State of New Jersey
Managed Long Term Services and Supports

Final Recommendations from the Steering Committee to the
New Jersey Department of Human Services
Division of Medical Assistance and Health Services
&
New Jersey Department of Health and Senior Services
Division of Aging and Community Services

June 13, 2012

Principles for Managed Long Term Services and Supports in New Jersey

New Jersey's overall goal is to provide quality long-term services and supports to individuals of all ages in the most integrated setting appropriate to their needs. New Jersey will build a system that is cost effective and sustainable for the future.

Home and Community-Based Services is the preferred service delivery method for people receiving Managed Long Term Services and Supports (MLTSS).

- Access to a broad array of coordinated services and options should be provided so as to enable people to make informed choices about how and where they live and to reduce the need for institutional care;
- Person-centered service options should be available so that individuals of all ages who use MLTSS are enabled to live in the community, in their own homes if possible;
- Criteria for community living should include: privacy; autonomy; respect; personal preference; cultural differences; dignity; safety; choice and control within the residential setting; integration with the greater community; independent advocacy when appropriate; and personal control over moving to, remaining in or leaving the setting; and
- Nursing Homes will continue to be an essential component of the continuum of MLTSS. Working collaboratively with the industry and other stakeholders, the State must consider the future of nursing homes that offer quality care in a home-like environment and that honors the residents' preferences and cultural differences.

Consumer choice and participation in selecting service providers and living settings, to the maximum extent feasible, should be a priority of New Jersey's MLTSS.

- People of all ages have the right to choose and, if they wish, direct their care plan;
- MLTSS will work with individuals to ensure that quality of life is as important as quality of care.
- MLTSS will work to maintain or improve the health and functional state of seniors and people with disabilities; and
- Easy to understand and accurate information will be provided to individuals and their caregivers.

Participation of all stakeholders in the planning and implementation of MLTSS.

- The State of New Jersey will establish a stakeholder process for supports.
- Development of transparent quality measurements is needed, with input from stakeholders, that emphasize quality of life outcomes and consumer empowerment and choice.

Workgroups defined

The mission of the New Jersey MLTSS workgroups is to solicit specific input from the New Jersey long term care community for consideration during the development and implementation of the program. The following groups met over a three month period with various stakeholders to gather information to formulate final recommendations to the NJ MLTSS Steering Committee.

- Assuring Access
- Assessment to Appeals
- Provider Transition
- Quality and Monitoring

The final workgroup recommendations were finalized by the NJ MLTSS Steering Committee on June 13, 2012.

Steering Committee Membership

The participants of the Managed Long Term Services and Supports Steering Committee are comprised of the 15-member Medicaid Long-Term Care Funding Advisory Council of New Jersey, managed care organizations and consumers. The Medicaid Long-Term Care Funding Advisory council was established to monitor, assess, and advise the commissioner on legislative matters and develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.

- Sherl Brand, Home Care Association of New Jersey
- Frank Cirillo, County Welfare Directors Association of New Jersey
- Karen Clark, Horizon NJ Health
- William Cramer
- James Donnelly, New Jersey Adult Day Services Association
- Theresa Edelstein, Post-Acute Care Policy & Special Initiatives, New Jersey Hospital Association
- Beth Eichfeld, Lutheran Social Ministries – Life Jersey City
- Scott Elliot, Progressive Center for Independent Living
- Eli Feldman, Metropolitan Jewish Health System
- Kathy Fiery, Health Care Association of New Jersey
- Deborah Hammond, Healthfirst
- Michele Kent, LeadingAge New Jersey
- John Kirchner, HealthFirst
- John Koehn, Amerigroup Corporation
- Paul Langevin, Health Care Association of New Jersey
- Susan Lennon, New Jersey Association of Area Agencies on Aging

- Evelyn Liebman, AARP New Jersey
- Andrew McGeady
- Charles Newman, New Jersey Association of County Disability Services
- Barbara Geiger-Parker, Brain Injury Alliance of New Jersey, Inc.
- Marsha Rosenthal, Rutgers University Center for State Health Policy
- Lorraine Scheibener, Warren County Division of Temporary Assistance and Social Services
- Milly Silva, SEIU local 1199 New Jersey
- Michael Simone, UnitedHealthCare
- Deborah Spitalnik, Boggs Center on Developmental Disabilities, UMDNJ-Robert Wood Johnson Medical School, Chair, NJ MAAC

Frequency and Scope of Meetings

The MLTSS workgroups met at a minimum bi-monthly and built a framework for discussion and learning. Stakeholders shared best practices from other state LTC programs, reviewed reports/analyses from industry professionals and heard presentations from New Jersey constituents. Each group worked independently from the other workgroups but some representatives participated in more than one workgroup. Reports, meeting minutes and preliminary recommendations were stored and shared with all workgroups on a secure project site.

External experts consulted

The Center for Health Care Strategies (CHCS) provides technical assistance and support to the State of New Jersey's efforts to implement a managed long-term services and supports (MLTSS) delivery system. Through its Implementing Innovations grant from The SCAN Foundation and its New Jersey System Transformation grant from the Robert Wood Johnson Foundation, CHCS was able to use its knowledge of New Jersey's administrative structure and stakeholder groups to help move the state toward its goal of providing more coordinated and better quality care to Medicaid beneficiaries.

CHCS convened and facilitated a MLTSS Steering Committee and provided information around best practices to four stakeholder workgroups (Assuring Access; Provider Transition; Assessment to Appeals; and Quality and Monitoring). These workgroups included a variety of stakeholders (e.g., providers, consumer/advocates, health plans, etc.) likely to be impacted by the implementation of a MLTSS program. Attentive facilitation of these workgroup meetings allowed stakeholders to explore program design issues in a supportive and collegial environment.

CHCS is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to help them develop and deliver better care to these populations.

Mercer Government Human Services Consulting (GHSC) provides ongoing policy and program development support for New Jersey's managed long term care program. Mercer brings a team of consultants, clinicians, actuaries, analysts and accountants to the program to ensure a coordinated approach to the administrative, operational, actuarial and financial components of the managed long term care program implementation.

Mercer's consultant team has assisted state and local governments for more than twenty years and has experience in over thirty five states. Throughout an engagement, Mercer draws on the extensive experience gained in working with numerous states to develop a strategy that fits the unique needs and specifications of our client state.

Recommendations by workgroup

Assuring Access: Final Recommendations

The Assuring Access Workgroup recommends the following Guidelines for Managed Long Term Services and Supports (MLTSS) or PACE:

- The MLTSS implementation will be based on a "consumer centered model" as set forth in the Comprehensive Waiver
- Managed Care Organizations (MCOs) and PACE Organizations (referred to as PACE in this document) will promote access by ensuring each consumer and/or authorized representative designee have input into development of the individual care plan
- MCOs and PACE will demonstrate the ability to engage each consumer and/or designee in making choices
- In addition to clinical care and provider choice, the consumer engagement process will consider cultural, linguistic and health literacy needs as well as consumer preference.

1. **Based on the recommendation of the Assuring Access Workgroup, the State should adopt a consolidated and comprehensive menu of MLTSS services with service definitions, combining like services under one name. The listing will distinguish between facility and community based services. In addition, standardized coding should be established and reviewed regularly.**

   Rationale: The group examined the totality of services provided through the four home and community based services waivers and found duplication of like services with different names, as well as differing limitations, and standards for providers. While recognizing that valid reasons for differences may exist, the group recommends that the state work to consolidate services, where possible, to create a more easily understandable "menu" of services for individuals who need MLTSS. Another confusing aspect of the current service taxonomy is that services provided in the individual's own home may have a different name than the same service provided in an out-of-own-home setting. The group recognizes that the payment structure may look different for like services in these instances, so recommends that the state retain coding differences between in-home and out-of-own-home services and work with providers, MCOs, PACE and other stakeholders in establishing standardized codes for all MLTSS services and establish an ongoing review process.

2. **The State should ensure network adequacy by performing the following activities:**
   - **Conducting ongoing surveys of consumers, care managers, Centers of Excellence, and community and facility based organizations/providers, including but not limited to mental health/addiction providers, nursing facilities and non-traditional providers by county, to identify current supply and demand for MLTSS services and barriers to accessing them and inform the work on service gaps;**
   - **Establish a subcommittee to identify reasonable metrics and interventions to address survey identified network gaps. See recommendation #3.**

- **Developing a tracking mechanism to be used ongoing to identify service gaps, including exploration of available technological solutions, e.g., software, and acquiring the most appropriate products;**
- **Facilitating the sharing of licensing data from The Division of Health Facilities Evaluation and Licensing (DHSS) and the Division of Consumer Affairs on the number and type of licensee data that might be included in an MCO network;**
- **Establishing a formal method of communication between county based organizations (AAA, Office on Disability Services, Special Child Health Services, and others), the State, ASOs, MBHOs, PACE and MCOs for the purpose of examining provider network adequacy should be established; and**
- **Establishing an information collaborative which serves to provide information about access to traditional and non-traditional HCBS providers.**

Rationale: Demographic data can give us a picture of what is happening statistically, but on-the-ground information is invaluable in determining if gaps in coverage that appear on geo-access maps are a result of little demand for service or are a true gap. Conversely, surveys also can give us information about gaps in coverage that are not readily shown on a geo-access map; i.e., where a service appears to be available based on the expected demand because of population size, but the demand for the service exceeds the historical demand or has been unreported, appointment availability, acceptance of new patients,

The information that the workgroup reviewed was specific to numbers of providers in a given area. What is not known at this time is the potential number of individuals who may need a service in the future. Incidence data should be examined, if available, to determine if the areas of the state with low provider penetration will have a potential lack of providers or if the numbers of people who will need the services are so low that the small number of providers is adequate. An examination of other states' methodology did not provide a roadmap for adequately exploring service gaps.

3. **The State should develop criteria to establish network requirements.**

Rationale: Utilization data that the workgroup reviewed showed that some services are infrequently used, but does not explain why; for example, do providers have difficulty with accessing authorization or is reimbursement an issue? But one can assume that those services are certainly valuable for the few people who used them. Using gap analysis as identified in the above recommendation should provide the State with information that would allow it to establish smaller than normal network requirements for low usage services that are historically low usage because of few requests, not because of lack of providers.

Similarly, high usage items may have an inadequate network that has not been identified by numbers, but may be able to be identified through consumer surveys and care management surveys. Are there items that are highly used, but are still difficult to attain? The numbers may belie this fact, but the anecdotal information may substantiate the difficulty.

4. **The State should work with the MCOs and Department of Banking and Insurance (DOBI) to identify opportunities to streamline credentialing processes and reduce the administrative burdens on providers and MCOs.**

Rationale: The Workgroup discussed the most recent experience with the addition of services to the managed care benefit package. Although most consumers were able to continue services with the same providers through the "continuity of care" provisions, many providers experienced difficulty in becoming credentialed to be in a network because of the different requirements of each of the MCOs.

5. **The State should require "Continuity of Care" provisions for existing consumers for MLTSS. Continuity of care for both care and case management needs to be further defined before implementation.**

   Rationale: The Workgroup has discussed the lessons learned from the "carve-in" of some of the community based services in July 2011 and wants to ensure that continuity of care provisions which exist in the Managed Care Contract are repeated in the MLTSS Article. The intent is that a consumer will be able to maintain the current provider until such time as the MCO has performed a comprehensive assessment and made recommendations about services and providers of those services.

6. **The State should ensure that consumers enrolled in PACE at the time of the addition of the MLTSS benefit to the MCO responsibilities are not auto-assigned to MCOs, but are given information about the MLTSS conversion and are afforded the same opportunities as NF residents and home and community-based program enrollees to change from PACE enrollment to MCO enrollment or to remain with their existing PACE Organization.**

   Rationale: Because consumers enrolled in PACE currently receive all services through one agency, confusion may be experienced when MLTSS is rolled out for all other Medicaid consumers who receive similar services as those provided through PACE.

7. **The State should recommend and support a Board of Nursing revision to the regulation, N.J.A.C. 13:37-14.3 (b), lifting the prohibition of medication administration by a Certified Home Health Aide (CHHA) in order to allow for appropriate nurse delegation of this task to a CHHA and should require the MCO to recognize in its reimbursement varying levels of care by Certified Home Health Aides (CHHA), such as medication administration, and the related increase in nursing involvement and oversight required for such services.**

   Rationale: Nurse delegation refers to a process whereby a registered nurse (RN) directs another individual to do something that person would not normally be allowed to do. Nurse delegation is a professional right and responsibility that requires both the authority and practice experience to implement. In the state of NJ the Nurse Practice Act recognizes nurse delegation however, N.J.A.C. 13:37-14.3 (b) prohibits CHHAs from administering medication and therefore this task cannot be delegated to a CHHA by a registered nurse.

   Recently the state of New Jersey completed a Nurse Delegation Pilot Program which permitted this restriction to be waived for Personal Care Assistance (PCA) clients and provided for the nurse delegation, when the nurse deem appropriate, of medication administration to the CHHA. Each registered nurse had the sole authority to delegate on a case by case, CHHA by CHHA basis. The program was a success and this "non-traditional" service allowed individuals to effectively manage their medications and it helped them to remain in the community setting. The pilot program has since ended.

Recognizing the documented success of the Nurse Delegation Pilot Program, the state should support a revision to the Board of Nursing regulation to remove the restrictive language "a Certified Homemaker-Home Health Aide shall not administer medication" therefore allowing this to be considered by the registered nurse via the delegation process.

Since delegation of medication administration and other high level tasks requires increased registered nurse involvement, oversight and training of Certified Home Health Aide staff, the state should require the MCOs to recognize these "non-traditional" CHHA levels of care and also reimburse at higher levels to accommodate for the increased registered nurse involvement, oversight, increased training for the CHHA and delivery of a higher level of care by the CHHA.

8. **The State should create and maintain both a paper and electronic standardized resource directory, via dedicated staff, for public, MCO, and PACE use.**

   Rationale: The Aging and Disability Resource Connections (ADRCs) currently use a guide that identifies community resources. County Area Agencies on Aging, County Offices on Disability Services, and other groups may have resource information available. For example, the Division of Disability Services in the Department of Human Services operates a telephonic information and referral service and creates and uses a guide that is updated regularly. One entity should assume responsibility for combining all available guides into one guide and then assume responsibility for updating.

9. **The State should use the Cultural and Linguistic standards contained in the MCO contract and the PACE agreement in all state points of contact with consumers and should use the same standards and procedures.**

10. **The State should examine its methodology for obtaining information related to ethnicity and language spoken to ensure that it captures accurate data and forwards information to the MCOs.**

    Rationale: Asking for language spoken in the home does not necessarily give the language that the person requires to be spoken by the provider of service. Currently the method for obtaining the information about ethnicity and language is not largely successful in gathering data (e.g., "S" is not the code for Spanish, but instead stands for a rarely spoken language. Spot-checking shows that the majority of individuals coded "S" speak Spanish, not the other language).

11. **The State shall build upon the current process and dialogue between MCOs and providers where opportunities for standardization and communication of the prior authorization process have been discussed.**

    Rationale: A barrier to access to services when personal care and medical day care services were carved in to managed care in July 2011 was the different prior authorization processes and tools used by each of the MCOs. Ensure that there is adequate provider education and awareness to mitigate delays or barriers to accessing services.

12. **The State should ensure that consumers within each unique MLTSS sub-population receive necessary care management and that the "Care Management Workbook" is reviewed and updated to reflect any necessary changes in protocol.**

Rationale: Trained case/care managers with an understanding of the specialized supports and services needed by individuals with complicated medical conditions will benefit the patient whose care will be monitored and coordinated. Designated case/care managers also will benefit the MCOs as they will have on-going utilization review of services and oversight of the progress and maintenance of consumer health.

The Workgroup recognizes that the Assessments to Appeals Workgroup had extended discussion about this topic. This Workgroup would like to have the opportunity to review any recommendations made about care management with the focus being any barriers to access for consumers after they are assessed and determined eligible for MLTSS.

13. **The State should examine the feasibility of implementing a provider staff training system similar to that operated by the College of Direct Support (CDS). The State should make recommendations to the appropriate regulatory bodies based on findings. Because licensure and training requirements exist for home health aides, the workgroup recommends that the focus of the effort should be to ensure continued education for direct support workers providing services to the elderly or persons with physical disabilities. The State should explore the use of the Money Follows the Person (MFP) rebalancing fund to pay for the continued education training and amend the MFP Operational Protocol to reflect the change.**

    Rationale: The issue of staff turnover has been identified nationally as a barrier to quality and consistent services across the community service delivery system. Standardized, easily accessible training has been identified as a key component to a service delivery system's attempt to address the issue of high staff turnover among direct support workers.

    The NJ Division of Developmental Disabilities has implemented the College of Direct Support for the Direct Support Professionals providing services in contracted group homes and day programs. This implementation is state wide and is funded through the use of Money Follows the Person (MFP) rebalancing fund dollars.

14. **The State should require that MCOs, ADRC, OCCO, and PACE provide adequate staff training on both the benefit package for MLTSS as well as the eligibility for MLTSS services. The state should ensure that its agency and state staff is adequately trained and materials are readily available to the public.**

    Rationale: A significant barrier to accessing services is knowing how to become eligible and what services are available. It is imperative that each MCO and PACE develop training material that is used to educate staff who have direct contact with consumers.

15. **The State should, in its communication plan, assure that information provided to individuals currently enrolled in ACCAP, CRPD, GO, or TBI or reside in NFs explains how MLTSS can effect their current service or delivery of the services. This information should address eligibility and services and should be used by all State, MCO, and PACE staff who have direct contact with consumers**

    Rationale: The accurate information about each of the four waivers (ACCAP, CRPD, GO, TBI) and NF services-- and any changes that will take place when those individuals receiving these services

convert to MLTSS -- should be communicated widely to everyone who has a role in helping individuals including, but not limited to personnel from the MCOs, DMAHS central office, Medical Assistance Customer Centers (MACCs), County Boards of Social Services, the Health Benefits Coordinators (HBC), Department of Children and Families, Division of Developmental Disabilities (DDD), Special Child Health Services at DHSS, the Division of Disability Services (DDS), families, and advocates. It is important that all letters that are drafted be reviewed thoroughly and disseminated widely so that all advocacy groups, providers, MCOs and PACE are aware of the information that is being sent to eligible consumers.

16. **Issue discussed and referred to other Workgroup – whether or not home and community based providers should be included in the "Any Willing Provider" grouping. The discussion did not include care or case management.**

17. **The Assuring Access Workgroup should continue to meet on an ongoing basis to finalize recommendations for service definitions, and recommendations for monitoring access to services and assessing network adequacy.**

    Rationale: The group members agree that MLTSS is a major course shift with all of the potential access problems when responsibility for services changes. The group plans to continue to meet on a regular and ongoing basis to continue the work of consolidating service definitions, to examine ways that demographic data, utilization data, and quality data can be used to measure adequate access, and to make recommendations to report back to the MLTSS Steering Committee on a regular basis.

Assessment to Appeals: Final Recommendations

1. **The Aging and Disability Resource Connections (ADRC) partnership (i.e. area agencies on aging, county welfare agencies, offices on disability services, centers for independent living, hospitals, senior centers, etc) shall serve as the single entry/no wrong door system for consumers to access MLTSS. The ADRC partners shall**:
   - **Conduct screening for potential eligibility,**
   - **Provide initial and ongoing Options Counseling on full range of long term services and supports including MLTSS,**
   - **Assist consumers to complete Medicaid application,**
   - **Track status of clinical and financial determination,**
   - **Ensure information is available to consumers via internet in understandable/accessible format for all consumers.**

   Rationale: NJ must establish a statewide single entry/no wrong door system that ensures all individuals have the same access to accurate and timely information and resources on LTSS, regardless of their first point of entry into the system. The ADRC partners will serve consumers beyond what will be the MLTSS population.

2. **The MCO/PACE shall use the "NJ CHOICE Assessment Tool" as the standardized functional assessment for determining Nursing Facility Level of Care (NFLOC), but may add additional data elements.**

3. **The State shall be responsible for conducting the NFLOC for non-Medicaid consumers or Medicaid consumers not enrolled in an MCO/PACE.**

4. **The MCOs/PACE shall be responsible for conducting NFLOC for current Medicaid consumers enrolled in their programs and forwarding the assessment to the State for final determination.**

5. **The MCO/PACE contract shall establish the timeframe for the State/MCO/PACE/ADRC to complete Clinical Eligibility and Options Counseling within TWO WEEKS of referral/notification for PAS and Level 1 PASRR Screen and if needed, Level II PASRR Review.**

6. **The State must conduct training for MCO/PACE/ADRC staffs on Options Counseling, produce an in-depth Options Counseling manual, and provide in-service training for community provider agencies that is tailored to regions local resources.**

7. **The State and ADRC partners are responsible for conducting Options Counseling to ensure consumers are continuously educated and have choice in selecting a MCO or PACE provider.**

8. **The MCO contract should include language that incorporates under MLTSS the principles of "Deeming" and "Waiver of Eligibility" currently permissible under PACE model.**
   - **Waiver of Eligibility: a disease or condition that complies with the Social Security Disability Compassionate allowances that is progressive resulting in continued nursing facility level of care.**

- **Deeming: based on annual reassessment member continues to receive services from the MCO, if that individual would meet nursing facility level of care without continued services and supports.**

Rationale: NJ must establish a core standardized assessment instrument for determining eligibility for LTSS to determine a member's needs for training, support services, medical care, transportation, and other services, and to develop a person-centered service plan to address such needs.

9. **Ensure that all completed MLTSS applications are processed within 45 days of submission to the County Welfare Agencies (CWA). If a person is under the age of 65 the CWA has 90 days to determine eligibility for Medicaid per the CMS 45/90 day rule. To achieve this goal the State shall:**
   - **Ensure that CWAs have access to all available State/federal electronic databases, which will eliminate individuals/informal caregivers having to search for or request citizenship, social security income, pensions, savings, etc.**
   - **Ensure Medically Needy for community residents (Special Category 217-like), including Assisted Living, is implemented in a streamlined approach.**
   - **Identify how to best to inform not only the member, but in some incidents the member's family/representative to expedite financial reevaluations.**
   - **Develop a Consumer "How to Guide" that clearly identifies each step and documents needed to apply for MMLTSS.**
   - **Establish ADRCs role to assist MLTSS members with their initial Medicaid application and annual reevaluation for continued eligibility.**
   - **Identify best practices to produce different forms of communications that informs members and their representatives of requirements for continued eligibility, provides telephone numbers to call for assistance and connects members to ADRC partners for 1 on 1 support.**
   - **Ensure SHIP Counselors are trained to assist and provide Options Counseling to potential/current members.**

   Rationale: NJ must establish a statewide financial eligibility system that educates, facilitates and supports consumers/informal caregivers to gather required documents, complete the MLTSS application, and be notified of the determination in a timely manner.

10. **The State in collaboration with the MLTSS network will establish a universal Options Counseling provider training curriculum and certification process, including written materials for State staff, MCO, NF, PACE, AL, and HCBS providers.**

11. **The State must ensure that through trained/certified options counselors consumers are educated and have choice in selecting a MCO or PACE provider.**

    Rationale: Options Counseling is a person-centered, interactive, decision-support process whereby individuals are continuously supported in their deliberations to make informed LTSS choices in the context of their own preferences, strengths, and values.

12. **NJ must ensure that care management is person-centered, goal-oriented and culturally relevant. Assure members receive needed services in a supportive, effective, efficient, timely and cost-effective manner. Care management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links members to services as necessary across providers and settings.**

13. **Ensure that MCOs establish clear delineation between organizational units responsible for LOC determination, service planning and coordination and utilization review.**

    Rationale: NJ must establish "Conflict-Free Care Management" standards that mitigate any explicit or implicit conflict of interest by ensuring individuals involved in the provision of LTSS shall not be influenced by variations in available funding. The plan of care must offer each individual all LTSS covered by the CMW and based on the evaluation and assessment assures that the individual qualifies for and demonstrates that the services are medically necessary.

14. **Identify triggers that notify MCOs/State/PACE of NF residents at risk for permanent placement in a nursing facility. The State and MCOs shall be responsible for the following:**
    - **MCO is responsible for identifying individuals whose level of care needs can be met in HCBS options and referring to OCCO for transition services.**
    - **OCCO is responsible for coordinating the transition process including the Interdisciplinary Team meeting.**

    Rationale: NJ must ensure that nursing home residents who have expressed interest in receiving their LTSS in an alternative setting are counseled. Should the resident choose a community setting, the State, along with the MCOs, NF and other designed health care professionals shall assist the resident to develop a person-centered discharge plan. Additionally, NF Transition/MFP advances the State's rebalancing efforts from reliance on institutionally based care to HCBS.

15. **The MCOs shall continue to meet and build partnerships with State agencies such as independent client advocates, Adult Protective Service (APS), Office of the Public Guardian, Department of Children and Families (DCF) and the NJ Office of the Ombudsman for the Institutionalized Elderly to address the health and safety needs of their members.**

16. **The State will ensure adequate/appropriate training is provided to the MCO to address health and safety concerns and obligations versus right of individual to make decisions regarding what services they will accept and not accept.**

17. **Options Counseling and care management should include addressing risks associated with making decisions to accept or deny services. The Money Follows the Person's (MFP) Interdisciplinary Team (IDT) risk agreement should be shared with MCOs as guidance for transitions from settings of care.**

    Rationale: NJ ensures that the member's preferences, values and choices are honored to the maximum extent possible, whereby the plan of care addresses health and safety needs and supports the member's choices for setting, LTSS and treatment.

18. **The State shall modify contract language pertaining to fair hearings after discussions with CMS are completed regarding changes to overarching state laws and present modifications to the MLTSS Steering Committee for their review. Member handbooks must be updated to clearly describe the MCO appeal processes and the State's Fair Hearing process.**

19. **Establish clear guidelines for the MCO internal Utilization Management appeal process for non-medical long term services and supports (Level 3 appeal process currently assumed by DOBI) or another State entity for final determination. Look at other states for best practices (i.e. Hawaii)**

    Rationale: NJ must ensure members are informed and understand their rights to contest medical and LTSS decisions rendered by the MCO either through the MCO's internal Appeal Process and/or the State's Fair Hearing Process.

20. **The MCOs will continue to integrate evidence-based disease prevention programs, including the Chronic Disease Self-Management Program, into their disease management and prevention programs. The MCOs may utilize a direct service, contractual or combined approach that supports and promotes disease management and health promotion activities as those presented at the meeting and other types of evidenced-based programs.**

    Rationale: NJ must ensure that MLTSS members and those at risk of NFLOC are identified and encouraged to participate in evidenced-based disease management, prevention, and education programs, which are designed to improve health outcomes and support members in practicing health behaviors.

21. **The State shall define responsibilities for early detection/intervention for behavioral health between behavioral health plans, - Accountable Service Organizations (ASOs) and MCOs/PACE.**

22. **The State shall arrange follow-up meetings among the Division of Mental Health and Addiction Services, MCOs/PACE, Behavioral Health Organizations and MLTSS stakeholders to discuss behavioral health carve-in into MLTSS.**

    Rationale: NJ shall ensure that all MLTSS individuals will have access to Behavioral Services. Individuals shall be assessed and provided services in collaboration with the member, the member's family and all others involved in the member's care, including other agencies or systems.

23. **Home and Community-Based Services, including care management should be accepted as "Any Willing Provider". This recommendation was transferred to the Provider Transition Workgroup.**

    (The Provider Transition Workgroup is recommending that Any Willing Provider apply only to NF and AL and continuity of care requirements for HCBS.)

Provider Transition: Final Recommendations

The workgroup's overarching principles in offering these recommendations are:

- predictability and stability are critical for the transition of beneficiaries who meet a nursing facility level of care, and
- simplicity to ease the transition.

1. **Any Willing Provider Provision - Contracts between MCOs and DHS should contain an Any Willing Provider (AWP) provision so that any Nursing Facility (NF) or Assisted Living (AL) provider that complies with the requirements of participation in the MCO can be included in the network of that plan. The AWP provision should be reciprocal whereby Any Willing Plan that meets a NF/AL provider's requirements can enter into a contract with them to serve Medicaid clients. The AWP provision should run for two years, and the State shall conduct an evaluation at 18 months to determine if the AWP provision can be converted at the end of two years so that the MCOs and providers would implement negotiated contracts with negotiated rates as needed to satisfy network adequacy requirements.**

Rationale

- The two-year AWP period balances the need to stabilize the provider safety net, with the resource demands AWP places on MCOs to credential and contract with more providers than they would otherwise need to offer an adequate network.
- It preserves the safety net of long term care (LTC) providers for Medicaid beneficiaries and offers at least the same access to NF and AL care that currently is available.
- It offers a plan for transitioning from fee for service (FFS) LTC care so that existing beneficiaries in NFs will not have to be discharged to accommodate out of network issues. Nursing homes and Assisted Living facilities are members' homes. We wanted to avoid requiring people to move from the place that has been their home because the facility was not in the MCO network. In the future we would encourage nursing homes to provide beneficiaries with information about their MCO participation before the beneficiary chooses to move into the facility.
- It does not trigger CN/Licensing decisions about Medicaid participation for nursing facilities and utilization rates that would have likely occurred with a closed network.
- It offers more stability to LTC residents who might select different MCOs over time without overlapping networks.

Rationale for limiting the AWP recommendation to NF, SCNF and AL:

- Nursing Facilities (NFs), Assisted Living (AL) and Special Care Nursing Facilities (SCNFs) must maintain a minimum % of Medicaid beneficiaries to meet licensure and certificate of need requirements. AWP enables these providers a transition period to ensure that these minimums will continue to be met and provides the State with the time needed to evaluate how/if these licensure requirements should be continued or altered following AWP;

- Other provider types do not have a minimum licensure standard for serving Medicaid beneficiaries;

- The managed care program requires that MCOs practice continuity of care for members in active treatment, thereby preserving existing provider relationships during a transition period. Therefore HCBS providers will continue to get reimbursed for services rendered for a transition period, and allow more time for HCBS providers to apply for and negotiate network participation in one or more MCO networks. This has already occurred for the 2011 carved-in services. Now, we are talking about other HCBS providers that are much more limited in number, and where AWP is a relatively moot point because the MCO must provide the services the enrollees need. Therefore, MCOs will have to work with the limited number of existing HCBS providers not yet carved in;
- A large number of home and community based service (HCBS) providers have already transitioned to managed care in 2011 when adult and pediatric medical day care, home health, and personal care assistant services were carved into managed care. These providers have had an almost year-long transition during which the MCOs were contracting with these provider types for the first time and had to build their networks. The MCOs welcomed all of these newcomers so they could accommodate their members and establish these provider types in their network;
- The greatest potential for cost-savings in MLTSS will be in delaying or eliminating higher cost NF placements and relying more heavily on HCBS. Although the delivery system will experience savings when MCOs negotiate NF rates and practice utilization management, this gain is secondary to the policy decision set forth to pursue MLTSS and provide quality care for beneficiaries in a less costly setting.
- The MCOs will provide in depth provider training on credentialing/contracting, prior authorization requests, billing and appeals for MLTSS providers prior to implementation to ease the transition into managed care.

Note: There is not consensus around this recommendation within the steering committee

"Upon special request, the Provider Transition Workgroup is still researching whether Community Residential Facilities that serve residents with traumatic brain injury should receive AWP status during the first two years. A conference call is scheduled for June 21, 2012 to discuss this suggestion."

2. **Any Willing Provider and LTC Pharmacy - Any LTC pharmacy serving residents of NF, AL, Hospice and/or Group Homes that meet the MCO criteria for network participation and rates can participate in that MCO network without time limits. The two-year AWP period shall not apply to LTC pharmacies. In addition, a LTC pharmacy can provide all pharmaceuticals, including specialty drugs as defined in the state guidelines to be determined.**

Rationale: Medicare Part D requires that any willing LTC pharmacy to participate in a managed care provider network provided the pharmacy meets the baseline performance and service criteria of the MCO. The majority of residents in NF/AL/Hospice and Group Home settings are dually eligible and their pharmacy benefit is Part D

3. Nursing Facility and Assisted Living Reimbursement Rates

- **Nursing facilities, excluding special care nursing facilities, should be paid for custodial residents at a minimum using the existing state case-mix index methodology during the two-year AWP period. However, this provision would not prevent any NF provider and MCO from entering into rate negotiations during this two year period.**
- **Assisted Living facilities should be reimbursed at a minimum using the existing state methodology during the two-year AWP period. However, this provision would not prevent any AL provider and MCO from entering into rate negotiations during this two year period.**
- **In the event a provider exits an MCO provider network, covered beneficiaries have the option to change MCOs, or the MCO will continue to cover the service by that provider as a non-participating provider.**

4. Special Care Nursing Facilities (SCNF)

- **All SCNFs would be paid at a minimum at the current FY12 Medicaid rate, pursuant to the FY12 budget, for a period of 2 years from the "go live" date of MLTSS by the4 health plans as MLTSS is put into place under the comprehensive waiver. However, this provision would not prevent any SCNF provider and MCO from entering into rate negotiations during this two year period.**

- **All SCNFs that meet the MCOs' requirements for contracting be permitted to contract with the plans (any willing provider) during this two year transition.**

- **Payments for specialized durable medical equipment, predominantly customization of wheelchairs, cribs, beds and other equipment related to the independence and physical functioning of residents/patients, should be carved out of the SCNF rate and paid for separately.**

- **Continue to carve out from the SCNF payment of all items that are already carved out from the rate such as: dialysis services, prescription drugs, diagnostic services, and physician services.**

- **Timely payment of SCNF claims should be defined in contract language as 15 days for electronic clean claims and 30 days for paper clean claims. SCNFs have statutory and regulatory requirements to maintain at least 45% of their resident population as Medicaid beneficiaries. Therefore, their financial dependence on Medicaid is not completely within their control, and in addition, the regular payment of Medicaid claims on a timely basis is critical to the operation of these facilities.**

- **The PAS process for clinical eligibility for SCNF placement should remain solely with the OCCO staff who will be within the Division of Aging Services in DHS until such time as the state has successfully trained and credentialed MCO staff as assessors. There are specific requirements**

for SCNF placement, and specific clinical assessment skills are necessary to determine if SCNF placement is warranted.

Additional Background on SCNFs: NJ SCNFs were created by the Department of Health in the 1980s at a time when populations requiring long-term, custodial special care and services were either remaining in acute care settings at great cost to the State or leaving the State because there was no capacity within NJ to address their needs. These included ventilator dependent (long term) patients, children needing long term care, older adults with severe behavioral management needs, and ultimately came to include patients with HIV/AIDS, as well as Huntington's Disease and other brain injury diagnoses. New Jersey decided to create special care nursing facilities (SCNFs), both freestanding and nursing home-based, so that the Medicaid program would pay NJ nursing home providers rather than spend these dollars in acute care settings or in other states' facilities. There are separate certificate of need and licensing requirements associated with SCNF providers based on the populations they serve.

5. **Timely Payment of NF, PMDC and ADHS Claims - Timely payment of NF, PMDC and ADHS claims should be defined in contract language between the State and the MCOs as 15 days for electronic clean claims and 30 days for paper clean claims.**

Rationale: Nursing facilities have a statutory and regulatory requirement to maintain at least 45% of their resident population as Medicaid beneficiaries. This sets them apart from providers that do not have such a significant requirement. Likewise, this recommendation also applies to pediatric medical day care providers and adult medical day care providers since virtually 100% of pediatric medical day care clients are Medicaid beneficiaries, and most adult day health service providers have more than 50% of their clients who are Medicaid beneficiaries.

Continuity of Care - Residents of NF and AL can remain in place without regard for whether their NF/AL is a participating provider with their MCO. The MCO will be responsible for covering them in their NF/AL for the duration of their residency. All residents should be counseled to enter an **in-network** facility to avoid the potential of having to change MCOs.

Rationale:

- It provides predictability of utilization and revenues for LTC providers.
- It fosters a more stable LTC provider network. The predictability of LTC expenses based on historic utilization and rate data could easily be incorporated into overall MCO medical expense ratios and state government in setting the capitation rates.

6. **Add a "good cause" provision to the Medicaid managed care contract that allows members to change MCOs or PACE when they become eligible for MLTSS.**

Rationale: Being determined to be nursing home level of care will lead enrollees to have to make significant, life-changing, decisions. Therefore, it is essential that the individual has the opportunity to re-assess whether the MCO/PACE they are enrolled in is best able to address their needs for MLTSS through its provider network. Although the contract already has a provision that allows a member to transfer to another MCO for good cause related to a change in their provider's participation status, we expect we cannot anticipate other reasons related to

MLTSS LOC designation that could prompt a member's request to change MCOs or to or from PACE.

7. **Standardized Billing Process Across MCOs - Establish a simplified, standardized billing form and proce**ss across MCOs for NF/AL providers. Agree to a simplified Medicare Billing Form (UB04, 1500).

   Rationale: A simplified, unified billing process will facilitate submission of clean claims and timely claims payment for providers new to managed care.

8. Provider Training Period - Establish at least a five-month training period before MLTSS implementation through a combination of educational methods using a standardized curriculum for NF/AL and HCBS providers on credentialing, MCO authorization, continuity of care, claims processing and other topics that are warranted.

   Rationale: Many MLTSS providers are new to managed care and will go through a steep learning curve to become managed care providers. A pre-implementation training period will ease their transition into the provider networks.

9. **Provider Claims Testing Period- Establish at least a three-month provider claims testing period before MLTSS implementation that overlaps with the Provider Training Period prior to implementation to minimize claims processing and payment problems.**

   Rationale: Many MLTSS providers are new to managed care and will experience a steep learning curve to become managed care providers. The provider claims testing period will enable the MCOs and new providers to test and resolve claims problems that could occur with the use of the wrong billing codes, errors in electronic claims submission protocol, and other system errors associated with claims that could result in an unintended claims denial.

10. Designate an MCO Claims Help Specialist for MLTSS Providers Each MCO will identify one or more staff members who can troubleshoot MLTSS enrollment, authorization and claims processing/payment problems for providers, who are available by telephone and email, and who take part in provider education sessions.

11. Electronic Visit Verification System (EVVS) - Research other state practices using electronic visit verification systems to determine if this should be required of providers. EVVS are used to prevent fraudulent claims. If the State decides to make this a requirement under MLTSS, the MCOs and providers should use the same EVVS.

12. A smaller Provider Transition Workgroup should continue meeting monthly at the beginning of MLTSS implementation, and at least quarterly thereafter, and as needed, as determined by the workgroup. This workgroup will include MCO claims and IT staff, trade organizations for provider groups, and State staff to monitor the implementation, identify and address concerns

13. Prior authorizations frequency for NF Level of Care - Nursing home providers should be able to use the NF LOC determination as a one-time authorization and should not have to obtain repeat MCO authorizations for members who meet the NF LOC. However, when a NF resident

returns to the community and later is readmitted, the MCO will determine if a new authorization is required.

14. **Develop an overview PowerPoint presentation for providers on MLTSS and share with specialty provider associations, stakeholder and consumer groups Communicat**ions Team). **It should be in two parts:**
    - **MMC update and the comprehensive waiver.**
    - **Provider specific presentation**

15. Nursing Homes should inform contracted MCOs of all providers who treat patients at the NF for potential credentialing and for quality monitoring.

Rationale: We need to avoid provider claims from being denied as "out-of-network" when a NF patient is seen by a non-par provider at the NF.

16. Establish a connection between the Office of Community Choice Options (OCCO) and MCOs.
- **OCCO will assess clients who are not yet financially eligible for Medicaid for Level of Care (NF LOC). OCCO will do options counseling.**
- **MCOs will assess enrolled members for NF LOC and OCCO will verify it and evaluate whether the member qualifies for SCNF placement. MCO will do options counseling with their members. If NF LOC is determined for an MCO member and the member remains in the MCO for MLTSS, the MCO will then develop a Plan of Care and authorize services with MLTSS providers accordingly.**

17. Patient Contribution to the Cost of Care - The State or its designee will collect premiums from members receiving home and community based care who qualify for the Medically Needy for HCBS (217 like) provision in the Comprehensive Waiver.

Rationale: MCOs do not have experience with this type of activity and it is not in keeping with their mission. Further, enrollees who elect to transfer from one MCO will be able to do so more easily if the premium process remains with a single entity set up by the State.

18. MCO-based Advisory Groups on MLTSS - Each MCO will fully integrate MLTSS on their consumer, and provider advisory groups and Pharmacy and Therapeutics Committee.

19. Nursing Facility Expansion of Services - Examine, and where possible, remove barriers that would prevent nursing facility providers from expanding into HCBS.

Continuation of work - A sub-group of the Provider Workgroup should be formed to work on the default rate methodology for gap payments to nursing facilities and SCNFs after the conclusion of the AWP period.

Other issues discussed that were not agreed upon

The workgroup is still researching whether Community Residential Facilities for residents with traumatic brain injury should receive AWP status during the first two years. We will contact Barbara Geiger-Parker, a member of the MLTSS Steering Committee to ask her to present justification for this request. The workgroup could not determine why this would be necessary for this provider type.

Quality and Monitoring: Final Recommendations

The Quality and Monitoring Workgroup of the Steering Group on Managed Long Term Services and Supports (MLTSS) sets forth the following guiding principles for this reform:

1. **Transparency** – The State's Quality Strategy for MLTSS should be transparent and broadly understood all levels; the Strategy should mandate data-driven decision making that ensures quality improvement systems in place at the delivery system level.

2. **Accountability -** The state should hold the government entities, providers and health plans responsible and accountable for quality assurance and quality improvement activities within their own settings and across systems. Ensure the availability of provider and Health Plan Quality Information so consumers may make an informed choice of provider and health plan based on quality performance. *The state is also accountable for making available the results of its quality monitoring to consumers and plans*

3. **Consistent Approach** - The State should design and implement consistent and coordinated quality framework and interagency approach across waiver populations while maintaining accountability and responsibility for quality monitoring, management, remediation and improvement within specific departments. The State should establish key performance e indicators with oversight and monitoring of quality assurance and improvement processes and activities conducted by its service providers, including discovery, remediation and improvement.

4. **Monitoring Quality** - The State should mandate the transparency of the monitoring process; use evidence based metrics that can be benchmarked wherever possible and which promote best practice and quality improvement; data collection should result in user-friendly access to data, analysis of key trends, reporting and dissemination of clear and concise information across all agencies with responsibility for Medicaid populations and to external stakeholders.

5. **Use of Benchmarked Metrics** - limit the use of "home grown" measures and instead, work with industry leaders to get metrics vetted, analyzed and rated. Two areas without benchmarked measures include quality of life/quality of care; look for CMS MLTSS data set in October.

6. **Quality of Life/Quality of Care** – The State's MLTSS system should recognize that different populations will require different measures e.g., measures for aging; measures for people with disabilities. The State should set measures to align with the profile of the target populations.

7. **Avoid Duplication and Administrative Complexities in data definitions and collection** –Limit MLTSS data collection to meaningful information; build on existing measures and acknowledge the incremental cost of added measures. Use measures that are relevant, measurable, meaningful, not burdensome to provider, which move toward and develop measures for integrated care and focus on outcomes and improvements. - not just a to complete a report.

8. **Consumer Empowerment and Choice**- Promote cultural change to promote client self -management to the maximum extent feasible. Consumers who have more information about and control over their health care and community support options, will make more reasoned and cost effectiv3e choices about their health. Consumers will become better health care purchases for themselves and their families when they have easy to understand and accurate information and timely access to a continuum of needed services.

9. **System Rebalancing and Community based care solutions —** the State's MLTSS quality strategy should support a balanced system of supports and services between facility based and community based options. However, consumers should be offered care in the "least restrictive setting" appropriate to their needs and the MLTSS should assist more beneficiaries who require long term services and supports to remain in the community. This is based on assumptions clearly articulated in the Olmstead law case and New Freedom Initiative, that an expanded continuum of care that includes community based services in addition to facility based services will result in improved health care, quality of life and more cost effective care. Closely monitor consumer choice of setting and shifts between facility based and community bare – set baseline and continually strive to restore lost balance

10. **Prevention, Wellness and Independence –** The State's MLTSS system should strive to better enable consumers to receive individualized health care that is outcome-oriented and focused on prevention, recovery, and retaining/maintaining independence and autonomy. Health and Safety and Quality of Life/Quality of Care **–** both are important.

11. **Promote Continuous Quality Improvement –** Have measures to address consumer satisfaction in ways to drive improvement; promote a quality improvement and management system that is designed to promote continuous improvement. Measure what you want because that is what you will get.

12. **Diversity, Cultural Competence and Health Literacy** – the State's MLTSS system should include measures for cultural competence, health care literacy and the reduction of health care disparities.

13. **Address the needs of consumers across the life span**– The State's MLTSS system should recognize the needs of both older adults and young adults with disabilities across the life span, with goals that vary in accordance with changing needs. The MLTSS system should have both safety and quality of life in mind across the life span.

14. **Improved Information Technology –** The State must make an investment in adequate and effective information technology and IT staff resources for MLTSS. Automate whenever possible using Information Technology robust enough to support MLTSSQI and QM goals; use appropriate technology tools to connect the current systems silos. Have an IT strategy that supports unified quality improvement efforts.

15. **Leverage Technology for Quality and Monitoring -** Current technology must be leveraged to take advantage of recent innovations and advances that assist decision makers, consumers and providers to make informed and cost effective decisions regarding health care. Simplify and streamline data collection and methodology; mandate consistent collection and meaningful use of all data. Ensure that state government has the capability and tools to receive/manage and interpret data to drive continuous quality improvement and effective MLTSS monitoring.

16. **Identify the "Lead" in MLTSS –** Identify key issues and measures with the most significant impact on quality improvement and focus on those.

17. **Keep System Capacity and Resources in Mind –** The State must keep system capacity and resource availability in mind as MLTSS Quality and Monitoring activities are designed.

18. **Care/Case Management –** The State should measure the capacity for care/case management and assure workable caseload ratios. The State should have robust care/case management across service systems – no duplication, conflict free, with coordination and collaboration as essential elements

Domains for Outcome Measures of a High Performing System:

Quality monitoring and improvement is dependent upon a robust system which uses benchmark metrics; supports data driven decision making; avoids duplication and administrative complexity; promotes continuous quality improvement and utilizes appropriate information technology.

A high performing system requires basic assurances and meets CMS requirements for health and safety, public accountability and transparency; includes effective transitions and assumes basic assurances are met; holds providers and health plans accountable and responsible for quality assurance activities that utilize relevant and meaningful measures. The State maintains accountability.

The workgroup identified the following domains:

1. **Health & Safety**

   Health and Safety including backup plans, crisis management, and critical incident reporting is addressed.

2. **Personal Preferences and Consumer Choice**

   A high performing system uses a person centered approach to MLTSS and places high value on allowing consumers to exercise choice and control over where they receive services and who provides them. A person centered approach that allows individuals to exercise choice and control and respects personal preference, including cultural preferences whenever possible. System accommodates a range of care options including processes of care.

3. **Access**

   A high performing system is one that is accessible at all levels of health literacy and promotes cultural and linguistic competence. Core elements include multiple languages, printed materials, website information, phone numbers, and access to physical locations

4. **System Balance Institutional and HCBS**

   A high performing system continually monitors rebalancing from institutional based care to HCBS. It promotes Money Follows the Person principles, seamless Nursing Facility Transitions and Diversions. Percentage of NF expenditures will decrease while percentage of participants utilizing HCBS will increase. Efforts establishes a baseline which sets a benchmark for monitoring change and ensure cost-effective care that considers not just the lowest cost option

5. **Transitions & Organization of Care**

   A high performing system of MLTSS is effectively coordinated with integrated health related measures including medical and social supports. There is effective coordination between acute and LTC services as well as coordination with behavioral health. There is a robust IT system that uses

appropriate technology tools and resources to integrate existing systems and has streamlined data collection and methodology.

6. **Quality of Care**

   A high performing system supports individualized health care that is focused on prevention, wellness, reducing readmissions, and maintaining independence and autonomy. Services provided maximize positive outcomes.

7. **Care Management**

   A high performing system has a robust care management system across service systems that has coordination and collaboration as essential functions. It is conflict free and ensures no duplication of services. It assures reasonable caseload ratios. Both medical and social issues are assessed, and incorporated into a holistic plan of care.

8. **Provider Networks**

   A high performing system has adequate networks for HCBS and alternative services. It ensures a qualified workforce and stable workforce with a timely and efficient process for credentialing. Continuity of workers and care, and low turnover are essential to a stable workforce.

9. **Services**

   A high performing system promotes innovative and flexible service options, including non-traditional supports. Service delivery is driven by consumer needs and preferences as reflected in the plan of care and based on data

10. **Quality of Life Across the Lifespan**

    A high performing system offers the right care at the right time in the right place/setting across the life span. This includes end of life care. Plan goals & services change in response to changing needs.

11. **Family Caregiver Supports**

    A high performing system offers family caregivers the appropriate supports, education, and skills to be able to assist the MLTSS member in meeting their personal goals. Dilemma: How to reflect supports to family caregiver role as a measure of quality of care in a Medicaid system?

Other issues referred to the MLTSS Steering Committee for further consideration:

- What should be the measure of rebalancing? What will be the percentage and over what time frame?
- Role of the Long Term Care Advisory Committee
- Supports to family/caregivers
- Need for continued opportunity for stakeholder input and participation in Quality and Monitoring, as this Workgroup concludes its task.