like us to be addressing the issue of individuals who have a dual diagnosis and an intellectual and a behavioral health disorder.

DR. SPITALNIK: Okay.

Dr. Whitman.

DR. WHITMAN: I would like an update on credentialing.

DR. SPITALNIK: Thank you. We will do that.

Anything else?

MS. EDELSTEIN: The transportation contract, the non-emergency medical transport (NEMT) contract.

DR. SPITALNIK: Non-emergency medical transport contract.

Gwen.

MS. OROLOFSKY: Gwen Orolofsky, Central Jersey Legal Services. I don't know if this will be appropriate for October or the next meeting, but to start to get a sense of the State's response to the newly enacted MCO regulations by CMS, how that's going affect Medicaid recipients, in particular, some of the grievance and appeal and hearing procedures because of significant changes.

DR. SPITALNIK: Thank you. Thanks so much.

Hearing no other questions, I would entertain a motion to adjourn.

MS. COOGAN: Motion to adjourn.

DR. SPITALNIK: All those in favor?

THE MEMBERS: Aye.

DR. SPITALNIK: The MAAC is adjourned. We wish you a good, safe, and healthy summer. And we'll see you October 19th.

(Meeting concluded at 11:56 a.m.)

CERTIFICATION

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

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Lisa C. Bradley, CCR

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