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# *Committee Meeting*

of

## SENATE HEALTH, HUMAN SERVICES, AND SENIOR CITIZENS COMMITTEE

*"The Committee will conduct a roundtable with invited stakeholders who are impacted by the proposed Medicaid Comprehensive Waiver, and individuals affected by the transition from Medicaid fee-for-service to managed care and other proposed changes to the budget that impact the provision of health care services in the State"*

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**LOCATION:** Committee Room 11  
State House Annex  
Trenton, New Jersey

**DATE:** June 6, 2011  
1:00 p.m.

### **MEMBERS OF COMMITTEE PRESENT:**

Senator Loretta Weinberg, Chair  
Senator Joseph F. Vitale, Vice Chair  
Senator Robert M. Gordon  
Senator Fred H. Madden Jr.  
Senator Dawn Marie Addiego  
Senator Robert W. Singer



### **ALSO PRESENT:**

Eleanor H. Seel  
Elizabeth Boyd  
*Office of Legislative Services  
Committee Aides*

Jason Redd  
Senate Majority  
*Committee Aide*

Christina Velazquez  
Senate Republican  
*Committee Aide*

***Meeting Recorded and Transcribed by***  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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**SENATOR WEINBERG (Chair):** I'd like to call the meeting to order.

Can we have a roll call, please?

MS. BOYD (Committee Aide): Senator Singer.

SENATOR SINGER: Here.

MS. BOYD: Senator Addiego.

SENATOR ADDIEGO: Here.

MS. BOYD: Senator Madden.

SENATOR MADDEN: Here.

MS. BOYD: Senator Gordon.

SENATOR GORDON: Here.

MS. BOYD: Senator Vitale.

SENATOR VITALE (Vice Chair): Here.

MS. BOYD: Senator Weinberg,

SENATOR WEINBERG: Here.

MS. BOYD: A quorum is present.

SENATOR WEINBERG: Thank you, and thank you all for being here. And I thank the audience for being here.

What we want to hear about today is the impact of the proposed Medicaid waiver, along with the move of a change to managed care. The purpose of this meeting is to identify concerns from residents and the providers about the implementation of these changes, and to provide recommendations to the Commissioners of both Health and Human Services.

The meeting is being transcribed, and we will send a copy of the transcript to both Commissioners and ask them to appear at a meeting later in the month to address whatever issues are raised.

The following groups have submitted testimony, which will also be included in the record, and they are: the New Jersey Primary Care Association, the Hemophilia Association, the Independent Pharmacy Alliance, the Plasma Protein Therapeutics Association, and the New Jersey Hospital Association.

And with that, I just want to read to you a-- Actually, first of all, I'll just tell you about an e-mail I got from a member of my staff in which she pointed me toward a letter to the editor that appeared in the *Sunday Record*, from which I'll read some excerpts to you. But, you know, we get the calls, and I'm sure I can -- my colleagues have probably shared in this -- we get the calls from the people who are directly affected. And this came right from somebody who handles some of these cases in the office. And she said the letter to the editor echoes a few of the heartbreaking calls we got this week: one from a 62-year-old single mother with a 38-year-old severely handicapped daughter, who just heard from her nurse that some of the needed services would no longer be available. Another from a father with two handicapped children, also desperate because the programs his children were in would no longer be available.

That's from somebody who answers the phone.

And then there was a letter that she referred to that appeared in the *Bergen Record*, as I said. And the letter writer says, "I've spent days trying to assist those who are being forced into managed care health plans or HMOs. These are Bergen County residents disabled in one way or

another who can't possibly figure this out on their own. How convenient." She goes on to describe what the four different plans are, and it says, "There seems to be many social workers on the list of the HMO plans, but family and general care practitioners are limited. One plan actually says a person can go to an emergency room and have hospice care, but there was little available treatment in between." The letter is quite lengthy, but again, these are people who just, unsolicited, have come forth to share their stories. And I'm sure it's just the beginning, as we hear more and more.

And with that, Senator Vitale, do you have any opening?

SENATOR VITALE: (Indiscernible)

SENATOR WEINBERG: I'm sorry you weren't listening.  
(laughter)

SENATOR VITALE: I was listening -- rapt attention. Sorry.

There are a couple of things I want to comment on; one is that I look forward to the comments of those who are going to testify today regarding the transition from fee-for-service to managed care. And I think in the very beginning, when I heard that this was going to be a policy change, I spoke with some of those organizations that will be affected by it, or those who they represent would be affected by the change. And they wanted to see, of course, more details, and I think that detail is provided, and the Assembly Committee hearing was helpful. And so hopefully today there will be more.

On the Medicaid side, I know that Mr. Castro is here today to testify -- Ray is here, right? -- to testify with respect to the global waiver and its impact on Medicaid and the freeze. And I can ask Ray questions when he presents -- or after he presents -- but I just wanted to say for the record

that for years New Jersey has been providing Medicaid coverage for the most vulnerable, the lowest income New Jerseyans, parents. And last year the Governor froze enrollment into the FamilyCare Program; it was frozen for those who earned between 200 and 133 percent of the Federal poverty level. They were frozen, that meaning that no new enrollees were accepted in this current budget year. It was contemplated, for this coming budget, a freeze from that 133 all the way down to 25 percent of poverty. The 133 to 100 is generally FamilyCare, where there's a match greater than the Medicaid match; below that it's Medicaid match, but it goes down to 25 percent of poverty. A woman -- single mom -- earning 25 percent of the poverty level is around \$3,000 a year, or \$3,300 a year. And if she finds herself unemployed and without health insurance as of whenever the waiver is approved -- if it is approved -- she would not be able to gain access into the Medicaid program. Those below 25 -- TANF, WorkFirst -- those who are the poorest among us -- not as if 26 percent of the poverty isn't poor -- would be still eligible for Medicaid.

It is, for anybody who sits on this Committee -- can understand the impact it will have on parents who will no longer be eligible for the program. They will, of course, in a couple of years when the Affordable Care Act takes effect and everyone who is uninsured has access into either Medicaid or into an exchange; but it's that period between whenever the waiver is approved and whenever we finally operationalize the Affordable Care Act that those individuals won't be insured -- won't have access.

The Governor's comments when he was asked about it, and it's not verbatim but it was essentially, "New Jerseyans have access to health care; if they really need it they can go to the emergency department, they

can go to a clinic, they can go to a FQHC, they can go to a benevolent physician" -- and there are plenty of those in the state -- but they don't have access to a pharmacy drug benefit, and no one will pay for it. And so they're out there on their own. It's the worst, in my opinion at least, the worst health policy decision I've seen in the 13 years I've been here in the Senate. And I've seen a steady march backward, starting last year, for coverage for those who work for a living, get up every day, do the right thing, work for small companies that probably don't provide health insurance, and they can't get it on their own. Anyone who knows this issue well knows that insurance is too expensive to pay for it on your own if you're making \$25,000, \$35,000, \$40,000 a year and have a family. It's impossible.

And so it is that we are hopeful that the Department -- Secretary of Health and Human Services Sebelius will deny that part of the waiver. We don't know what will happen yet, and so we'll wait and see. That's horrible policy, in my opinion.

And lastly, those who will be removed from coverage immediately -- well, immediately as of July 31 -- will be the 1,400 who are considered childless adults who have been grandfathered in, have been covered by the State -- all State dollars -- who have been covered by the State for several years. I met a woman the other day and we did a program together, and she is one of the victims of that cut. She works part-time -- has two part-time jobs -- and she has some physical issues, she has mental health issues as well. But she's one of those childless adults, so as of July 31, not literally but figuratively, they are going to go into her purse and they are going to take out her card, and they're going to rip it in half, and

she's no longer covered. So where does she go? And that will apply to 1,400-and-change individuals in this state who are, State dollars only, covered by Medicaid as a childless adult.

So I look forward to that discussion, and to raise comments as well when he comes up. Thank you.

Any comments from the Committee, or questions, I'll be happy to answer them.

SENATOR WEINBERG: Any comments from other Committee members -- or we'll get right to it. Thank you.

I'd like to call Ray Castro from New Jersey Policy Perspective. And then we're going to be calling people up in panels.

**RAYMOND CASTRO:** Thank you.

First, I would like to focus on the results of new research we are releasing today on the impact of proposed New Jersey FamilyCare cuts in the waiver on both parents and children, and then later discuss the need for more transparency and accountability in the waiver process.

The impact of closing enrollment of poor working parents in FamilyCare that has been proposed in the waiver would have a major negative impact across the counties. And by the way, you should have my testimony, and next to it is a packet of charts -- so I'll be referring to those charts.

Our analysis of the county data has found that low-income parents -- the first table shows what the impact is in each county -- our analysis of the county data has found that low-income parents will be denied FamilyCare in all counties, no matter how affluent or suburban, and that these cutbacks will be particularly severe because they will be in

addition to the reduction in parent eligibility that was implemented last year in FamilyCare. The combined impact of these cutbacks represents an anti-family policy that will reverse the progress that has been made in FamilyCare.

The first chart I provided you shows the number of parents that will be denied health care in FamilyCare in each county, as a result of last year's and the proposed cutbacks in eligibility. As might be expected, the counties with the largest number of working parents who would be denied FamilyCare -- Essex and Hudson -- are mostly urban. However, there is also a major impact in some of the most suburban counties, like Ocean, which ranked third-highest in the state. Even some of the most affluent counties in New Jersey, such as Morris and Somerset, have large numbers of uninsured working parents who will be denied health care.

As you know, last year the eligibility level for new parents was reduced to 133 percent of the poverty level, from 200 percent. According to the Administration's newest estimates, that resulted in about 43,000 parents being denied FamilyCare in 2011. In 2012 that number will increase to an estimated 70,000. As part of the waiver, the Administration has also proposed closing enrollment to all new parents between 25 percent and 133 percent of the poverty level. And the Senator gave an example of the income range. This policy would result in another 23,000 parents being denied healthcare coverage this year.

So the total number of uninsured parents being denied healthcare coverage in Fiscal year 2012 is a staggering 93,000. Even that figure is conservative, because it does not take into account proposed



increases in cost sharing for parents in the waiver that will discourage further participation.

One of the reasons for the large impact is that while only new parents would be denied eligibility in FamilyCare, the current enrollment would also decrease due to attrition. Under the proposed new rules, once a parent left FamilyCare they could no longer come back if they are uninsured, unless they were impoverished and became eligible for welfare. As the second table shows, there has already been a 37 percent decrease in current enrollment of parents between 133 and 200 percent of the poverty level since enrollment was closed to those parents about a year ago. We expect the same attrition in enrollment for those parents affected by the proposed cutback in the waiver.

At this rate, in less than three years, there would not be any parents left in FamilyCare. Sadly, that is the stated goal of the Administration: to return Medicaid to the days when only children were served.

Since it appears that children are a priority of the Administration, we also researched the impact of closing enrollment of parents on their children. As the third table shows, the first month that enrollment of parents was closed last year, child enrollment stopped increasing; and after a year there still has not been any increase. This has resulted in an estimated 18,000 fewer children who would otherwise have enrolled in FamilyCare in this income category in the first year. We expect that number to double to about 36,000 children who will not be enrolled as a result of cutbacks in parent eligibility.

We also compared enrollment of these children with children whose parents would continue to enroll in FamilyCare. There was a 10 percent increase in enrollment of children whose parents were allowed to enroll, compared to a 1 percent decrease in children whose parents were denied FamilyCare during the same period when parent enrollment was closed. Unfortunately, it is those new parents, whose children have been increasing in FamilyCare, who are the targets of the cutbacks proposed by the Administration in the waiver. Thus we can expect fewer children enrolled in that category in the future as well.

These findings are consistent with our study of the impact of closing enrollment of parents in 2002 on children in New Jersey, as well as studies in other states. Such a further reduction in child enrollment will be devastating in a state that already has the 28th lowest child insurance rate in the nation.

The proposal also cannot be justified on a financial basis. The Department of Human Services estimates that out of the \$300 million that will be saved in the waiver, closing enrollment of parents will only save \$9 million. Furthermore, the State will lose \$17 million in Federal matching funds, so there will actually be a net loss of \$8 million in revenues to the State. Such action completely contradicts one of the goals of the waiver -- to maximize Federal funds.

I'd just like to make some brief comments on the overall waiver. The \$300 million in savings that is assumed in the budget, in addition to the \$240 million in the other Medicaid savings, is excessive and disproportionally cuts Medicaid to balance the State budget. We oppose all requests in the waiver to broaden State flexibility to expedite cuts in

services. The State should only apply for waivers that improve services or make them cost-effective without compromising quality.

There is also a major lack of information on the changes that will be made as a result of the waiver. There appears to be some good ideas in the concept paper, but they are impossible to evaluate without a detailed plan and a complete financial analysis of where the savings in the waiver will be generated. There also needs to be sufficient time for the public to comment on the waiver and the plan.

The Administration has indicated a willingness to work with the Legislature and the public on the waiver and, therefore, hopefully will act on these recommendations for greater transparency. If not, we urge State legislation, similar to which exists in many other states, which will limit the Executive branch's discretion to reduce eligibility in Medicaid and FamilyCare, and authorize greater oversight and approval of all Medicaid waivers by the Legislature.

Thank you.

SENATOR WEINBERG: Any question for Mr. Castro?

So where are all these people going?

MR. CASTRO: Well, they're going to a lot of places. I mean, we know in our study of 2002 that charity care went up \$750 million over a four-year period. Some of them are going to go to community health clinics, but there is a waiting list there and, as the Senator mentioned, they don't get all the services they need. Some of them are just going to get sicker, and some of them-- And it's going to affect the welfare of the family, because if they're not healthy how are they going to support their kids? And that's sort of like the misconception in the waiver: that somehow we

can completely separate services from children and from their parents. And we know over-- We used to do that in the old AFDC program -- we only provided welfare assistance to children, and then we found that the family became homeless because, of course, the mother could not support the child. The same thing is true in health -- and a healthy mother is needed for a healthy child.

SENATOR WEINBERG: Thank you.

Senator Vitale.

SENATOR VITALE: Ray, you mentioned the waiver and you talked a little bit about the maintenance of effort. And so, was the last year when the Governor froze enrollment to parents down to 133 -- that was as far as they could go because of the maintenance of effort as part of the Affordable Care Act; is that right?

MR. CASTRO: That's correct.

SENATOR VITALE: So they need this waiver, they need this global waiver--

MR. CASTRO: Exactly.

SENATOR VITALE: This is one of the elements of the global waiver -- there are many things in the waiver -- but this is one of the-- This is the element in the waiver that affects Medicaid--

MR. CASTRO: Right, exactly.

SENATOR VITALE: --and perspective enrollment. I remember some of the testimony that took place in this room -- I listened to it -- and the Department said that this is one way in which to ensure that we continue covering children and have the resources to do that.

I guess my question is: We've been covering parents in Medicaid above the 26 percent of poverty for years. In your opinion, what makes it different than last year? I mean, the-- I know that for the past two, three, four, five years we've had budget issues and we've had difficulty meeting the demand for the services we provide. But where is it that-- Have you done any kind of analysis of the cost this year, or going forward, in this new budget proposal versus last year? Is there a greater demand for Medicaid services? Is it about the same?

MR. CASTRO: Well, no, there's clearly a greater demand. In fact, the very children that-- One of the reasons why there's been such a big impact on the last cutback is because that particular group -- people between 133 and 25 -- was one of the fastest growing populations in FamilyCare. These are the working families who are losing their jobs. And as a result of cutting that, that's why the impact is so large.

I think the other issue here is that while we've had cutbacks in the past, they have never occurred when the economy has been so bad. In 2002, the unemployment rate was 5 percent; and now it's 9 percent, and we're going on the fourth year of this high unemployment, and the forecast is another four years. So this is a long-term economic problem that working families have. In 2002, within a couple of years, the economy turned around. That's not happening this time around. I think that's a critical difference; somehow we have to be a lot more sensitive to what working families are going through in this state.

SENATOR VITALE: Thank you.

SENATOR WEINBERG: Senator Addiego.

SENATOR ADDIEGO: Actually, I was following up, and you kind of hit on it a little bit.

You're comparing this to 2002. Could you -- I'm sorry. You're comparing this to 2002. Can you explain to me a little bit more about what happened in 2002, and comparing it to today?

MR. CASTRO: Well, the same trend occurred. In 2002 we were able to track what the enrollment of children was over a four-year period, and we found that there were 45,000 fewer children enrolled during that time. We also found that there was over a billion lost in Federal funds.

I want to point out that last year New Jersey was only one of two-- Because I know that a lot of states are cutting back on Medicaid, but states are not cutting back on FamilyCare, which is called CHIP nationally. And the reason is, is because of the high Federal matching rate. New Jersey was only one of two states last year that cut back eligibility for parents; the other state was Arizona. And the other issue, of course, is because of the economy -- states are not cutting their programs.

But in 2002, we lost, I believe, it was like \$1.3 billion in Federal funds because the matching rate is so high. And that, of course, has a huge impact on the economy because FamilyCare has what's called a multiplier effect on the economy. So for every \$1 New Jersey invests, it increases small business income by about \$4. So it has a huge impact on the state.

SENATOR ADDIEGO: So back in 2002 -- correct me if I'm wrong -- we did something very similar. The Governor back then--

MR. CASTRO: We closed enrollment to all parents.

SENATOR ADDIEGO: And that's what the Governor did back then?

MR. CASTRO: Yes, right.

SENATOR ADDIEGO: And then what happened?

MR. CASTRO: That's when we-- Well, basically, parent enrollment went down, as well as child enrollment. And it's really following the same pattern that our research for this year is showing as well. One table where we have a graph and you see the-- Because, actually, FamilyCare has been very successful in enrolling children and has been going up steadily. The first month that child (*sic*) enrollment closed, which was April of last year, it leveled off; it went completely flat. That's exactly what happened in 2002.

So it affects both the parent and the children.

SENATOR VITALE: Could I just add one thing, Senator?

SENATOR WEINBERG: Yes.

SENATOR VITALE: When we have-- That's a good question, Senator. After it was frozen, we eventually began to enroll parents again. And we did legislation that would incrementally increase enrollment over, I think, a three-year period. And it was from 1 to 133; 133 to maybe 1-something; and then that 200 on the third year. So we did this incrementally so that we had the resources available to us as a State to provide the State's share, which was around 35 percent of the cost of the plan, and the rest was paid for by the Feds. And there was a premium contribution, too, by some enrollees depending on their income. So they were paying part of it as well -- small contribution, but they were paying into it, nonetheless.

And so we increased it incrementally to where we were 200 percent of poverty for parents; led the nation with parents; led the nation in kids at 350 percent of poverty. Several hundred thousand of each category were enrolled in that program, including Medicaid, and it was successful. And we saw the benefits of that, of course.

I guess what's ironic is that when we passed that reformed legislation back in 2000 -- and I don't know when it was -- it was unanimously supported by every Democrat and every Republican in the Senate. And it passed the Assembly overwhelmingly with upwards of 90-some percent of the vote. Because we not only set aside the moral argument, because it's the right thing to do; we made the fiscal argument that it cost the State of New Jersey more money not to insure those who need the insurance coverage than it does to provide our 35 percent.

And we had actuaries do the work. We had Mercer, which used to work for the State -- they did actuarial work for the Department -- run the numbers. And we travelled around the country and met with smart groups of people and healthcare economists, and they told us that this makes financial sense for you to cover them because of all the cost-shifting issues, in terms of the commercial market, that would be impacted if we continued down the road of not insuring individuals, and that cost-shift cost. But it's all the other things, the elements -- charity care; absenteeism in schools; the affect it has on businesses when you have a greater share of individuals who are unhealthy, not working, and productivity suffers as well. So that all passed, and it was wildly successful and we held fast.

And I've criticized the Governor for the cuts; I also criticized Governor Whitman; I criticized Governor McGreevy, and I criticized



Governor Corzine -- so it's an equal opportunity criticism. (laughter) But it's-- I don't know. It doesn't make sense. It's the wrong policy.

SENATOR ADDIEGO: Why did they do it? Why did the State do it in 2002?

SENATOR VITALE: Well, I-- Then-Governor McGreevy made the decision that we couldn't afford our share, and so he froze it administratively; he froze the GA program as well. And we saw an enormous uptick in charity care -- I think it was upwards of \$100 million -- \$90 million to \$100 million the next year. So the lag year, when all the claims come in, and the documentation comes in; then when more people are then accessing the charity care program in New Jersey. When we unfroze the program, we saw a drop-off in charity care claims, and we saw less obligation-- The State's obligation stayed the same, because we're not going to take money away from hospitals right away. But it was that the amount of charity care claims that were submitted by hospitals to the State fell off dramatically once we began to enroll parents once again. So there's a direct relationship-- And the GA population as well, with the poorest below 25 percent. But it had direct impact, so there's a cause and effect in all that.

SENATOR ADDIEGO: Thank you.

SENATOR WEINBERG: Any other questions? (no response)

Thank you; thank you, Mr. Castro.

And now I would like call the first panel, which we hope we will hear about individuals impacted by the proposed changes: that's Diane Russell -- is it Diane? Mary Coogan, who is the Assistant Director, Advocates for Children of New Jersey; Megan Ducoff, Policy Analyst,

Alliance for the Betterment of Citizens with Disabilities; Tom Baffuto, Executive Director of The Arc; Phil Lubitz, Associate Director of NAMI; and Yitz Szmidt.

Is there room for all of you up there?

And why don't we start with the order in which I called you --  
Diane Russell.

**D I A N E   R U S S E L L:** Hello. Thank you, Senator -- Chairwoman Senator Weinberg, Vice Chair Senator Vitale, I'm here to tell you my story.

My husband, Edward Russell, has severe COPD emphysema. He has 14 percent lung capacity and is on Medicaid. Currently he is under the exemption status, meaning he is not enrolled in an HMO managed care program. The reason for this is because we live in Montague, New Jersey -- the very last town in New Jersey. It's a very rural area; there are very limited doctors. He needs to be under the constant care of a pulmonologist. There are only three within the area: one which is 15 minutes from our home, in Milford, Pennsylvania; and two over the border in New York state. Subsequently, the hospital that is closest to our home is 10 minutes away, in Port Jervis, New York -- Bon Secours Hospital. Currently under the exemption status, he's under the FFS -- fee-for-service. So Medicaid only receives a bill when he goes to the doctor; when the doctor orders testing, blood work, x-rays -- which is all conducted at the hospital.

My husband is very ill and could not be here today, and also is very ill and cannot travel well. If you don't understand what emphysema is, just getting up from that chair to walk here he would need 15 minutes to recuperate.

I received a letter April 29 from the Director of Medicaid's office basically stating that there will no longer be any exemptions. Everyone must be enrolled in an HMO.

From the day that I received that letter, I took two courses of action: one brought me here to speak to you today; the other I tried to follow the coordinated efforts of the Medicaid Department to enforce this radical change, which is effective July 1.

It's a dead-end road. There's no help out there for people like us. Long story short: My husband's medical services will be cut off. Medicaid will be receiving a monthly bill for his enrollment, and there's no pulmonologist in Pennsylvania that will receive payment because they're not enrolled in the New Jersey Medicaid HMO program. I've called each and every single HMO -- there's no way around this. I've spoken to Trenton; I've spoken to my county level. The answer is, simply, this is going to happen. You have to enroll in an HMO.

Nobody will pay for his doctor; nobody will pay for the hospital that's 10 minutes from our home. All the HMOs offer very limited services. The only pulmonologist available is in Newton. That's a good 50-minute ride from our home. He cannot take the trip.

If you go ahead and you pass this budget, and you allow the exemption status to go away, severely disabled people like my husband and many others who live in rural areas, where we do not have access to multiple doctors, specialists, and clinics, will be cut off from services. And the State will be paying a monthly Medicaid bill for nothing.

I understand there are budgetary concerns. I know you have many things to balance. Shared sacrifices out there -- I understand. But to

cut off the exemption status means cutting him off entirely from all his medical services. He doesn't know what he's going to do; I don't know what I'm going to do.

There needs to be another way for you to address this. If you need to cut costs, you're not going to balance the budget on the backs of severely disabled people. These are not people who have colds; their conditions do not go away. I understand there's a minority in every insurance pool that is high-risk, whose medical costs exceed the sum of the total of the healthy majority. That case will always be. If you have a chronic condition -- for example, emphysema -- or perhaps you have a child with autism or a relative with cerebral palsy, those conditions do not go away. Those medical fees and services will always cost what they cost. If you want to add a monthly fee to, basically, a useless HMO management plan, that's money being thrown out the window, and I logically do not see the savings. Maybe on paper this makes sense, but I ask you all to think about this before you make your vote for the budget.

I have no paperwork to leave here with you, just an impression. You have people who are going to fall through the cracks -- severely disabled. The measure of our society is how we take care of our most vulnerable. I don't understand why you would even consider this option. There's not been a study or committee put together to see the impact. I'm only an individual here to speak of my story.

I'm trying to keep it as brief as possible, but I also want to let you know you are not prepared for this change. To let you know how unprepared you are, the letter dated April 29 said that I would be receiving a packet of information. There are no telephone numbers for the four

HMOs listed here, in this letter. But the information packet was supposed to have all the information I needed to make the proper decision for the best HMO for us. It is June 6; that letter packet has never arrived. Shame on the Department of Medicaid. How dare you try to push this plan through without being fully prepared for this?

On top of it, the numbers you have to call -- I'll give you a little quick run down. The first call I made was to my Sussex County Department of Human Services. Their answer was, "I'm very sorry, we're getting flooded with phone calls -- many people like you; there's nothing we can do; this is going forward effective July 1." I proceeded to call Trenton. I was directed to call the Office of the Health Benefits Coordinator, which was supposed to help me organize information, again, to make the best decision for which HMO to join. I called that office, and the response that I received was, "It is not our job to help you, but we are going to give you the number for your local medical assistance center." I, in turn, took that number and called that number, which was the Morris Medical Assistance Center. Reminding you again that I live in Sussex County -- that's a county away. I called that number to get a message that says, "This number has been changed," and it gives you an 800 number. I hang up, I call the 800 number. The 800 number is a machine that loops though and tells you to type in your ZIP code, "We will give you the number of your local medical assistance office." Knowing that I was going to get the wrong number again, I avoided the prompt to speak to a human being. When I got past the prompts and was put on hold for a human being, I quickly received, within 30 seconds, a message that said, "All our lines are busy; please call back later" and was hung up on.

I proceeded to call Trenton, the Director of Medicaid's office. I said, "Where is my packet of information? My deadline to choose an HMO is June 10, otherwise you will choose one for me and then I have to jump through hoops to get out of that HMO if it's the wrong one for me." Needless to say, they're all wrong, but that's besides the case.

I got a very shameful apology that the number I as given was wrong, because the Morris Medical Assistance Office had since closed. They didn't know what else to do, so they routed the number to the 800 number. They're sending people on a wild goose chase.

My husband is sick. I have to take care of him. I don't really have the time or the patience to sit here going through these phone numbers. I'm here today because of my due diligence, to let you know how wrong this is. There are thousands of people out there too ill, with no advocates for them to do what I'm doing for my husband or don't understand. Maybe they got this letter; they may not even know what it means. They'll leave it alone, they'll be really sick; they'll go to their doctor one day to be told, "Oh, we don't take your services any more." And then you have a sick person sitting in the doctor's office going, "Now what do I do?"

If you don't take some time to think about this and stop this crazy pushing this forward -- through in six weeks-- There's been an extension issued which I found out on the 31st, because I've been working with the Disability Rights of New Jersey. That extension is until July 18, only due to the fact that there was a typo in one of the letters from the Director of Medicaid's office that had that date. So by default, you're just forced to allow that extension to happen.

You're not prepared for this. And if my local Sussex County Department of Human Services is being flooded with phone calls of what to do, and there is no information -- because I've taken all the proper channels and made all the calls that you could make. By the way, I did eventually get a number for another medical assistance center, in Passaic County -- now, two counties away. The only other option was Essex County -- three counties away. The apology was, again, that the office is closed. "I don't know when the information packet is going out, but you can call this number."

And I also inquired and got the numbers for all four of the HMOs at the same time, and proceeded to make those phone calls. I called the Passaic Medical Assistance Center -- which is supposed to be staffed with nurses and people knowledgeable about the system and the HMO managed care system -- again, to help me choose and provide me with information. Do you want to know what the answer I received was? I told my story, quite simply: my husband's sick, doctor's in PA, hospital's in New York, what do I do? "You need to call the HMO." But I didn't have the number for the HMO because the Medicaid office still hadn't sent out the information packets. I had to call them to get the numbers. This is ridiculous. You're not set up for this. Your numbers make sense on paper, but they're not representative of the faces and people who stand behind those numbers. You will not balance the budget on the backs of the needy. Their medical services will always cost more.

I got this invitation Thursday afternoon, and I did try to reach out and get some figures for you from the Department of Sussex County Human Services, but I did not get any calls back. I don't know if people

didn't believe me that I was coming to speak to you today, or they can't get those numbers together. Severely ill people are severely ill for a reason; we were in exemption status for a reason: the HMO managed care system does not meet the needs of these people.

SENATOR WEINBERG: Ms. Russell, you certainly put a face--

MS. RUSSELL: Thank you.

SENATOR WEINBERG: --onto this problem. And I think when I started the Committee meeting I read you a couple of comments from people in my office who are fielding these phone calls, too, from, I'm assuming, people like you who found our phone number.

MS. RUSSELL: Exactly.

SENATOR WEINBERG: You got the original letter on April 29, you said, or it's dated April 29?

MS. RUSSELL: It's dated April 29. I have it with me.

SENATOR WEINBERG: And it said the packet of information would be out when?

MS. RUSSELL: It didn't specify, but it said soon. And again, the deadline to choose an HMO is June 10; today is June 6. No information.

SENATOR WEINBERG: And that extension to July 18, did that cover the choosing of an HMO?

MS. RUSSELL: Yes, and again I stress only because there was a typo, and you are now bound to give that extension because you sent that out in black and white in writing.



SENATOR WEINBERG: When you say “you,” don’t include all of us. (laughter)

MS. RUSSELL: I don’t mean you; I’m sorry. I apologize. I mean the Office of Medicaid and the Administration’s wishes.

SENATOR WEINBERG: Right.

MS. RUSSELL: There’s nobody to turn to for help within the State. The folks fielding these calls have no idea how to answer these calls, or where to send people like me for information.

SENATOR WEINBERG: Yes, just an aside: I wish the State would get more invested in the 2-1-1 number. I’ve talked to them about that, which would be a great advance to all these 800 numbers if they really wanted to save some money. But another subject for another day.

MS. RUSSELL: May I also add: better training for the people who are answering these calls so they have a better understanding of the people who they are talking to. I find it very irritating and aggravating to get a flippant answer that I can just simply “go to another doctor.” One of the people who I spoke to at one of the medical centers just seemed to not understand. I said, “Do you know where Sussex County is? Do you know where I live?” She was from Irvington. She had no concept of living in a rural area where I have to drive 20 minutes to get to a supermarket. She could walk down the block to the little local deli and buy a sandwich or a soda; I can’t do that. So you need better training. You need more time to do this.

And you just can’t cut people off. It’s akin to-- Let me give you an example: If you have a family of four, and the father gets a cut in pay, well, every night of the week you don’t choose one member of the

family of four to not eat -- because we don't have enough for everyone to eat, so we're going to let one starve today and the other three are going to eat. It doesn't work that way, and that's what you're going to be doing if you follow through with this, getting rid of the exemption status and forcing everyone into an HMO. It's not one-size-fits-all. It may work very well for you if you're healthy enough and you have a cold and you go to the doctor once in a while, or you have a toothache here or there. It doesn't work if you have a chronic condition and special needs.

SENATOR WEINBERG: We appreciate your coming here. I know it was an effort for you to do that and, as I said, putting a face on what this whole bureaucracy is like, trying to get through it.

Any other questions for Ms. Russell?

SENATOR VITALE: Nothing; no thank you.

SENATOR WEINBERG: Thank you very much.

MS. RUSSELL: Can I just ask you one thing?

If this should go through, where do I turn? Who do I talk to? I've exhausted every number I can call, and every person I can talk to. What do I do? I'm asking the Committee -- the Senate Health Committee.

SENATOR WEINBERG: First of all, I think some of us have contrary feelings about how this should be implemented. And second of all, you'll get answers because, also, as I said at the outset, the transcription of this hearing will be going to both Commissioners, and we will call them in in a very short length of time, thereafter, to answer the questions that have been raised here.

So thank you very much.

MS. RUSSELL: Thank you.

SENATOR WEINBERG: Mary Coogan.

MARY E. COOGAN: Good afternoon.

Senator Weinberg, I'd like to thank you for inviting ACNJ to participate in this discussion. Those of you who don't know ACNJ, it's Advocates for Children of New Jersey; we're a statewide policy and research organization based out of Newark. One of the publications that many of you receive from us is the *Kids Count* data book.

With reference to the global waiver, I have a couple of comments. I did submit written testimony, and I'll just highlight a few things, in light of time.

You heard from Ray Castro about transparency; we do think it's critical. We think these conversations are really good, worthwhile, and we would urge you to all to continue to have them. I think it's through these conversations we learn about the situation from the last speaker, and these are real issues that we all do need to work together to resolve.

There's little detail in the waiver. I think there are some good components of it; I think some of the goals are very laudable. But I think we do need more information and would urge everyone in this room to seek that information.

While the concept paper states that child eligibility will not be affected, we think it might be affected in two ways, and our background, as ACNJ -- we were strong advocates for FamilyCare and worked with many of you to continue the reauthorization and the funding for that. So our focus is the child care. First, the significant reduction of parent coverage we think will, ultimately, in fact, impact child enrollment and the significant progress

that's been made to date in reducing the number of uninsured children. And there's some data in the *Kids Count* book to support that.

Secondly, the concept paper states that New Jersey is seeking flexibility in defining covered services and adopting limits on the amount, duration, and scope of services, as well as imposing co-payments and other cost sharing. This is of concern for us -- I'll get to that in a minute in terms of details.

I think there has to be questions raised in terms of the premiums -- what they're going to look like.

With reference to the parent coverage, the *Kids Count* report for 2011 showed that we reduced the percentage of children without insurance by 19 percent. This is significant, and it is because everyone in this room -- from the providers to the HMOs to the individuals to the educators to the mental health professionals -- all got together, identified children who did not have insurance, and enrolled them. And in order to enroll many of them we enrolled their parents.

New Jersey is well on its way to meeting the New Jersey Health Reform Act of 2008, which many of you supported and voted for, and which did expand parent coverage up to 200 percent of Federal poverty, with the recognition that in order to enroll all the children we needed to enroll many of their parents. And that is because the research shows there is a connection. I added to my testimony an article which is from the George Washington University School of Public Health and Health Services, and they had done a literature review, and I just want to highlight two things that they found: Parent coverage appears to be associated with

the more effective use of coverage among children, as measured by access to care, use of preventive services, and having a regular source of care.

Studies do support the conclusion that with family coverage, health coverage tends to be more continuous and less interrupted. And I think there was some earlier discussion how New Jersey has already gone through that, in terms of we did stop parent enrollment back in 2002. We saw a drop off of child enrollment, and then we enrolled the parents again and we've seen the increase again.

But there's another piece to this, and this is this idea of *churn*. And churn is when you have people who are eligible come on and off insurance despite their eligibility. And they come on and off for a variety of reasons. There was a workgroup, we looked at this; didn't get as far as we wanted to, but there are things like people not realizing that with FamilyCare you need to renew every year -- which is unlike private insurance where we all just get our insurance card at the beginning of the year; it's automatically renewed as long as we're employed.

People forget to pay premiums. They can't afford to pay premiums. Now, I think because eligible people come on and off, we have a cost associated with that -- both from the administration for FamilyCare and for the Department of Human Services, but also for the HMOs, because then they have to send out information as new members, even though these people are not new members. I think we need to address the gaps in services.

And the last item I want to talk about is the cost sharing. Cost sharing, as I understand it, is a way to change the behavior of the people who are covered. And again, I understand the positive outcome that we are

seeking. The question is whether or not we're going to get there, because we don't know all the details about the cost-sharing proposal. As I understand it, this can be the premiums, this can be the co-pays, but it also can be having to pay for services that are no longer covered because we've changed out benefit packages, okay? And just educating myself -- and I thought I'd share this with you: I attached an article from The Center for Children and Families at Georgetown University, and they go through all the cost sharing and things we need to look out for. While I understand we need to consider this, I would urge us all to do it in a thoughtful way. And we need to have mechanisms to study this and to find out whether we are helping people or hindering them, because there's really nothing out there that defines what is reasonable in terms of a co-pay.

And there is research that talks about focus groups, where families are saying they're willing to contribute. But you could raise a premium, which is talked about in the comprehensive waiver. You could also increase co-pays for people which, if you have-- From a child advocate perspective, if you have children who are fairly healthy -- who might go for a checkup once a year and have one or two illnesses, and their parent may have to pay a \$10 co-pay; versus a child who has a disability -- who might be going to the doctor on a fairly regular basis, or has some type of chronic disease and they're going to the doctor very often -- that, however small, a co-pay can become an enormous burden for a low-income family very quickly.

So I would just urge that we continue to have these conversations and we try to gather more information so that we proceed in a thoughtful and helpful manner.

Thank you.

SENATOR WEINBERG: Thank you.

Any further questions?

Yes, Senator Addiego.

SENATOR ADDIEGO: You had said that it has to be renewed yearly. Why is that?

MS. COOGAN: Because they have to redetermine eligibility. So if my income-- Well, currently my income is going to have to be less than \$5,300 if I want myself covered and my children. So every year FamilyCare has to determine -- or the local Medicaid Office -- that I am still making wages at that level or less, and that I still do not have insurance through some other mechanism.

So it's an affirmative renewal process. And I think in some ways the Department, through FamilyCare, has worked to streamline that, in terms of, with the Healthcare Reform Act of 2008, there were efforts to say you have to produce less documentation; we've reduced the applications, the renewal forms. They try to send people pre-formatted forms, so any information they would have about me is already in the form and I just say "okay." But I still need to sign it.

There's also been efforts by the Department to try to determine income a passive way -- meaning that they go into different databases. The problem I think they've run into -- because the last I heard, maybe with 20 percent of the people can they do it that way -- is because a lot of times working poor people have different jobs, their income changes. And so you wind up having to produce some type of pay stub, or getting information current; and there's further interaction. I think sometimes, from the calls

that we get, people just kind of give up. Or because there are other things going on in their lives, because they're not that stable, they miss that deadline, they don't get the paperwork in, they don't understand it. So I think the more that can be automated, which I think the State is trying to do, the better. But until we get to that automated process, I think we have to be aware, again, that everybody's not the same; people have a variety of issues. We don't have a debit card like-- You can't put FamilyCare on a credit card, as far as I know. You could always have your premiums deducted.

There are things that probably could be done that would help, but there is still going to be some people who don't fit the typical scenario, and I think we need to be sensitive to those. But that's the long answer to your question, which is--

SENATOR ADDIEGO: Have you been working, by any chance, have you been in contact with-- Has the Department been in contact with you, and have you been able to make suggestions along these lines?

MS. COOGAN: Well, I was involved in a workgroup that went on for about a year and a half, and a lot of these suggestions were put into a report that I'd be happy to send you. And many of those things the Department is working on. I think, to the Department's credit, they have drawn down a lot of available dollars to improve their IT systems -- through the Affordable Care Act as monies become available. And so I think there are attempts to better connect different databases, which will help.

We also, in New Jersey, took advantage of the express lane application, in terms of trying to enroll kids automatically. But I don't



think we've been able to resolve that renew-it part. I think our enrollment is much better, but we still-- The last numbers I looked at, there are 20,000 adults and children who come on and off FamilyCare on a regular basis because of payments of premiums and renewal issues.

SENATOR ADDIEGO: Thank you.

SENATOR WEINBERG: Thank you very much.

Megan Ducoff.

**M E G A N D U C O F F:** Thank you.

The Alliance for the Betterment of Citizens with Disabilities would like to thank the Chair, Senator Weinberg, and the other members of the Committee for the opportunity to provide comments about the proposed comprehensive waiver. Each of you should have a copy of my written testimony, but there are just a few points I'd like to touch on.

I'm Megan Ducoff, Policy Analyst for ABCD, a statewide organization representing member agencies that provide an array of community-based services to more than 15,000 people with complex physical and neurological developmental disabilities, and their families. My testimony today will focus solely on the areas of the comprehensive waiver, which will impact people with developmental disabilities.

We are generally pleased with the scope of the comprehensive waiver in respect to this issue. In February, ABCD expressed, in budget testimony, it's intrigued with the Medicaid restructuring discussed in the budget summary; but there's too little information at this time to fully analyze its impact on the Medicaid program and its beneficiaries.

We support the idea of more flexibility between Medicaid programs; such flexibility will allow an individual to receive services

regardless of their initial waiver, changing the funding silo mentality of services to people with significant needs.

ABCD has long been a proponent of maximizing Federal funds for home and community-based services. There are two options in the Affordable Care Act which New Jersey should explore as a part of Medicaid restructuring. The first is the Community First Choice Option, which allows a State to include Medicaid home and community-based attendant services for long-term supports as a part of the Medicaid State plan. Initially, this program was not included in the concept paper, but we have since been informed by DHS that it will be. New Jersey will receive a 6 percent increased FMAP for participating in this program.

The second option is the Balancing Incentives Payments Program, which we're pleased to see was included as a revenue stream in the concept paper. This program will provide enhanced Federal Medicaid matching funds to states that adopt strategies to increase the proportion of their total Medicaid long-term care spending to home and community-based services, and implement delivery systems reform. New Jersey will receive a 2 percent enhanced FMAP for participating in this program.

Since the available information related to Medicaid restructuring and other long-term care proposals in the budget demonstrates the Administration's interest in moving away from nursing homes toward serving people in the community, it is imperative that these two options are included in the discussion in order to maximize Federal funds. We look forward to working with the Administration to make them a reality.

We support many of the initiatives in the concept paper involving change to the system of supports and services for people with

developmental disabilities. For example, we are pleased that the Department plans to move forward with rate setting for providers. Currently, providers' rates are primarily based upon when they started to provide services. So if an organization started a new program 25 years ago, their rates are based upon that level and the small amount of annual contract increases provided over the years. And, of course, it must be noted that this is the fourth year without a contract increase.

So to continue: If an organization started up a new program within the last few years, their rates would be based upon the current amount of funds which a person with a developmental disability receives now. Hence, an agency that has served an individual for 20 years receives funds at a level far below the amount that the Division currently contracts with agencies for individuals with lesser needs.

ABCD is, however, concerned with the provision in the concept paper regarding the elimination of the intake applications process for children who will not enter the waiver system for three years or more. This may simplify the administration of the system for the Department, but it also hinders the Division's ability to plan for the future services these children will need.

We are pleased that the concept paper explains that the Department will develop policies to manage the waiting list and ensure that individuals with greater needs are prioritized in order to avoid serving them with State funds (*sic*). However, we are concerned that this is a significant change for the developmental disabilities community overall, and we want to ensure equity and fairness in this process.

So there are many concerns about the current assessment tool used by the Division in determining needed services. Two years ago a workgroup convened by the Division recommended the use of the Support Intensity Scale over the current tool. The SIS focuses on support needs and lends itself to the person-centered planning process, and it's overall better suited for this process. It has been adopted by at least seven other states, and we urge the Division to adopt it as well.

The concept paper also explains that New Jersey is moving forward to implement a new supports waiver to increase in-home supports for families currently funded by State-only money, and ABCD has actively participated in the workgroup developing the family support waiver. It has become clear to ABCD and the workgroup that the family support waiver will fail without full reinvestments of these new Federal funds. We urge the Administration and the Legislature to ensure that all Federal funds from the new Family Support waiver be reinvested into community services for people with developmental disabilities.

Also, we're very pleased the concept paper includes the recommendations of the Dual Diagnosis Task Force report, including a priority recommendation to begin building a crisis responses system to replace the use of uncoordinated and dislocated services like 9-1-1, EMS, ambulance transport; and in order to avoid inappropriate admission to State psychiatric hospitals and developmental centers. We are looking forward to working with the Administration and others to create this system of caring to maximize Federal funds for it.

Overall, the concept paper on the comprehensive waiver provides many changes to services for people with developmental

disabilities which will promote efficient use of scarce resources and maximize Federal benefits. There are still a number of questions related to the details of the proposal to be answered, and we look forward to working with the Administration to resolve them.

Thank you.

SENATOR WEINBERG: Thank you.

Any questions? (no response)

Thank you.

Where we have written testimony, could you just try to summarize it, rather than reading through it? But just based upon a little bit of testimony that we've heard, I would suggest that one of our first questions to the Commissioners is going to be about the timeline and how this is actually going to be implemented in this length of time to, not only implement it, but to make sure that if, in fact, they move ahead with it that it's implemented appropriately.

So thank you.

Tom Baffuto -- Tom.

**T O M   B A F F U T O:** Thank you, Chairwoman Weinberg and members of the Committee, for the opportunity to participate in today's discussion about the State's proposed comprehensive Medicaid waiver and the mandatory shift to managed care for all the ABD population.

I'm Tom Baffuto, Executive Director of the Arc of New Jersey. I'd like to address the comprehensive waiver first, and then offer some comments on the shift to managed care.

With regard to the comprehensive waiver, well, The Arc of New Jersey shares the concerns of many advocates as well as policymakers. We

simply don't have enough detail at this time to properly evaluate the proposal. While helpful in outlining the broad strokes, the concept paper that DHS has released is very light on details, and this is a problem for several reasons. We can't completely tell you what this comprehensive waiver will accomplish; we can't assess how the savings are going to be realized; and since this is expected to save between \$200 million and \$300 million, it's a little scary not to understand the math, from our perspective. We can't identify potential problems and thus begin working on potential solutions; and, more importantly, we can't guarantee that this will, ultimately, not be detrimental to people with intellectual and other developmental disabilities, and their families in New Jersey.

We're also very concerned about the limited opportunity for public input on the waiver. That being said, we've had numerous conversations with the Commissioner of Human Services and the Deputy Commissioner, and they've given us assurances many times that people with developmental disabilities will not be hurt by the waiver. We truly appreciate their intentions and are very hopeful that it will play out this way, but without more information we remain concerned about what could happen.

Some specifics we have some concerns about: We are concerned about the \$25 co-pay imposed on non-emergency use of hospital emergency departments. We feel this will be particularly unfair to individuals who are brought to emergency rooms as a result of staff fear, and be in violation of Danielle's Law. This is a big problem for us -- the law, which had the best of intentions when passed, has been plagued with implementation problems, and many folks with intellectual and other

developmental disabilities are brought to emergency rooms against their will, against their families' will, and imposing a \$25 co-pay just seems unfair to us.

Provider rates: We're also concerned about that section that refers to the revision of provider rates; particularly, we're hopeful that providers are brought to the table as we negotiate these new rates that are set forth in the waiver.

Waiting lists: Additionally, we're concerned that a section states that the implementation of the new supports waiver will, essentially, allow New Jersey to serve the majority of people on the current waiting list, while we have absolutely no evidence of this fact and assertion. It's a concern to us to say that that would be eliminated.

Managed long-term care: We also have some general concerns about what this means in terms of possibly opening up the developmental disability system to managed care for the long-term services that we provide. Is this part of the plan? What it's going to look like? These are all concerns to us without the details.

The Dual Diagnosis Task Force recommendations: We're very, very supportive of the Department's plans to implement those recommendations of that Task Force, and we fully support that being in there.

Flexibility: We also support the need to offer more flexibility in terms of people being able to access different waivers at the same time. We think that's good.

At the end of the day, though, I can't tell you that people with developmental disabilities will be helped or harmed by this proposal; and

until we have those assurances, our job from The Arc of New Jersey is to stay on this and to get the details as they come forward.

Moving on to the mandatory shift to managed care: We have some concerns about the implementation of this change. Certainly the timeframes are of concern to us. We're concerned about the speed at which this is being done. Families only recently began to receive letters about the change, and are given very short timeframes in order with which to research and select an HMO that best meets their loved ones' needs.

On the positive side, we've heard recently that DHS has taken some steps and has extended that timeline by a month.

While we are really appreciative of the Department taking those steps, we do continue to have concerns about the speed at which this mandatory enrollment is occurring. Our office is receiving calls daily from families expressing frustration and anxiety because they don't understand what is happening with these changes to Medicaid and how to ensure that their loved one will still be covered for all the needed medical services within the managed care system.

We see care management as a key element to making managed care work for people with developmental disabilities, and we're truly hopeful that the HMOs bring on the necessary care managers who can really help people and connect them to the services they need.

We are very concerned about the adequacy of networks. We are not confident at all that the networks are adequate to handle the people with developmental disabilities who currently have very complex medical needs. While we have been given assurances that they will be adequate eventually, and that people will be ensured a continuity of care in the



meantime, we continue to worry about people falling through the cracks. And in light of this, we are asking for a temporary exemption for folks with very complex medical needs who currently have a system in place of care providers. But trying to fit all of those players into a managed care system may take a bit of time. We think it's a small number of people, but we have requested from the Department that they be given an exemption until those networks have an adequate number of service providers to meet their needs.

We were very concerned about the inclusion of anticonvulsive medication in the pharmacy benefit carve-in. However, we are happy to report that the Department of Human Services has now agreed to grandfather in any consumers currently on an anticonvulsive regime, ensuring they would not lose access to the current anticonvulsive medication. So we are very grateful for the Department making that decision.

I think at the end of the day, the Department has been working with us on our concerns and we are appreciative of that. However, with the short timeframe for such major changes to be implemented, and knowing the medical complexity of some individuals we represent, we continue to be concerned about this transition until we can be sure that everyone will be able to continue to get the medical care they need.

Thank you for the opportunity to provide this testimony.

SENATOR WEINBERG: Thank you, Tom

Any questions?

Thank you, Tom.

SENATOR SINGER: Madam Chairman, just one. Loretta, just one -- just one thing.

Thank you, Madam Chairman.

I just wanted to mention one thing. I did send a letter to the Commissioner a couple weeks ago. One concern I had in general was that people on FamilyCare who are using out-of-state physicians -- in some cases there are none in state that treat that particular illness; as well as the fact that people on-- As you know, what happens is when a person is on FamilyCare, once they go out of state it transfers to Medicaid. And we're eliminating that aspect in the budget; they will not be allowed to go out of state in the future, as of July 1 -- with one exemption.

SENATOR WEINBERG: Well, apparently, July 18 now.

SENATOR SINGER: Well, there's one exemption, I think; one particular thing. And also the fact people on Medicaid can go out of state. So I asked the Commissioner, number one, to grandfather everyone who is presently in, in. I understand we'll have to take a second look on new patient factors, but people who are going out of state right now for those services, who cannot and have not been able to find that service within state -- in some cases, they're not in-state because that specialist might be in Philadelphia, that specialist might be in New York City, just are not-- Because we're between these two great cities, as you know, many of those specialists are there. For example, I have a daughter with an illness that the top person in that illness is in Boston, not in New Jersey. But fortunately someone in New Jersey used to work for that doctor. But I understand the problem of having someone with issues.

So I've asked the Commission-- I (indiscernible) response back to my letter -- if you like, I'll send you a copy of it. But I am concerned with the fact that there are numerous people with different illnesses, who are going presently out of state, that as of July 18 will not be able to. And we may not have that particular expertise within the state. So I think that at least grandfathering it in right now, until we get a handle on this, might be a positive factor to let those people know that they're not being left out in the cold.

SENATOR WEINBERG: Thank you, Senator.

Any other questions or comments? (no response)

Thank you, Tom.

Phil Lubitz, Associate Director of NAMI.

Phil.

**P H I L L I P   L U B I T Z:** Thank you, Senator Weinberg, members of the Committee. I'm Phil Lubitz from NAMI New Jersey -- National Alliance on Mental Illness. NAMI's the largest grassroots organization advocating for people with mental illnesses and their families.

We support many of the objectives of the waiver to rebalance or shift away from reliance on institutional or acute emergency services towards preventive and home-based care, to the extent that inpatient care, however, remains available when appropriate.

There is some evidence, at least in the case of people with serious mental illness, who generally do not receive very good physical or systematic health care, that those who have previously voluntarily enrolled into Medicaid match care have experienced greater access to health care, particularly dental care, and have had some positive experiences with the

management of complex medical needs -- a little bit different experience than people with developmental disabilities.

Although we support the goals of the comprehensive waiver, we remain concerned about plans to bifurcate mental health care by carving out adults with less severe needs into managed care for behavioral health services. This seems to be a step back from the objective of having a truly integrated mental health system. As we now have the opportunity to design a unified system, incorporating all behavioral health services under an administrative service organization -- as has existed really for the past eight years in the children's system of care -- I think we should really consider placing all behavioral health services for adults under the administrative service organization. In addition, we may also want to consider -- because I think the plan calls for all of those services in the children's system to be under the ASO -- we may want to consider having one ASO, rather than one for adults and a separate ASO for children. You know, there obviously could be an administrative saving by having an administrative service organization that would be managing the behavioral health care for both children and adults.

We believe that prior to developing an RFP -- Request for Proposals -- for this ASO that the Department of Human Services should specify how stakeholders, including families and individuals who live with a serious mental illness, will be included in planning and oversight of the request for information, the request for proposals, and the contracting process; and indicate how it will incorporate advocates' recommendations, priorities, and feedback. I think that is something that my fellow panel members have stated. Because psychiatric medications have never been

covered under Medicaid and the ABD managed care plans in the past, it is unclear if the proposal will interfere with the access to proper medications. It is our recommendation that the Legislature take a close look at this proposal to assure that medication decisions are based on clinical decisions and efficacy, rather than on shortsighted cost considerations. To that end, we may also want to create a reimbursement for board certified psychiatrists to consult with general practitioners who are currently the major prescribers of psychiatric medications.

SENATOR WEINBERG: The general practitioners are the major prescribers?

MR. LUBITZ: Yes, yes, right.

Our experience with past efforts to move individuals who receive Medicaid as a result of being blind, aged, or having a disability into managed care-- And remember, this has really gone on, and starts and stops on a voluntary basis, for, really, the past 10 years. That experience suggests that we should exercise caution when disrupting the insurance coverage that has tied these often fragile individuals to essential medical care. Therefore, we recommend sufficient outreach must be provided to individuals and their caretakers before this system of care changes.

And lastly, the Department should assure a comprehensive plan for the inclusion of stakeholders, and for the planning and execution of this initiative.

So again, I'd like to thank you for the opportunity to speak this afternoon.

SENATOR WEINBERG: Thank you.

Any questions here? (no response)

Thank you very much.

And could you just reverse seats -- I know you have a microphone there, but just so everybody on the Committee could see you, Mr. Szmidt.

Thank you.

**YITZ SZMIDT:** Thank you, Madam Chair, and Senate Committee members, for allowing me this opportunity to have my voice and concerns heard.

I'm also here on behalf of my doctor, Dr. Shanik from Pediatric Affiliates. He's one of the largest pediatricians in the state; he has several locations and has an approximate patient population of 40,000 patients.

I'm also here on behalf of an organization called High Lifeline, which is a national organization; and among several services they provide, they also do a lot of advocacy when they feel it's necessary.

The first thing I'd like to talk about is my own personal experience. Sixteen years ago, my wife and I were blessed with a very special child. Up until that point we had healthy children who sometimes get sick. Yet 16 years ago, things changed -- our life turned upside down. For seven months we had no idea what our child even had. Nobody in New Jersey knew. We went to CHOP; they didn't know anything -- they almost killed the kid. We went to Long Branch -- they had no idea. After seven months, they said, "Nobody in New Jersey can help you. You have to go to NYU; that's the only place that can help you, because we believe your child has what's known as an *orphan disease*." And he was correct. There are approximately 350 people on the face of this planet that share what my

child has. It's known as an orphan disease. There is no one in New Jersey that specializes in this very, very limited population of ill people.

I have no choice-- And by the way, I'm hearing sometimes in the press about the concerns for fee-for-service -- that people abuse the system; they run to emergency rooms for headaches and stuff like that. I don't know what they're talking about. I don't like going to hospitals. I don't like going to doctors. I certainly don't like going to hospitals an hour and a half away. I don't like to do that. I do it because I have no choice; because if I would not do it, the State would have legal rights to take my child away from me because I'm being derelict in my duties to properly care for my child. It's a fact, and this is not the only orphan disease out there. Unfortunately there are other orphan diseases out there where no one in New Jersey can care for those diseases. We do have a primary care physician, and we are thankful to him for the tremendous services that he has provided. And we try to utilize him as much as possible. And, thankfully, thankfully our child is doing well.

Incidentally, the child we had 16 years ago-- At the age of 2 years old, Memorial Day weekend, our nurse did not show up -- she called in sick, she couldn't come in Memorial Day weekend. That evening we did not have proper access to health care, and the next morning my son did not wake up. I am very worried about having proper access to health care.

You know, we have another child with the same illness; it's a very rare diagnosis -- I don't think anyone has heard about it; I've said that before. But it's important for the panel to hear this again: There are a lot illnesses out there that cannot be cared for over here. And, thankfully, because we knew the diagnosis and we had proper access to health care

through the fee-for-service program, he's doing well today. He's mainstreamed in a regular school. He's a bright boy. He's socially adept. He's the sweetest kid around. But he's got medical challenges -- a lot of medical challenges.

My concern is that this transition from fee-for-service to managed care is simply unmanageable -- it's unmanageable for me. The doctors are not in the network. I don't know if the doctors negotiate. The State is telling us, in the very brief FAQs which they provided -- very general and ambiguous piece of paper -- that, "Don't worry about it; you can first enroll, and after enrolling they'll work things out." They'll negotiate with your specialist. And I'm concerned about it, because from everything I've read, from everything I've heard, and from the network of people I've spoken with, it hasn't been the case.

If this panel would permit, I would like to just read briefly from a letter I have from my doctor. I will only read an excerpt, not all.

I'm going to start from the third paragraph. "My experience in attaining authorization from managed care for these medical needs is terrible." And he lists several different diagnoses, which I will provide and submit to the panel. "On the most part, there is no chance for negotiation. Specialist and hospital personnel out-of-state are hardly able to come to a reasonable agreement with managed care. In a few cases, authorization was given and then was rescinded after the appointment, the surgery date, leaving the parents with the bill. These experiences have left me unable to trust an authorization even when it was given."

"For the chronically ill, the need to receive medical supplies through managed care has been a nightmare as well, as their vendors and



covered benefits change often. The quality of the supplies provided by managed care pales in comparison to Medicaid and impedes on the care given. And yes, it does matter.”

“Limiting our chronically ill and disabled population to managed care is, in the best of scenarios, a compromise; and to some, a death sentence.”

I’ve attempted to get answers; I have a lot of questions, and it’s not just me. There are several dozen people, who I am here on behalf of, who I know personally. And there are many, many more across the state. I’ve called everybody I can possibly call, just like Ms. Russell did; I’ve even reached out directly to the Administration -- I’ve sent an e-mail. And if I could, perhaps, just read a very brief excerpt from that e-mail, I’d like to show you what the response was and where we are standing today. I sent them an e-mail approximately two-and-a-half weeks ago, and I said we need to discuss scheduling a forum in our area, a question-and-answer forum that’s going to help-- It’s going to answer questions for parents; parents want to know: what kind of choices do they have? What are the benefits, what are the limited benefits, what do they cover, what do they not cover, what is the difference? These are reasonable questions; these are reasonable questions, especially when you’re dealing with extremely sick children. We need to know. When a regular child has a 102 temperature, it’s not the worst thing if you wait a little while. It’s not good; you shouldn’t do it. When a sick child gets a 102, that could spell fatality -- it really could. And we need the answers -- we need the answers before we enroll. We can’t get them afterwards.

Now, it's my understanding that the Administration decided to hold two forums: the first one was on May 25. No one I knew, no one I know absolutely knew about it -- nobody knew about it. It was way up in North Jersey; I had no idea. I heard about it after it happened -- I heard about it after it happened. And that was a two-hour Q and A; I don't know who was there. From what I understand, there was very limited attendance. And please keep in mind that this transition is going to affect 121,000 people. They had, maybe, 60 people show up at that first attendance. The second one is going to be June 8 -- June 8 is on the other side of the state. I can't make it there; it happens to come on my holiday. And I have, specifically -- I've reached out, I said, "Can you please hold the forum? I know many people -- both who have the holiday and who don't have the holiday -- who would like a forum in our area so we can ask questions." And the answer was, "I'm sorry, sir. We don't have enough time." That's the answer, and I have this in an e-mail directly from the State Administration. I've reached out to the higher-ups. I've also spoken with the county personnel; I've spoken to everybody I possibly can. I've wasted too much time on this.

SENATOR WEINBERG: What county do you live in?

MR. SZMIDT: I live in Ocean County -- I'm sorry.

The County Administrator says, "I am as frustrated as you are." Medicaid officials have told me, "I'm as frustrated as you are, because we don't have training. We have to make decisions. We are guardians for people who can't make their own decisions, and have no other guardians to do it for them. And we don't know how to decide. We haven't had training. We can't answer your questions, and I don't know how to train

my personnel. I am sorry. If you talk to anybody at the State, please tell them that they need to reach out to us and communicate, because they haven't so far."

Now, it's my understanding that when this hearing came about, Thursday they decided to quickly arrange a meeting for county personnel, which will be held tomorrow with limited seating available. And you had to register, I think, by Friday. So I don't know if that e-mail even went around.

SENATOR WEINBERG: Did you have the same experience that Ms. Russell talked about? You got a letter on April 29, with a promise that you would soon get a packet which has not yet been forthcoming?

MR. SZMIDT: I did, although it was quite different. My experience is that letter, dated April 29, didn't show up in my mailbox until May 10. At that point, I had 30 days to make a quick decision which would severely impact--

SENATOR WEINBERG: But did you ever get a packet?

MR. SZMIDT: Never got a packet. A packet never came to my door, ever. I haven't gotten a packet.

If I could just, quickly, just read again just a short excerpt of the e-mail back to the State, and I still haven't heard back from them. When they told me, "I'm sorry, there's just not enough time, we don't have enough time to put the experts together for you." I wrote them back: "I hope we're all on the same page. The May 25 event had low attendance. DHS has not even advertised this forum on its website or the news media. The next and only other two-hour window being made available to the individuals whose medical care will undergo drastic changes is highly unfair

to families in this part of the state. Stakeholders are frantic with worry. Proper information regarding this very important proposal is unavailable. The phone number provided by DHS is equally insufficient.” The person answering those phone lines claimed they have a printed script of very general information that they specifically tell you, that no further guidance or details are available. They can only assist with actual enrollment and nothing more. Even personnel at the county Medicaid or DDD offices are thus far information-less and have themselves been feeling frustrated at the lack of information available, and are desperate for the State to communicate with them. Additionally, when attempting to communicate with the HMOs, we can only speak with low-level reps who are also in no position to discuss specifics. They inform us that we must first enroll, and only after some period of time can answers be made available.

Please understand that many in this exempted population are suffering with uniquely complex, disabling conditions. They have good cause to be apprehensive. They are anxious for specifics before a decision is made or even contemplated. Information has not been forthcoming enough and there are many ambiguities. The mere fact that this proposal is being so rushed with practically no time to understand the ramifications is on its own enough reason for meaningful outreach effort.

Additionally, they just extended the deadline last week, and I see no reason why they can't fit us in. There are 121,000 of us. The first forum, I think, had a limited capacity, due to fire regulations, of perhaps 100; the second one is the same issue -- you can only fit 100 into the place. There are 121,000 people who are going to be impacted here; I think it's fair to beg the Administration to please reach out and talk to us.

But I have two other important issues that I would like to discuss. The Governor mentioned there are 121,000 people who are exempt in the fee-for-service right now. I don't know exactly what kind of populations make up that 121,000 figure. I believe that many of those in that 121,000 exempted population don't necessarily mind going to HMOs. I'm not saying an HMO is a bad idea; I'm saying it's a bad idea for some people -- not for all people, there are many people who don't mind. There are people who are foster-cared, there are people who are in DYFS. You can go through the regulation, you will see several different groups that have automatic exemptions or can request an exemption. In my particular case, I asked for an exemption. The State looked at my application, and the State, based on the facts, granted an exemption. The State acknowledged that an HMO will not meet the needs of my child.

I don't know what changed; I don't see the HMO model of business getting any different. I don't see my child's condition getting any different. I'm not sure what changed. But the State is on record at the New Jersey Register, back in 2006, especially comment No. 25. Somebody asked the State, "We're worried about the particular wording with special needs children going into HMOs." If you're going to leave it up to their discretion, reasonable discretion -- there's a lot of room over there. There are too many issues and we fear the adverse impact on this particular part of society. The State answered as follows: The Administration went on record as saying, "You're right. The answer to your question is that these children can get exemptions; they don't have to go on managed care, because we acknowledge that it's a problem. And not only that, we acknowledge it may be a violation of the Federal Americans with Disabilities Act if there are

barriers put to their access of proper health care.” I don’t know what changed; that’s still there. The laws didn’t change; the laws, maybe, got stronger.

And the last thing I’d like to mention is that the current Administration obviously realizes and acknowledges these issues, and they still have carved out or retained specific exemptions. And my question is: Why did they choose some illnesses over others? Cystic fibrosis -- and my heart goes out to anybody who suffers this illness, and I dare not compare, I dare not do that; because I know what suffering means, and I will never compare -- but I don’t know why cystic fibrosis got a pass; and familial dysautonomia, or spina bifida, or some of the other complex and difficult-to-deal-with-on-a-daily-basis illnesses did not get a pass. So that’s my question: Can we get a pass also, and perhaps trim that figure from 121,000 down to only seriously, complex, uniquely complex illnesses where HMOs -- by the State’s own admission, in the past, at least -- can’t meet their needs?

SENATOR WEINBERG: Thank you very much.

Thank you all for being here. Hopefully, we will be getting some answers -- if there are answers -- to these very good questions that you’ve all raised.

We have another panel to come up, so I’ll ask you all to relinquish your seats: Yaakov Friedman from the New Jersey Adult Day Services Association; Dr. Kevin Saluck, President of the Jersey Association of Medical Equipment Services; and Jean Alan Bestafka, from the Home Health Services and Staff Association.

And there’s one more panel after you.

Mr. Friedman.

**Y A A K O V F R I E D M A N:** Thank you, Committee Chair Weinberg, Vice Chair Vitale, other members of the Committee.

A lot of the concerns I wanted to raise have been mentioned earlier, so I will be brief. I also did submit written testimony to the Committee, so I will rely on that. I'll just mention a few points that have not been raised.

My name is Yaakov Friedman; I'm the CEO of First Healthcare Management Company. We operate three adult medical daycare facilities in Central and North Jersey.

I'd like to say it's truly gratifying to be in a field where we help people every day by providing quality health care in the home and community, and helping keep these individuals alive and healthy, all while -- the added benefit of being preventative, saving the system money.

We're not opposed to managed care, per se. On the contrary, we applaud the efforts to be innovative, and for the State to explore ways to achieve efficiencies and to ensure the smart spending of Medicaid dollars -- that's really important. Our concern is mostly, as you heard from almost everyone here, it's a hasty and half-hearted, haphazard implementation. There's immense mass confusion; we have hundreds and hundreds of individuals we serve who have said the same things you've heard earlier. We get letters; they promise packets -- they don't come. We now have three start dates: first it was July 1, then some of the population --dual eligibles and others -- were postponed to sometime in the fall; then, because of an error in the letter from the State to beneficiaries, they postponed it. Now we have a July 1 date, an August 1 date, we have a September-October

I date -- this is very, very confusing for everyone. I have social workers fielding calls; they want to help and they are very well trained, but they can't help because they don't have information. We spoke with HMOs and they complained to us that they don't have information.

This is too fast. The idea is good, the concept paper is good, but this needs more time. In fact, Mercer Consulting, which is the State's own consulting firm, has said to New Jersey, and to other states who they're contracting with now, the minimum is 18 to 20 months to see this through. And, in fact, there is a Department of Health report, that was a requirement in the 2009 budget, titled *Managed Long-Term Care New Jersey*, April 2009 -- this report also recommends a three-to-five-year timeline. That should be followed. That includes three years of pilot programs to sort out the issues. I've been following events in Florida and other states -- they have four years of pilot programs, follow-up discussions, ironing out the kinks-- The concept is great; the concept paper is very good. And, like I said, we support efforts to be smart about how we spend our money -- we should be. But one thing's for sure: If there is going to be an environment of chaos with interruptions in care, this will not save any money. No savings will be achieved in an environment of chaos.

There are many outstanding issues: oversight, rates, provider enrollment requirements and processes, access issues to beneficiaries, appeals processes, fair hearings, covered services -- and the list goes on. Each of these items needs to be addressed -- and they will be; I'm sure we can come up with something really good. I look forward to working, and the Association looks forward working, with our shared goal of providing quality health care for everyone.



I would just mention two specific concerns, and I'll end with that. Our first concern is the structure. Under the proposed structure, your managed care organizations are responsible for hospital care, community care, but not for nursing home care. This is problematic. In this structure the managed care organizations are incentivized to ignore the individual's health and allow the patient to deteriorate into a nursing home, where it goes to fee-for-service and the cost is borne by the State. In the State's own report, one of the specific recommendations -- and that's in the handout -- on page 19 the report by the State points out this issue, and I quote, "Giving plans no risk for nursing stay gives them a perverse incentive to admit high-cost members to nursing homes." This is a problem. It should be all-inclusive -- that's the idea of managed care where the managed care, company assumes all the risk, not just some of the risk.

Another issue is the rates. The way it works typically, by managed care organizations, it's the law of the markets. It's trial and error in the marketplace to determine rates. Now, with our vulnerable population, the stakes are simply too high to allow a trail-and-error process to determine rates. I urge your Department and the Legislature to require a rate floor similar to what the Department of Health's own report recommends. There should be a rate floor supported by a recent cost study done by the Department. On the same page 19, the report recommends protecting existing Medicaid rates -- to encourage plans to focus on cost-reduction efforts, on avoiding high cost services, and not on reducing Medicaid rates.

Chairwoman, may I address the co-pay in the budget?

The proposed budget includes a co-pay, which is another issue with access to care. Co-pays are inappropriate for preventative care. New Jersey Administrative Code 8:43F, on the scope and purpose of day care, defines its purpose to provide preventive--

SENATOR WEINBERG: Mr. Friedman, I did give you permission to address that, but we can't really usurp the responsibility of the Budget Committee here.

MR. FRIEDMAN: Understood.

SENATOR WEINBERG: If you could sum up.

MR. FRIEDMAN: I will sum up.

We are in favor of managed care or any other innovative way to save money. This is too fast. I urge the Committee to require the State to follow its own recommendations to do this carefully, and with pilot programs, with more input, and more clarity.

Thank you for the opportunity.

SENATOR WEINBERG: Thank you.

And I'm not sure that you addressed this clearly enough, but wasn't one of the problems in terms of the adult medical day care with how managed care firms will handle things like medical equipment? And I guess we do have somebody from the medical equipment field here, so it may be better addressed--

MR. FRIEDMAN: That's fine.

SENATOR WEINBERG: --to him.

MR. FRIEDMAN: Thank you.

SENATOR WEINBERG: Okay, thank you.

If I could -- because it's on that same subject -- Dr. Saluck.

**KEVIN A. SALUCK:** Ms. Chairwoman, and members of the Committee, thank you very much for inviting me to testify. Written testimony has been submitted to the Committee.

I'm Dr. Kevin Saluck, and I'm the Vice President of Clinical Operations and Business Development for Central Medical Supply Group. Our corporate office is located in Flanders, New Jersey, and we have a branch in Cherry Hill, New Jersey. Central Medical Supply Group is a member of the Jersey Association of Medical Equipment Services. I'm here today representing the home care community, specifically the home medical equipment sector. My goal is to explain why the proposal to mandate managed care for the remaining fee-for-service aged, blind, and disabled Medicaid population will not achieve its desired outcome.

Home medical equipment companies provide a valuable service to thousands of patients who are in need of medically necessary supplies and equipment that include recurring monthly orders for medical supplies, complex rehab mobility equipment, and clinical respiratory services such as life-sustaining patient ventilation. Having such a robust arrangement of diverse home medical equipment companies throughout the State of New Jersey allows for a timely discharge of patients from acute-care hospitals and sub-acute facilities. These companies are an integral part of the continuum of care, and allow for these patients to enjoy a seamless and timely transition from the inpatient facility to the home environment. As the home environment is the preferred setting for the patient to convalesce or manage their disease state, the home medical equipment companies are a critical component in helping to decrease the length of stay and prevent readmissions.

While reviewing Section 1115 Demonstration Comprehensive Waiver Concept Paper, we are concerned about the--

SENATOR WEINBERG: Dr. Saluck, excuse me -- you're not going to read all of this, are you?

DR. SALUCK: No.

SENATOR WEINBERG: Okay.

DR. SALUCK: We're concerned about the portion of the paper under section V, titled "Delivery system innovations." Concerns are raised by the Association with the proposal to move the dual-eligible, the aged, blind, and disabled populations from the fee-for-service model to the managed care. This move would place a high-needs population into a care arena that, from what we have seen typically, does its best to reduce expenses by significantly limiting provider participation. This reduction in providers will cause problems in several key areas defined below.

The population tends to be high-volume users of durable medical equipment and supplies, and, due to ongoing medical issues, typically have an established relation with a DME provider of their choice. As a part of the continuum of care, these patients rely on the DME providers to monitor their supply quantities and delivery schedules; stock appropriate levels of quality medical equipment and supplies to service their needs in short timeframes, including emergency situations; and communicate with their medical professionals involved in their care. Interrupting this delicate cycle would prove harmful to the patients as they reestablish themselves with new medical providers, who must assess their conditions and needs; and then provide necessary medical documentation

for new DME providers who will have to obtain authorizations to dispense the medical supplies and equipment.

Considering there is a large reduction in the amount of DME providers permitted to service New Jersey Medicaid recipients through this waiver, the individuals who are accustomed to dealing with their local providers will be forced to deal with unfamiliar providers who may be 50 to 75 miles away from where they live. People prefer to deal with local providers and be given a choice of maintaining a long-term provider-patient relationship they have formed throughout the years. With mandatory managed care, these options and choices will be eliminated and the recipients could have to cope with delayed access due to a lack of proximity of participating providers.

Family members or caregivers who are used to obtaining repairs on equipment while they wait will no longer have that option available. Decreased safety in complex rehab mobility devices and increased risk of patient injury will occur in situations where DME providers who supplied the equipment are not in the managed care network. This could lead to the inability to utilize that wheelchair, restricting the patient to bed confinement and subjecting them to secondary complications. DME providers who are participating in the managed care network may be unwilling to perform repairs on equipment not initially provided by their company. In the case of complex rehab mobility, hospital systems and facilities are concerned that their quality providers for this type of equipment are currently not participating in the Medicaid managed care networks. We are concerned with the volume a move to managed care --

that these recipients will not get qualified providers, presenting a scenario of delayed access the patients must endure.

Clinical respiratory patients who often take from several weeks to several months to safely transition from another provider will be subject to this process almost overnight due to this proposal. The patients are ventilator-dependent and have been on service with their current providers for many years, and in most instances have maintained a continuous relationship with the same physician. This continuity of care should be encouraged and designed to continue. Under the proposal, this continuity of care will severely be disrupted and DME providers of clinical respiratory services believe that there's not enough time afforded to them, the patient, the nursing service, or the prescribing physician to collaborate together to establish a safe transition and a protocol, or even allow the DME provider to contract with the chosen managed Medicaid

Patients currently in need of complex rehab mobility products are finding their prescribers' written orders cannot be submitted for required prior authorizations, due to short timeframes under which this proposal is set to occur. There is simply not enough time to obtain the prior authorizations to build a complex rehab mobility product according to the necessary specifications for the individual's condition.

As detailed above, clinical respiratory patients require several medical--

SENATOR WEINBERG: Doctor, I don't want to interrupt you, but I am going to interrupt you.

Can you sum up? We do have all this written testimony and it will go into the record. Can you sum this up for us, please?

DR. SALUCK: I would like to make one point on this clinical respiratory that's very important -- is that managed Medicaid has-- They have been capping out things like ventilators and Bi-PAPs, which promotes a problem. Because if they are capped out, these are frequently serviced items and the State of New Jersey's Board of Respiratory Care, the licensing board for respiratory care practitioners, clearly prohibits testing and exchange of these devices by unlicensed assistants--

SENATOR WEINBERG: What do you mean by *capping out*? What is--

DR. SALUCK: That means that--

SENATOR WEINBERG: They're giving their-- Go ahead.

DR. SALUCK: They're saying after 10 months, that's it; it's owned by them. And who is then going to-- Typically, for a complex rehab or a clinical respiratory patient, we're available 24 hours a day, 7 days a week. If it's owned by the patient, who is available to do that? There's no more payment, so who's available to do that? And it's going against the New Jersey Respiratory Board.

And I'll just sum this up by saying that we have strong concern for a population of children and adults with severe developmental disabilities and cognitive impairments, as well as dually eligible Medicare and Medicaid beneficiaries, who are incapable of navigating the additional procedural complications inherent to a managed care system. I'm very concerned about the health and well-being of these populations being severely and negatively impacted in a private managed care system.

Thank you for this opportunity.

SENATOR WEINBERG: Thank you, Doctor.

Any questions? (no response)

Okay, Jean Bestafka from the Home Health Services.

**J E A N   A L A N   B E S T A F K A:** I'm the CEO of the state Home Health Services Association.

And you've heard all the frustrations that clients have. We have 30,000 PCA clients; and these comments also refer to EPSDT clients -- those frail children who get home care through private duty nursing, 16 hours a day for tracheotomies, ventilated dependent care, gastrostomies. And I won't go through all that again.

I want to give you a couple examples of what the frustrations are from the side of providers. As I said, we have 30,000 personal care clients that we need to transfer. When will they transfer? Here's a silly example: We're supposed to transfer to-- PCA is supposed to transfer July 1. However, if you're dual eligible, then you're going to transfer in September. Unless, of course, you're a dual eligible who chooses an HMO before July 1 -- well, then you're going to transfer July 1. Unless, of course, you were involved in that glitch -- and so then you won't transfer until August 1.

Now, how is a provider--

**SENATOR WEINBERG:** Now, what is your problem with all of that? (laughter)

**MS. BESTAFKA:** Yes, how is a provider going to say to my client on July 1, "Well, I don't know if we can take care of you any more because I don't know what HMO I'm in," because the HMOs are now starting to say to us, "Not one of my 178 unduplicated providers" -- so it really comes out to a couple of hundred providers -- "has gotten an ancillary



contract.” And one of the HMOs has already said to us, “Well, even if we gave you an ancillary contract today, it takes 30 days to get a provider number. So you won’t be able to bill us until then.” Okay, so how are we going to know?

The State had originally said, “On June 17 you are going to be able to go to the verification system for the State and see which HMO every one of your 30,000 clients has gone to.” Oh, except that now that’s changed; now it’s has to be August. And then we got a message from the Department saying, “Well, we will no longer authorize care for new clients after June 30; but now we’re not really starting until either August or September.” Well, what about those clients from June 30 until August or September?

But the issue really is: We cannot help our clients choose, because the HMOs are not letting us know who they’re going to let it. They’re going to wait to see how many clients they have in what geographic areas and what providers they’re going to pick. But these people are still going to need care at the end of the month.

And then, as I told you before, PCA is a very low-cost, very high-effective program. We make between 2 cents and 9 cents an hour. All of a sudden we’ve been told we have to use a State clearinghouse to do the billing. These clearinghouses charge per transaction, per invoice, and then another transaction fee per receipt of payment. One of our providers was told it’s going to cost him \$68,000 a year. We won’t be able to provide under the program.

And we agree with everybody else, and I'm just summarizing that. We need to do this in a more orderly manner; we're saying at least September 30. Why move in piecemeal? Move everybody at one time.

Thank you. You have the rest of my testimony.

SENATOR WEINBERG: Thank you; thank you, Jean.

You know, I'm looking at the April 2009 "Managed Long-Term Care in New Jersey" -- it was put out under a prior Governor and a prior Health Commissioner from the New Jersey Department of Health and Senior Services -- that set out the timeline that I guess you referred to, Mr. Friedman. And it's interesting, because under the timeline -- which is a very, very short, easy to understand paragraph -- it says that "it's anticipated that the planning phase will require from 8 to 12 months." So let's say they started right on May 1, 2009. That would bring us -- which I doubt -- but that would bring us to May 1, 2010. And then it says, "The next would be the implementing of the planning process," and they figure 3 to 6 months for that, which should bring us toward the end of 2010.

And then they say, "Following the two phases, if all of those went without a glitch, we will initiate three time-consuming administrative processes involved in establishing a pilot managed long-term care in New Jersey." And they say -- they go on to say that they would have to identify, address infrastructure needs; and after the pilot program it would take another 12 to 18 months to complete.

Sounds like a very different timeline than the Department decided to implement -- in a great, big hurry.

MS. BESTAFKA: And some other states that have done that, and practiced that prime line, and done the pilot programs have decided not to change.

SENATOR WEINBERG: Yes; sounds like we skipped over a few sentences in that timeline.

Thank you very much.

Any other questions? (no responses)

Okay, the last panel is not really a panel, but by himself: Ward Sanders from the New Jersey Association of Health Plans.

You're on, Ward.

SENATOR VITALE: Just one thing, Madam Chair.

SENATOR WEINBERG: Yes, Senator.

SENATOR VITALE: This would also open the record, just until we have the Commissioners look at it.

I'd like to feedback on the PACE program -- and we're progressing with that -- and how that will affect this entire thing. I know they've only rolled it out in several counties; there are some counties that don't have it yet. And I think that program might have some effect on this entire aspect of things. You know, that's the merger -- if you're not familiar -- some of the members are not with familiar -- that's the merger of the Medicaid and Medicare program, where one provider gets both things and takes -- encompassing the entire well-being of that individual. It's not housing, per se. They stay at their home, but it's that merging-- Seventeen other states have done it very successfully. They're rolling it out--

SENATOR WEINBERG: You're talking about the global--

SENATOR VITALE: Yes. Right now--

SENATOR WEINBERG: --rebudgeting.

SENATOR VITALE: --we're doing it in Jersey City buildings, but a lot of the other counties have not come into effect with it. And that might have some effect, too, on this whole thing. So I hope the Commissioners might, at least, address that in their comments to us, as to if that's an effect on their program, and how they plan to implement it into the program.

SENATOR WEINBERG: Yes, thank you.

SENATOR VITALE: Thank you, Madam Chair.

SENATOR WEINBERG: Ward, go ahead.

**W A R D E L L S A N D E R S:** Thank you, Madam Chairwoman. I'm wondering whether panel is a plural word, or singular. But I appreciate the opportunity to testify today.

I represent the Association of Health Plans. Our organization represents the six major managed care organizations in the state that cover about 7 million residents. Included in those six plans are three plans where the major Medicaid plans cover almost 1 million people in New Jersey.

I want to, again, thank you for the invitation to testify today. And I'll try to focus on the transition of the services and populations from fee-for-service to Medicaid.

I have submitted written testimony, which, I believe, is in your packets; if not, I'll be sure to get it to you. So I'll try to be brief and cover a couple of points orally.

Since the mid-1990s, managed care organizations have partnered with the State to improve access to health care for the Medicaid/FamilyCare beneficiaries and to effectively manage healthcare dollars for

Medicaid. Managed care organizations do this in two important ways: They provide quality, cost-effective care, and they emphasize prevention and coordination of care. So this is how much of savings and access is improved.

In addition, managed care organizations currently provide a lot of services that are not provided in fee-for-service Medicaid. Translation services, 24-hour nurse help lines, community outreach programs, health literacy and education programs help to facilitate communication and access for services -- and, again, these are not routinely available through the fee-for-service Medicaid program.

At the same time, the State has noticed -- I heard Commissioner Velez testify on this, or say this at a meeting -- that managed care clients represent 75 percent of the total members, yet the expenditures to managed care companies represent only 28 percent of the total program cost.

Health Plans does understand that Medicaid beneficiaries are unique; it's a unique population, different from the commercial population. In comparison to the general population, Medicaid beneficiaries have much higher rates of poor health; they have fewer resources by definition, because of eligibility; and lower rates of health literacy. These beneficiaries need integrated systems of care that promote access to necessary services and improve health care. And they especially benefit from outreach efforts to assist them in making and attending medical appointments, and obtaining needed care on an ongoing basis.

When I first took this job a number of years ago, I toured Medicaid managed care organizations and I was struck by the sort of

workforce they had. It really is, sort of, a sea of nurses and other healthcare professionals -- doctors and dentists. Clearly one of the challenges that you face with this population is, sort of, underutilization of care and making sure that people with needs get those needs met. If someone has diabetes, plans will aggressively outreach to these folks to make sure that they're receiving the care. If there's no claim for a pharmacy benefit -- that they should have been receiving care and there's no claim related to accessing benefits -- it's the kind of thing where plans will reach out to their membership and work with them to try to make sure that they're receiving necessary care.

And we recognize that chronic conditions require focused programs that are tailored to the clinical and care management strategies.

The managed care organizations know this population well and their needs well, and we believe that they provide the services to meet these needs. They currently do have a significant amount of folks with high healthcare needs, just to be clear.

If we were to walk away with one message--

SENATOR WEINBERG: You just kind of threw that sentence in: They currently have a high--

MR. SANDERS: Sure. Just as an example: I mean, there are a number of high-needs populations currently in -- the aged, blind, and disabled population has--

SENATOR WEINBERG: Can you get us information and some statistics on that?

MR. SANDERS: Absolutely.

SENATOR WEINBERG: Thanks.

MR. SANDERS: And a just a note as well: I know there are a lot of things that have been brought up today. I was going to ask my members to go back and listen to the transcript of today's hearing -- or if there's a written one available, to take a look at it -- if there's an information gap, we'd like to try to address some of these concerns. You know, as different things were popping up as people were testifying, that I think that would benefit from some of our input. Just the one that pops into my head right now: In prior authorization, there's this notion that the plan could provide prior authorization, which is a medical necessity determination, and then revoke it somehow. I mean, the Department of Banking and Insurance has regulations against that kind of revocation. I'm not quite sure what led to the fact pattern that led-- It could be that someone was covered, received a prior authorization from the plan, and then, maybe, they were no longer covered by that insurance plan or something. I'm not quite sure what that-- But it's not revoking the prior authorization. It could be that the plan said, "Well, we're no longer in the insurance company that's insuring that person on the date of service." But there are certainly things that have popped up like that, where I think that some clarification would be necessary. And I would be more than happy to try to outline that after today's hearing.

If I was going to ask you to walk away with one message today, it's that the managed care organizations are focused on providing a very smooth transition from fee-for-service to managed care. And to be clear by that, what we mean is no interruptions in service to our clients, additional outreach to assist clients with the transition, and timely payments to

providers. And we are investing significant time, and energy, and staffing resources to try to ensure that transition.

I was just talking to one of my plan members; there was a mention of the hearing in Totowa. I think there were 60 or so people who attended that hearing. And I think the plans found it enormously helpful. They were there helping to answer and respond to questions that came up, and they do believe that's a good process.

SENATOR WEINBERG: Ward, let me ask you a question.

Do you know, was there-- I kind of read, from the timeline from the April 2009 report-- Was there any kind of a pilot program actually put into effect any place?

MR. SANDERS: You're talking about the managed long-term care?

SENATOR WEINBERG: Yes.

MR. SANDERS: I'd have to check with the plans about that. I'd be more than happy to get back to you on that.

SENATOR WEINBERG: Okay, thanks. We'll check with the Commissioners too, obviously.

Go ahead; I'm sorry.

MR. SANDERS: That's fine.

I did want to talk about the continuity of care, because I think there was some misunderstanding about how that process will work.

So as I understand right now, the contract that the Medicaid managed care organizations have with the State has a continuity of care provision. On July 1, if there's a transference from fee-for-service to managed care, it does not mean if someone is seeing their doctor on July 1,



if that doctor is not in network they're no longer able to see that doctor. They can see him; there is a continuity care provision that tries to provide for that smooth transition. During that period the plans are, in most case, going out and trying to get that doctor in network so they can pull that person in.

SENATOR WEINBERG: So the plans will-- You're saying that the plans honor the continuation of care if that doctor is not in the network?

MR. SANDERS: That's correct.

SENATOR WEINBERG: And we'll pay that doctor accordingly?

MR. SANDERS: Yes, it's not in perpetuity. But there is a transition period -- I'm not sure quite how long that period is -- but the idea is these transitions happen all the time already. Obviously there's a larger shift here, but plans are going to require it under that contractual provision and just because it's the right thing to do. You want to transition that person so that if they're seeing Dr. Weinberg on June 30, on July 1 if they need to go to see a doctor they don't have to fumble around. They can still see Dr. Weinberg. The plans will try to reach out to Dr. Weinberg to try to bring that physician into their network -- sometimes they're successful, sometimes they're not successful. They will do a health assessment of that person -- look at their meds, look at who they're seeing, who their doctors are, and so forth -- and try to pull that person in if they can. After a certain period, then there is a transition to a network physician.

There has been some talk about how that process works. There was testimony from the first person -- I didn't catch her name -- it was very

moving testimony, and I would like to follow up with her. I think some of the concerns that she has may be addressed by some of the requirements that currently exist.

Plans today will do agreements with physicians to make sure that someone receives care. So if a patient needs to see a bone cancer specialist in Cape May County, and because of, really, the supply and demand issues, the plan doesn't have one in its network, the plan is required under the law and under its contract to go out and make sure that that person has access to services, and will do a contract. They might not technically be in the network, but it's a one-offer -- sort of a single-case agreement with that non-par provider to make sure that that person receives the services.

So for the woman who testified about her husband who needed a pulmonary specialist, that's the kind of thing that if the plan does not have someone in its network to address that very specialized need, they can-- The plan, in some cases, will do a single-case agreement to make sure that-- They're required to do that to make sure that that person -- if there's nobody in the network.

SENATOR WEINBERG: Does geography come into play on--

MR. SANDERS: Sure; it's a good question.

The network adequacy requirements the plans have do have geographic components to the rules. So you're measured by your network adequacy in part by the proximity of the providers, the population from where you provide service. So yes, geography is a component of this, and there are transportation services available under these contracts as well.

So while this person may have found that the provider who they work with is out-of-state or whatever, or is non-par, it doesn't mean that there wouldn't be an ability -- or requirement, rather, on the plan to make sure that person receives services. I know that Senator Singer's not here right now, but he did mention something about out-of-state coverage; it's something I very much-- I want to look into that, because I'm not aware of any restrictions on plans-- I know that they have providers who are out-of-state, so I'm not quite sure-- I'll try to pursue that with him or look at the transcript. I'm not quite sure what that concern was. I do know that there is coverage by out-of-state providers. And in these single-case agreements also, you can have a network provider who is in New York or Pennsylvania. If somebody's traveling in New Mexico it might be a single-case agreement with a pulmonologist in Albuquerque.

Because I do want to be clear about that; I think sometimes there is-- I heard her frustrations about accessing information and the frustrations that she had with governmental entities, and her fear of moving to managed care. I do think we can try to address, to talk to her and others, as we have in these public forums, about what that process looks like so that there's not -- at least there's not an information gap as to what's going to occur next.

But this continuity of care provision is a very important feature of this contract; that I think that some folks look at July 1 as an absolute cliff, and I think it's just a little bit different.

If I could, too, I did want to mention our work with the State. We've worked through various administrations since 1995 -- the managed care organizations have -- with the State, and there have been a lot of

changes. We've worked very closely with Commissioner Velez and Medical Director Harr, and their staff, to try to ensure that this is a successful transition. We've certainly been very engaged with them and with other stakeholder groups. We-- In addition, just to knock off a few: there's the Medical Assistance Advisory Commission (*sic*) meetings, the monthly contract issues meetings, the Medicaid MCO CEO roundtable meetings. We've been in various stakeholder and work group meetings. There are work groups on the-- The home health work group, the Division of Developmentally Disabled work group, the adult pediatric medical day work group, and the dual-eligible clients work group.

In addition, Commissioner Velez-- There are some pharmaceutical concerns; she asked the representatives from PHARMA to meet with us, so they were nice enough -- two representatives from PHARMA came in and met in my office last week to work through some of the issues and concerns that PHARMA had with this transition to managed care. And we've committed to them to try to work through some of their questions and concerns that they have.

With respect to network, because I do want to address this -- on network adequacy. With respect to primary docs, those are areas where the plans really, for the most part, meet and exceed the network adequacy requirements. There are challenges out there in the networks, especially with these super specialists in certain geographic counties, and it's largely a function of the supply and demand issue. If there is only one of a certain kind of doc in a two-county area, it's challenging to meet those requirements. But as I say, we do have a requirement to make sure that

people receive care from a specialist. To do so we may need to do ad hoc contracts.

And as I said, they are, today, working very hard, working to contract with the additional providers to build these networks up. And, again, it's not this cliff of July 1, necessarily; there is this continuing care provision that provides a little bit more time for the contracting period.

With respect to the comprehensive waiver, I don't want to address that too much; I've read the 18-page document that the State has published. Just to note: There are certain elements of this that were supportive of the promotion of primary preventative care through the medical home model and the accountable care organizations for high utilizers. I know that some of you have talked to Dr. Jeff Brenner; we're very supportive of his bill and his work, and we look forward -- if the legislation does move forward -- to working with him in the Medicaid space. We're very supportive of those kinds of projects, and excited about it.

We're also-- On managing integrated behavioral health services -- supportive of that. As one of the previous folks who testified on this, one of the challenges that the plans have right now is that they are tasked with coordinating care for certain care for certain individuals. This population has a significant number of folks with behavioral health issues and challenges. It is very hard to provide care management when the nurses of the managed care organizations are dealing with physical problems but they can't know about or don't have access to the information regarding behavioral health. One of the first things I heard when I started working with the Association five years ago is -- I had a meeting with the medical directors, and the doctors from the Medicaid organizations came in, and

one of the first things that they said to me is that this is one of the greatest challenges we have -- is that there is this wall between behavioral health and physical health. And it's nearly impossible to manage the care for this population if you can't have access to this information; and this really needs to be integrated. So we're very supportive of these efforts to try to integrate this care so that folks have, sort of, one home rather than sort of a split -- a divided house.

SENATOR WEINBERG: And who would be in charge of that home?

MR. SANDERS: For services under this waiver it would be the managed care organizations. We honestly, firmly believe that we could do a better job. I think the record has proven that we have built networks that are better than the fee-for-service networks. The mental-health network under fee-for-service, I would suggest, could use some improvement. And again, providing that care -- this is what plans do. This is how they help folks, and how they drive savings for various states in servicing this population.

The third point in the comprehensive waiver was the transition to managed long-term care. It is something that we are supportive of on those three elements.

We look forward to continuing to work with the State and other stakeholders in trying to roll this out as requested.

I'd be happy to take any questions you folks have.

SENATOR WEINBERG: Any questions?

SENATOR VITALE: I do.

Thanks, Ward.

There was a-- When this first happened, when it was first proposed by the Administration, there were some questions about cost, and that there would be, obviously, less cost to the State, more efficiencies. How is it that they-- And then you reconcile the cost from fee-for-service to the managed care. Is it a requirement that you come in under the cost that fee-for-service now provides?

MR. SANDERS: Well, first let me correct-- On the contracting side, generally, fee-for-service rates for providers, for the most part, are sort of the floor for contracting. Plans pay, generally, north of that amount in provider contracts. The savings occur because plans are good at coordinating care, making sure that folks who aren't receiving care through the underutilization piece do receive the services that they're supposed to be getting. Those chronic care cases-- These folks need a lot of touches, in many cases. So if you have somebody, again, with diabetes or something like that, or cancer, and they have health literacy issues, they have access issues, they need people to talk to and help guide them through the system in a way that you don't really see quite that level of hands-on touch in the commercial marketplace.

It's a specialized market; I mean, they have specialized -- the beneficiaries -- have specialized needs. So plans are able to help drive savings through making sure the folks get appropriate utilization in coordinating that care, and say, they have better access than generally you'd see under fee-for-service. And as demonstrated throughout the country, I sort of see a significant increased shift to managed care. I think there's-- I saw an NGA report recently that said 19 states, currently, are looking at carving out additional populations or additional services to managed care.

SENATOR VITALE: Who's coordinating the networks for the fee-for-service community now?

MR. SANDERS: That's the State.

SENATOR VITALE: Right. And so if it is-- If the patient needs some special care -- they have mental health issues or whatever -- the woman who was speaking before about some of the more acute care that her husband needs and some others who would need it -- they're sort of on their own to find their provider?

MR. SANDERS: Yes. We've done the best we could on the physical -- the treatment side as to the level of touches; that plans do to try to help navigate folks through the fee-for-service system. I have to check on exactly how -- what level of engagement the plans have on that.

But what's challenging for them, just to be clear, is that they don't see the behavioral health medications, necessarily -- some of the other treatment that the people are receiving. There is sort of a bifurcation here, where there's-- They see the physical side, but they don't see the mental health side. And to really, truly coordinate and manage care, you need to be able to see both sides.

SENATOR VITALE: Who's doing mental health services, though, for the plans? Every plan has a different provider?

MR. SANDERS: I have to, sort, of check. I know that some-- Traditionally, some plans do that in-house. Some folks have contracted entities.

SENATOR VITALE: With Magellan, or some of--



MR. SANDERS: Yes, I'm not quite sure on the Medicaid market, the three plans that I represent, whether-- But I can certainly get you that, Senator.

SENATOR VITALE: In other words, you know, the old story that people complain about network adequacy -- and they get their book, and they open the book, and sometimes the doc's not in there any longer. Or they're in there, and they call, and they're no longer participating. And that's a function of providers coming in and out of the network.

How are you now going to deal with that issue?

MR. SANDERS: It's a challenge. The network directories -- or at least you used to get paper versions; in the day, you sent it to the printer -- it's no longer in date. There are doctors who have moved, doctors who passed away, doctors who come in, doctors who join the network, doctors who drop the network. There's a communication that has to occur between the plan and the provider effectively to make sure that those directories are kept up-to-date. Today, the electronic directories are much more up-to-date. I think plans, either twice a year or once a year, still have to produce a hard copy. But it is a challenge to do that.

We have made great strides in the credentialing process through a standardization of that, through an entity called CAQH. I met with the medical society nurses and others who really like that process, because you just -- rather than credentialing with Horizon, and then AmeriGroup, and different plans, there's an ability to, sort of, credential with one entity on one form.

SENATOR VITALE: Right.

MR. SANDERS: So we have moved forward with that.

SENATOR VITALE: Thank you.

SENATOR WEINBERG: Any other questions? (no response)

Thank you, Ward.

MR. SANDERS: Thank you.

SENATOR WEINBERG: That ends the invited guests and the people who signed up.

My initial reaction to what we've heard today is, at the very least, there is an informational problem out there. And I would like to ask our staff, through the Committee, to find out what's been done since April 2009 to comply with the timeline that was laid out in this report: how much of it was complied with, and how much of it was skipped. Because it seems to me we've gotten to June of 2011, and some portions of this timeline were not implemented. And that could be the cause for much of the misinformation. And now I'm not talking about the good or the bad of the actual plan, in terms of the managed care aspect. We still have many questions, I know, about the whole Medicaid waiver; about the amount of money that is perceived to be saved in here; about the idea that if somebody makes \$103.10 a week with a family of three, that somebody is not only not going to get managed care, they're not getting Medicaid. So there are a lot of questions about the way this has been handled.

If anybody has anything they'd like to add to it, to what I just outlined here, please feel free.

SENATOR VITALE: I'd just repeat myself, and it will be annoying.

SENATOR WEINBERG: You what? I'm sorry.

SENATOR VITALE: I said, I'll just repeat myself, and it will be annoying. (laughter)

SENATOR GORDON: Madam Chair.

SENATOR WEINBERG: I'd never call you annoying, Senator Vitale.

Senator Gordon.

SENATOR GORDON: I would assume, at some point, we're going to get the Commissioners in here to respond to these issues.

SENATOR WEINBERG: Yes, yes.

Do we have any idea how long this transcript will take to produce?

HEARING REPORTER: It should be done by the end of the week; it goes to the proofreader; early next week it will be finished.

SENATOR WEINBERG: Good, thank you very much. That's much faster than a lot of other things I've seen around here, so thank you.

Thank you. The Committee meeting is closed.

**(MEETING CONCLUDED)**

## APPENDIX

## NEW JERSEY POLICY PERSPECTIVE

### **STATEMENT OF RAYMOND CASTRO, NEW JERSEY POLICY PERSPECTIVE, BEFORE THE SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE, ON THE MEDICAID COMPREHENSIVE WAIVER, JUNE 6, 2011**

Thank you for the opportunity to testify on the Department of Human Services' proposed Medicaid Comprehensive Waiver. First I would like to focus on the results of new research we are releasing today on the impact of proposed NJ FamilyCare cuts in the waiver on both parents and children and then later discuss the need for more transparency and accountability in the overall waiver process.

#### Impact on Parents

The impact of closing enrollment of poor working parents in FamilyCare that has been proposed by the Christie administration in the waiver would have a major negative impact across the state. Our analysis of the county data has found that low-income parents will be denied FamilyCare in *all* counties, no matter how affluent or suburban, and that these cutbacks will be particularly severe because they will be *in addition* to the reduction in parent eligibility that was implemented last year in FamilyCare. The combined impact of these cutbacks represents an anti-family policy that will reverse the progress that has been made in FamilyCare.

The first chart I have provided you shows the number of parents that will be denied health coverage in FamilyCare in each county as a result of last year's and the proposed cutbacks in eligibility. As might be expected, the counties with the largest number of working parents who would be denied FamilyCare - Essex and Hudson - are mostly urban. However there is also a major impact in some of the most suburban counties - like Ocean which ranked third highest in the state. Even some of the most affluent counties in New Jersey, such as Morris and Somerset, have large numbers of uninsured working parents who will be denied health care.

As you know, last year the eligibility level for new parents was reduced to 133 percent of the poverty level from 200 percent. According to the administration's newest estimates, that resulted in about 43,000 parents being denied FamilyCare in FY 2011. In FY 2012 that number will increase to an estimated 70,000. As part of the waiver, the administration has also proposed closing enrollment to all new parents between about 25 percent (on average) and 133 percent of the poverty level. For example, eligibility for a parent in a three-person family would be reduced to \$439 a month from about \$2,000. This policy would result in another 23,000 parents being denied health coverage.

So the total number of uninsured parents who would be denied health care in FY 2012 is a staggering 93,000. Even that figure is conservative because it does take into account proposed increases in cost sharing for parents in the waiver that will discourage participation.

One of the reasons for the large impact is that while only new parents would be denied eligibility in FamilyCare, the current enrollment would also decrease due to attrition. Under the proposed new rules, once a parent left FamilyCare they could not come back if they are uninsured again unless they were impoverished and became eligible for welfare. As the second table shows, there has already been a 37% decrease in enrollment of parents between 133 and 200 percent of the poverty level since enrollment was closed to those new parents about a year ago. We expect the same attrition rate in enrollment for those parents affected by the proposed cutback in the waiver.

At that rate, in less than three years, there would not be any parents left in FamilyCare. Sadly that is the stated goal of the administration, to return Medicaid to the days when only children were served (as well as people with disabilities and seniors).

#### Impact on Children

Since it appears children are a priority of the administration, we also researched the impact of closing enrollment of parents on their children. As the third table shows, the first month that enrollment of parents was closed last year, child enrollment stopped increasing, and after a year there still has not been any increase. This has resulted in an estimated 18,000 fewer children who would otherwise have enrolled in Family Care in this income category in the first year. We expect that number to about double next year.

We also compared enrollment of these children with children whose parents could continue to enroll in FamilyCare. There was a ten percent increase in enrollment of children whose parents were allowed to enroll compared to a one percent decrease in children whose parents were denied FamilyCare during the period when parent enrollment was closed. Unfortunately it is those new parents whose children have been increasing in FamilyCare who are the next targets of the cutbacks proposed by the administration in the waiver. Thus, we can expect fewer children enrolled in that category in the future as well.

These findings are consistent with our study<sup>1</sup> of the impact of closing enrollment of parents in 2002 on children in New Jersey as well as studies in other states.

Such a further reduction in the child enrollment rate will be devastating in a state that already has the 28<sup>th</sup> lowest child insurance rate in the nation (there were 228,100 uninsured children in New Jersey in 2008-2009).<sup>2</sup>

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<sup>1</sup> Raymond Castro, *Falling Short: Time to Keep the FamilyCare Promise*, New Jersey Policy Perspective, 2007.

<sup>2</sup> Kaiser Family Foundation, *Health Insurance Coverage of Children 0-18, states (2008-2009), U.S. (2009)*, based on Current Population Survey.

The entire premise of this proposed cutback is wrong; we cannot be fully successful in helping kids without also helping their parents.

This proposal also cannot be justified on a financial basis. The Department of Human Services estimates that out of the \$300 million that will be saved in the waiver, closing enrollment of parents will save only \$9 million. Furthermore the state will lose about \$17 million in federal matching funds so there will actually be a net loss of \$8 million in revenues to the state. Such an action completely contradicts one of the goals of the waiver, to maximize federal funds.

#### Overall Waiver and Recommendations

With respect to the overall waiver, the \$300 million in savings that is assumed in the budget, in addition to the \$240 million in other Medicaid savings, is excessive and disproportionately cuts Medicaid to balance the state budget.

We also oppose all requests in the waiver to broaden state flexibility to expedite cuts in services and eligibility. The state should only apply for waivers that improve services or make them more costs-effective without compromising quality.

There is also a major lack of sufficient information on the changes that would be made as a result of the waiver. There appear to be some good ideas in the concept paper but they are impossible to evaluate without a detailed plan and a complete financial analysis of where the savings in the waiver will be generated. There also needs to be sufficient time for the public to comment on the waiver and the plan.

The administration has indicated a willingness to work with the Legislature and the public on the waiver and therefore hopefully will act on these recommendations for greater transparency. If not, we urge state legislation, similar to which exists in many other states, which will limit the executive branch's discretion to reduce eligibility in Medicaid and FamilyCare and authorize greater oversight of all Medicaid waivers by the Legislature.

Thank you.

NEW JERSEY POLICY PERSPECTIVE

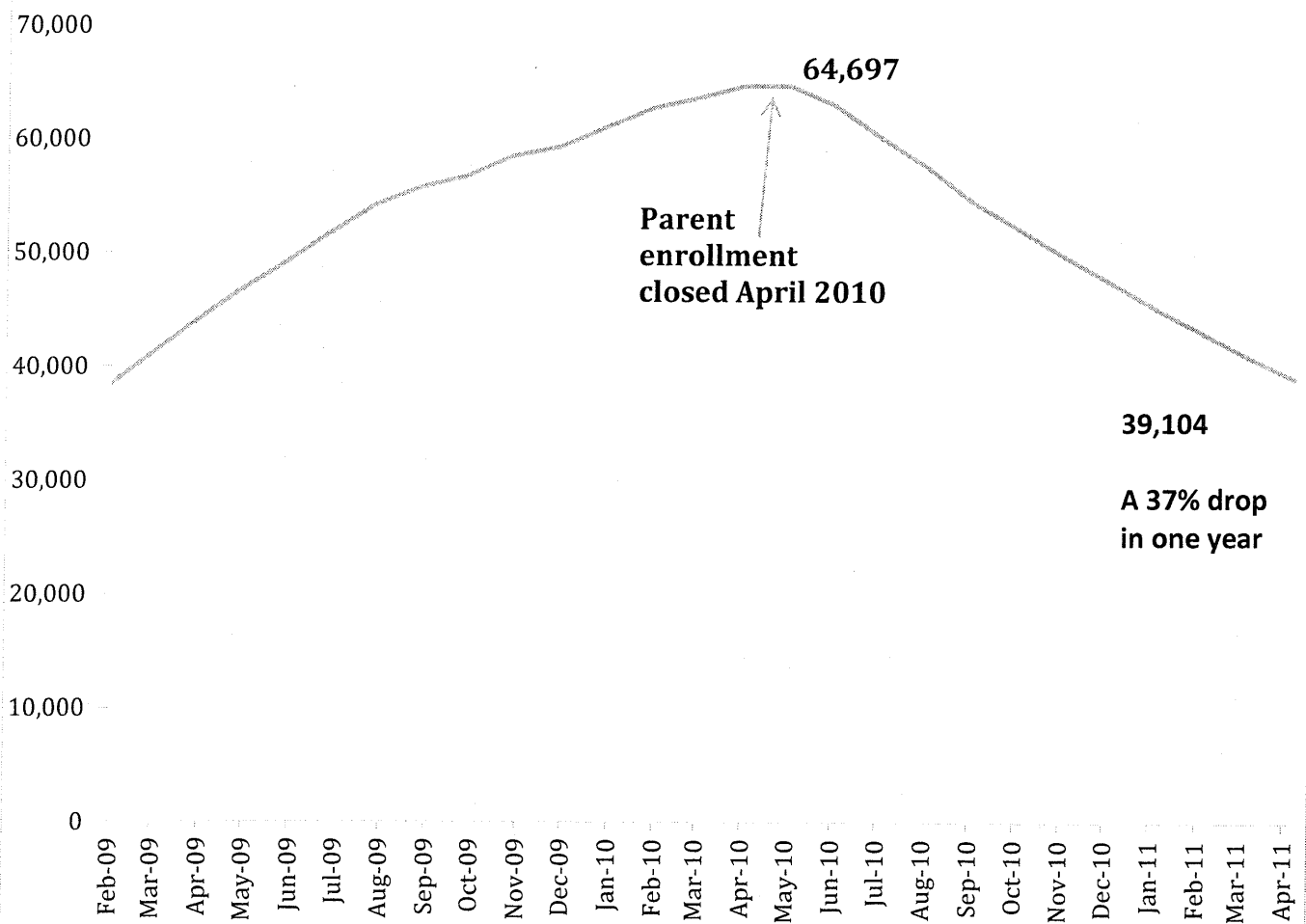
<b>Parents To Be Denied NJ FamilyCare Due to FY 2011 and Proposed FY 2012 Eligibility Reductions</b>					
	<b>Eligibility Cut to 133% of FPL from 200% in FY 2011</b>			<b>Proposed Cut to 25% FPL</b>	<b>Combined Cutbacks</b>
<b>County</b>	<b>Parents Denied FamilyCare FY 2011</b>	<b>Additional Parents Who Will Be Denied FamilyCare FY 2012</b>	<b>Total Parents Who Will Be Denied FamilyCare FY 2012</b>	<b>Parents Who Would Be Denied FamilyCare FY 2012</b>	<b>Total Parents Who Would Be Denied FamilyCare FY 2012</b>
<b>Atlantic</b>	1,486	933	2,419	831	3,250
<b>Bergen</b>	3,401	2,136	5,537	1,386	6,923
<b>Burlington</b>	1,816	1,141	2,957	708	3,666
<b>Camden</b>	2,991	1,878	4,869	1,535	6,404
<b>Cape May</b>	637	400	1,037	230	1,268
<b>Cumberland</b>	1,325	832	2,157	538	2,695
<b>Essex</b>	4,336	2,723	7,058	2,833	9,891
<b>Gloucester</b>	1,614	1,013	2,627	581	3,208
<b>Hudson</b>	4,316	2,710	7,026	2,816	9,842
<b>Hunterdon</b>	229	144	372	92	465
<b>Mercer</b>	1,455	914	2,369	684	3,053
<b>Middlesex</b>	3,639	2,285	5,923	1,792	7,715
<b>Monmouth</b>	2,306	1,448	3,754	1,108	4,862
<b>Morris</b>	1,297	815	2,112	515	2,626
<b>Ocean</b>	3,763	2,363	6,127	2,365	8,491
<b>Passaic</b>	3,849	2,417	6,266	2,161	8,427
<b>Salem</b>	379	238	617	270	887
<b>Somerset</b>	793	498	1,290	251	1,541
<b>Sussex</b>	635	399	1,034	212	1,246
<b>Union</b>	2,166	1,360	3,526	1,907	5,433
<b>Warren</b>	566	355	921	185	1,106
<b>TOTAL</b>	<b>43,000</b>	<b>27,000</b>	<b>70,000</b>	<b>23,000</b>	<b>93,000</b>

SOURCE: County estimates based on distribution of NJ FamilyCare parents as of January 2010 for FY 2011 cutbacks and April 2011 for proposed FY 2012 cutback applied to NJ DHS estimates of total persons affected.

\*Percent of 2011 Federal Poverty Level (FPL) for a family size of three (varies by family size).

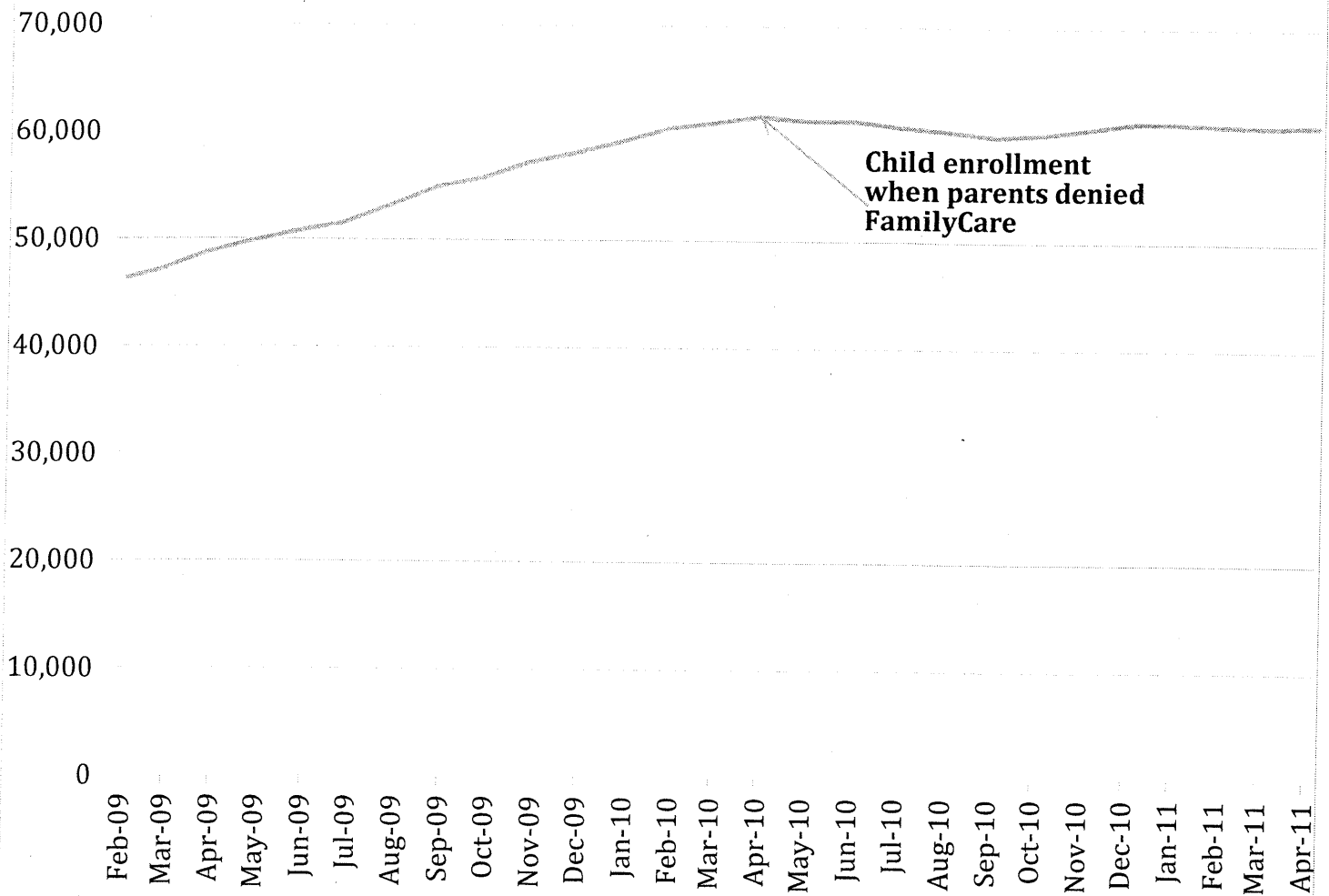


## Enrollment of Parents at 134-200% FPL in NJ FamilyCare After Enrollment is Closed to New Parents



SOURCE: New Jersey Division of Medical Assistance and Health Services monthly enrollment reports

# **Child Enrollment in NJ FamilyCare with Incomes between 134%- 200% of the Federal Poverty Level**



SOURCE: NJPP analysis of New Jersey Division of Medical Assistance and Health Services monthly enrollment reports



Giving Every Child A Chance

**TO: Members of the Senate Health, Human Services  
and Senior Services Committee**  
**FROM: Mary E. Coogan, Assistant Director  
Advocates for Children of New Jersey (ACNJ)**

Senator Weinberg, thank you for inviting ACNJ to participate in this discussion about the proposed Medicaid Comprehensive Waiver and other proposed changes to the budget that will impact the provision of health care services in New Jersey. The more conversations we have about the proposal the better as we all seek to understand the details and the impact of the proposed waiver will have upon children and families here in New Jersey.

Transparency is a critical component in the waiver process. We need a commitment to an open process where we get all the information we need in a timely manner to provide good feedback. As you may know the meeting of the Medicaid Assistance Advisory Council (MAAC) scheduled for next Monday, June 13 has been extended to a 4 hour meeting and moved to a larger location so that stakeholders and members of the public can come together to learn more and ask questions. I think this is a good indication that Commissioner Velez and Director Harr are interested in stakeholder participation. To ensure that the feedback is helpful and timely we need details regarding the components of the proposal and details regarding the anticipated \$300 million savings.

There is minimal information regarding the actual components of the waiver, including how the state believes it can achieve the purported savings and what kind of cap would be imposed on federal Medicaid funds coming into New Jersey. Detailed information must be provided so that there can be an informed discussion.

While the concept paper states that children's eligibility would not be affected, we believe it would be affected in two ways:

1. First, the significant reduction of parent coverage will ultimately impact child enrollment and the progress made to date in reducing the number of uninsured children in New Jersey.
2. The concept paper states that New Jersey is seeking flexibility in defining covered services and adopting limits on the amount, duration and scope of services as well as imposing copayments and other cost sharing. Specifically premiums for parents with incomes over 100

7x

percent of the federal poverty level are mentioned in the concept paper. Will these premiums be family premiums or will child-only coverage with no premium continue to be available?

### **Parent Coverage**

NJ FamilyCare is one of New Jersey's greatest success stories. ACNJ's NJ Kids Count project provides critical data on child well-being to state leaders, advocates and the public can use data to drive decisions. This leads to smarter choices that help more children.

### **Our 2011 NJ Kids Count data show:**

- The percentage of children without health insurance dropped from 11 percent in 2005 to 9 percent in 2009. This represents a 19 percent drop in the number of uninsured children, going from 234,000 to 190,000 uninsured children.
- The number of children enrolled in NJ FamilyCare increased from 538,020 in 2006 to 657,443 in 2010. This is a 22 percent increase.

New Jersey is well on its way to meeting the mandate of the *New Jersey Health Reform Act of 2008* to enroll all children in private or public health insurance. This is because many schools, community leaders and organizations, health care providers, faith-based organizations and others partnered with NJ FamilyCare to disseminate information about the program and to encourage parents to enroll their children, and low-income parents to enroll themselves. The proposed restrictions on parent enrollment are a giant step backwards.

As we all know, dependable health coverage helps kids get the checkups and preventive care they need to stay healthy and allows them to see the doctor when they are sick.

Children with health insurance are more likely to have regular doctors, or "medical homes," receive preventive care and receive consistent care for chronic illnesses like asthma and other conditions, such as near-sightedness. This avoids costly visits to the emergency room and prevents problems that can keep kids from attending school and succeeding in life.

Attached to my statement is an article from the George Washington University School of Public Health and Health Services entitled, *Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature*. Published in June 2007 and examined the research that explored "the relationship between public health insurance coverage of parents and the rate and effectiveness of coverage among children, as measured by insurance levels, coverage continuity, and appropriate use of pediatric health care." According to this literature review, the studies do suggest that parental coverage is associated with greater participation by children. The authors concluded that:

- Parental coverage appears to be associated with the more effective use of coverage among children as measured by access to care, use of preventive services, and having a regular source of care.

- Studies support the conclusion that with family coverage, health coverage tends to be more continuous and less interrupted.

As you all know our state's experience mirrors the research. When NJ FamilyCare program was established in 2000, insurance coverage was available to both children and low-income parents with household incomes up to 200 percent of the federal poverty level. Child enrollment increased until parent coverage was halted in 2002. Subsequently, the state experienced a decrease in child enrollment. Beginning in July 2005, the state gradually reinstated parent enrollment. The *Health Reform Act* reinstated the enrollment of parents up to 200 percent of federal poverty level, because you and other members of the New Jersey Legislature recognized the impact of covering parents on children's insurance enrollment. And we saw the enrollment numbers of children increase.

It is critical that we see data on what has happened to the children in families with household incomes between 134 percent and 200 percent of the federal poverty level in which the parent(s) were dropped from NJ FamilyCare coverage last year before a final decision is made regarding this aspect of the comprehensive waiver.

Commissioner Velez stated at a prior hearing that the state expects to save \$9 million by closing NJ FamilyCare to parents who earn more than about 25 percent of the federal poverty level, which amounts to about \$443 a month for a family of four. We need to see more details regarding the basis of this proposed savings.

### **Renewal and Churn**

NJ FamilyCare unlike private insurance requires that the insured renew each year. Although the waiver concept paper states that New Jersey will not terminate coverage for anyone now served in the program who remains eligible, we understand that many parents who are eligible and have been receiving NJ FamilyCare for several years are being terminated upon renewal because of the way income eligibility criteria is being administered.

I believe that some people do not realize they need to renew, forget to renew, or do not have the money to pay the premiums and are terminated from NJ FamilyCare thus creating a "churn" problem, i.e. situations in which eligible individuals lose and regain coverage in a short period of time resulting in the often unnecessary gaps in health care coverage. New Jersey, like many states, has a churn issue. There are administrative and fiscal costs associated with churning are also problematic. The process of enrolling, disenrolling and re-enrolling clients includes added paperwork burdens, staffing and resource demands, enrollment verification practices, other system updates and the delivery of "new member" related services to people who are not truly new members. Monthly DHS enrollment data from September 2008 through February 2009 reflect that an estimated 20,000 individuals (children and adults) were disenrolled each month.

### **Cost Sharing (Premiums and Copayments)**

Cost sharing can be used to change behavior and that is one stated purposed in the proposed waiver, i.e. to engage the population covered by Medicaid to use health care services appropriately. We do not take issue with the goal. However it is important that we learn more and avoid unintended negative consequences.

I am providing copies of an article on cost sharing from the Center for Children and Families at Georgetown University for members of the Committee. Cost sharing in Medicaid, which includes premiums, deductibles and copayments, can depress enrollment and reduce utilization, at times increasing the number of uninsured. "Unaffordable cost sharing places financial burdens on families and providers, despite the stated willingness of families to pay a reasonable share of costs." Providers and safety net institutions like community health clinics and public hospitals may have bear the burden of providing care without being able to collect the patient cost share.

The difficult question is what constitutes "reasonable and affordable" cost sharing? If a child is taken to the doctor once or twice a year for check-ups and/or illness, a \$5 or \$10 charge for an office visit is affordable. But for a family of a child with a chronic illness who has monthly or weekly visits or a child with a disability who requires multiple medical appointments each week, those copayments quickly become an enormous burden.

The article suggests that since there is no "correct" answer as to what level of cost sharing is appropriate for low-income families, we should consider "establishing a mechanism to monitor the impact of [our] cost sharing policies and to modify them if appropriate." The authors also suggest following the trend of some employers that exempt a wider array of services from cost sharing when it is cost effective to do so and creating family-friendly ways to make cost sharing payments.

### **Retroactive Eligibility**

The concept paper discusses seeking a waiver of retroactive eligibility for many categories of Medicaid beneficiaries. This change would primarily affect children as they are the largest group enrolled. We need a clarification as to whether the state is seeking to waive Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for children, and if so, we need to know, in what circumstances.

Again ACNJ thanks you for this opportunity and encourages members of the Committee to continue to ask questions and seek information throughout the waiver process.



## Cost Sharing for Children and Families in Medicaid and CHIP

### Framing the Issue

Cost sharing is an established part of health insurance in this country, but it is imperative to use it judiciously in Medicaid and CHIP to avoid deterring low-income children and families from using needed health care services. While some families served by these programs are able to pay premiums or make copayments, others, especially those at lower-income levels or with extensive health care needs, may find that such fees make it difficult for them to access needed care. The research on cost sharing is clear that premiums and cost sharing charges will decrease enrollment and use of services among low-income families, but cannot definitively answer the question of “What is an appropriate premium level?” or “How much cost sharing is acceptable?” As a result, policymakers must carefully consider the tradeoffs and their competing policy goals when setting premium and cost sharing levels in Medicaid and CHIP.

### Definitions

Cost sharing is a common feature in both private insurance plans and public insurance programs. While primarily a financing mechanism, cost sharing can also be used to affect the extent to which people enroll in or use services. There are three main types of cost sharing:

- **Premiums or enrollment fees** are payments that families must pay periodically (e.g., monthly, quarterly, or annually) to enroll in and continue to receive health care coverage.

- **Deductibles** are a specific dollar amount that a family must pay out-of-pocket before the insurance plan begins to cover services.

- **Copayments and coinsurance charges** are charges that beneficiaries pay when they receive a service. A *copayment* is a dollar amount that someone must pay when using a specific service. *Coinsurance* is similar to a copayment, but is expressed as a percent of the cost of the service received (rather than as a flat dollar amount).

Along with cost sharing charges, families may face other out-of-pocket costs for health care if they need services that are not included in their benefit packages. As a result, their total out-of-pocket costs can sometimes significantly exceed the amount that they spend on premiums and other cost-sharing charges.

### Legislative/Regulatory Authority

Within federal standards, states have discretion to impose limited cost sharing on children and families in Medicaid and CHIP.

**Medicaid.** Since Medicaid was originally designed largely for people with very limited incomes or serious health care conditions, it historically has sharply limited cost sharing. As a result of new federal standards adopted in 2005 (through the Deficit Reduction Act), states now have somewhat more flexibility to impose cost sharing and premiums on Medicaid beneficiaries, especially those who

are not deeply impoverished.<sup>1</sup> The detailed rules now governing state flexibility to impose cost sharing on children and families in Medicaid are outlined in Table 1. In general, they are designed to allow for only minimal cost sharing at the lowest income levels, but somewhat more if states expand coverage further up the income scale. For example, states cannot impose any cost sharing on children below 150 percent of the federal poverty level except in a narrow range of circumstances (e.g., using an emergency room for a non-emergency and for certain medications). Even at more moderate-income levels, federal rules also exempt some special services, such as preventive care for children, from any cost sharing.

**CHIP.** Created in 1997, the CHIP program allows states to expand Medicaid, create a separate CHIP program, or use a combination of both. Cost sharing rules in CHIP-funded Medicaid expansions are the same as those in Medicaid, whereas, as shown in Table 1, states have more flexibility to impose cost sharing in separate CHIP programs.

The CHIP law enacted in 2009 also requires states to provide a 30-day premium payment grace period under CHIP (for new coverage periods beginning on or after January 4, 2009) before terminating a child's coverage and to provide a notice to families within seven days of the possible termination and their right to appeal.

### Where States Stand

Due to the federal standards largely precluding it and states' sensitivity to the negative impact of cost sharing, most parents and children in public programs with income below 150 percent of the federal poverty level are not subject to significant cost sharing. The only states imposing premiums on children below 150 percent of the federal poverty level are Alabama, Arizona,

California, Delaware, Florida, Georgia, Idaho, Nevada, Rhode Island, and Utah, and they can do so only because they operate separate CHIP programs (or have received federal waivers to do so for their Medicaid population). The use of cost sharing varies far more across states when it comes to children with family income above 150 percent of the federal poverty level. According to a January 2009 survey of Medicaid and CHIP programs, 24 states charge premiums at 151 percent of the federal poverty level and 24 states charge premiums at 200 percent of the federal poverty level.<sup>2</sup>

Low-income families also sometimes pay a cost when using services, usually in the form of copayments. As of January 2009, 19 states require copayments for a non-preventive physician visit for a child with family income at or above 200 percent of the federal poverty level (ranging from \$5 to \$20), and 24 states require prescription drug copayments for children at this income level.<sup>3</sup>

(View

<http://ccf.georgetown.edu/index/medicaid-and-schip-programs> for up-to-date information on premiums for children in Medicaid/CHIP by state.)

### Research on Cost Sharing

The body of research on cost sharing is extensive and has been summarized in detail by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and by the Center on Budget and Policy Priorities (CBPP).<sup>4</sup> It indicates that cost sharing in Medicaid and CHIP can depress enrollment and reduce utilization, at times increasing the number of uninsured. Furthermore, unaffordable cost sharing places financial burdens on families and providers, despite the stated willingness of families to pay a reasonable share of costs. These themes are elaborated on in more detail below.



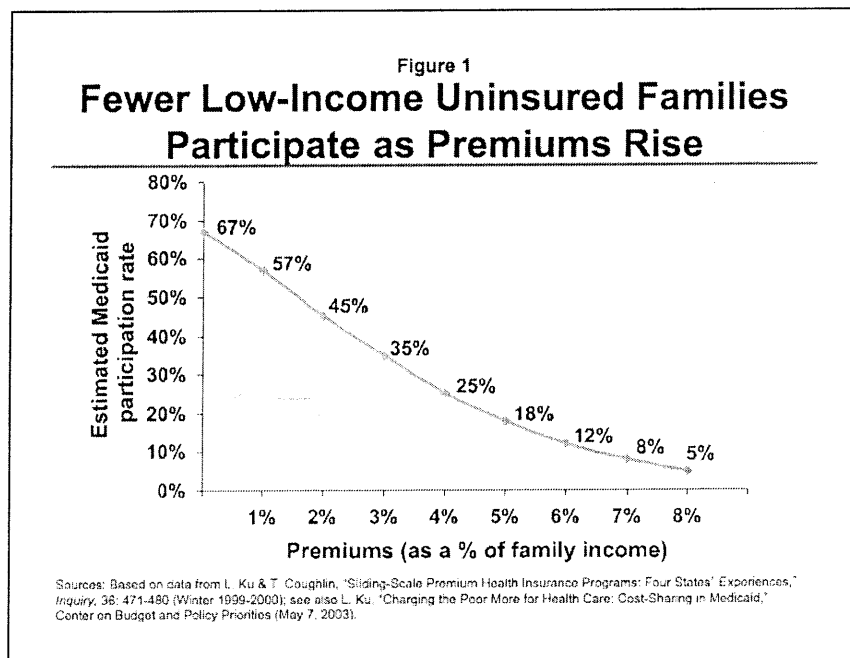
**1. Premiums in Medicaid and CHIP can reduce enrollment.** Research shows that premiums in Medicaid and CHIP can depress enrollment if the financial burden is too great in light of families' income and other expenses. This occurs both because fewer families will apply and more families will disenroll if premiums are too high. For example:

- An Urban Institute study of Medicaid expansions during the 1990's estimated declines in enrollment of 16 percent when participants are charged premiums that equal one percent of family income, enrollment declines of about 49 percent if premiums equal three percent of family income and enrollment declines of about 74 percent if premiums are set at five percent of family income.<sup>5</sup> In other words, even small premiums discourage participation, with higher premiums resulting in even less participation (Figure 1).

- New or increased premiums have been shown to reduce enrollment or increase/hasten disenrollment in CHIP programs in Arizona, Florida, Kansas, Kentucky, Maryland, Missouri, New Hampshire, New Jersey, Rhode Island, and Vermont.<sup>6</sup> A Florida study, for example, found that a \$5 premium increase reduced CHIP enrollment length by more than half, with lower-income children more severely impacted than higher-income children.<sup>7</sup> Another study of children in rural Arizona estimated that a \$10

increase in monthly CHIP premiums would cause 10 percent of enrolled children to lose coverage.<sup>8</sup>

**2. Even relatively small premium changes can lead to disenrollment.** Among low-income families, even modest-sounding changes in premiums can have a notable impact on enrollment. For example, in January 2003, New Hampshire increased premiums from \$20 to \$25 for children with income between 185-250 percent of the federal poverty level and from \$40 to \$45 for children with income between 251-300 percent of the federal poverty level. A study of the impact of the premium change found that the CHIP caseload dropped and then resumed growing three to five months after the premium increase, although at a slower pace than before the increase.<sup>9</sup> Overall, the study authors estimate that the implied effect was a 4 percent reduction in monthly caseload. Disenrollment occurred particularly among children with incomes between 251 percent and 300 percent of the federal poverty level.



### 3. Cost sharing can reduce use of services.

The seminal work on the topic of how copayments and coinsurance affect use of services comes from the classic RAND Health Insurance Experiment (HIE).<sup>10</sup> In the HIE, which ended in 1982, families were randomly assigned to either a free health plan or a health plan which required varying levels of cost sharing. The analyses of the HIA conclude that:

- Cost sharing reduces the use of both needed and unneeded health services, primarily because patients sometimes do not initiate care when faced with a cost-sharing charge;
- Cost sharing reduces the use of both effective and less-effective care, suggesting cost sharing has little impact on the appropriateness or quality of care sought; and
- Cost sharing seems to have little effect on health, however, the most vulnerable (i.e., the poorest and sickest) participants in the experiment had improved health outcomes under the free plan.

In sum, the HIE indicates that cost sharing is a somewhat blunt instrument for changing people's use of health care services – it will reduce the use of necessary and unnecessary care, and its impact is greatest on those with the fewest resources. In general, these same themes have been reaffirmed and echoed by more recent research on the topic. The KCMU and CBPP reviews of the literature on cost sharing in public programs for low-income families found that service-related cost sharing in Medicaid and CHIP, even when modest, can reduce utilization, result in unmet need, cause financial stress, and burden providers.<sup>11</sup>

### 4. Cost sharing has significant implications for providers and safety net institutions.

Due to their low incomes, some Medicaid/CHIP enrollees may be unable to afford cost sharing, and providers often bear the burden by providing care without being able to collect the patient cost sharing. For example, Oklahoma Medicaid providers in one survey reported that only 29 percent of the time do Medicaid beneficiaries pay cost-sharing charges.<sup>12</sup> Safety net institutions, such as public hospitals and community health clinics can end up being affected when cost sharing results in the loss of Medicaid/CHIP coverage. For example, research has confirmed that when children lose public coverage they are likely to become uninsured, and as a result, some care shifts from ambulatory care settings to more costly emergency department and hospital inpatient settings.<sup>13</sup>

**5. Medicaid and CHIP enrollees are not averse to reasonable cost sharing requirements and practices.** Many Medicaid and CHIP beneficiaries are prepared to pay a share of their health care costs. For example, a survey of potential Medicaid enrollees in Oklahoma found that 68 percent felt that a modest monthly premium was reasonable, 67 percent felt that \$5 - \$20 copayments were acceptable, and 53 percent thought that total annual out-of-pocket health expenses of 1-2 percent of family income was reasonable.<sup>14</sup> A focus group with parents of current and former CHIP enrollees also found that most do not mind paying premiums when they are reasonable and affordable, although sometimes the process of paying premiums can be problematic.<sup>15</sup> Focus group participants noted their appreciation of the balance between coverage and cost sharing. For example, participants would not necessarily want lower premiums if it meant higher copayments or less comprehensive benefits.

## Strategies

Some strategies for developing cost sharing and premium policies consistent with the goals of CHIP and Medicaid in providing coverage and necessary services to children and parents in low-income families include:

1. **Ensure that premium and cost sharing charges are affordable.** In making cost sharing decisions, it is critical to match premiums and other cost sharing charges to the amount that families can afford to pay. With the wide variation in the cost of living across states, state-specific studies on the amount of income available to low-income families to finance health care expenses after paying for other essentials, such as food and housing, should be taken into account when establishing cost sharing policies.
2. **Eliminate or minimize cost sharing for the lowest-income families.** The evidence is overwhelming that low-income families are more sensitive to cost sharing charges than their more moderate-income counterparts. In light of this, it is critical not to impose any cost sharing charges on the lowest-income families or, at a minimum, ensure that they are very modest. Most states already do this; for example, only ten states with separate state CHIP programs charge any premiums for children below 150 percent of the federal poverty level.
3. **Protect children and parents with extensive medical needs from excessive cost sharing charges.** For children and parents with extensive medical needs, even modest-sounding cost sharing charges can add up quickly. For example, a \$5 charge for an office visit may be affordable for the low-income family with a child who sees the pediatrician once or twice a year, but an enormous problem for a family with a child with a disability who requires multiple medical appointments each week. In response, some states have established monthly caps on the dollar amount that families can be required to pay in cost sharing charges, effectively preventing cost sharing charges from accumulating and imposing an excessive burden on those with particularly extensive medical need. For example, Minnesota imposes a small charge (\$3 per prescription) on parents filling prescriptions, but only for the first four prescriptions that they fill in a given month, and some mental health drugs are exempt from the copayment.
4. **Monitor the impact of cost sharing and make changes as needed.** Given that there is no “correct” answer as to what level of premiums and service-related cost sharing charges are appropriate for low-income families and children, it is important to consider establishing a mechanism to monitor the impact of a state’s cost sharing policies and to modify them if appropriate. Virginia, for example, discontinued CHIP premiums and Florida rescinded a premium increase after seeing the potential effects on enrollment. Specifically, Virginia imposed a \$15 per child per month premium for children between 150-200 percent of the federal poverty level; the state spent \$1.39 in administrative costs to collect every \$1 in premiums and some 6,000 children were at risk of losing coverage for failure to pay the premium.<sup>16</sup> In the face of this significant cost and potential loss of coverage, the state permanently eliminated the premiums in April 2002 and cancelled the coverage terminations. Florida increased its KidCare premium by \$5 in July 2003 but rescinded the increase for children with income below 150 percent of the federal poverty level in October 2004 after enrollment length decreased by 63 percent for children with income 101-150 percent of the federal poverty level.<sup>17</sup> A number of other states have sponsored studies to evaluate the impact of premium changes, which can be used to document if the impact of cost sharing

changes are greater than expected and pave the way for modifications.

**5. Exempt critical services from cost sharing charges for cost-effectiveness reasons.** Federal rules already prohibit states from imposing cost sharing charges on certain services, such as preventive care for children. States, however, may want to follow the growing trend among some employers of exempting a wider array of services from the usual cost sharing charges when it is cost-effective to do so. For example, in order to link cost sharing to value,<sup>18</sup> CHIP and Medicaid programs could exempt copayments for physician visits and medications needed to control asthma, diabetes, mental illness, and other conditions that lead to higher costs and complications if not managed well. The emerging evidence is that doing so can help people to better manage chronic conditions, potentially reducing long-term costs associated with complications. For example, one recent study found that a large employer's decision to reduce copayments for five chronic medication classes (e.g., diabetes) in the context of a disease management program lead to markedly better compliance with medication regimes.<sup>19</sup>

**6. Create easy, family-friendly ways to make cost sharing payments.** Most states accept premium payments through the mail, but a number of states are providing families with other options to make premium payments, such as on-line, at drug or grocery stores, or through automatic deductions from checking accounts.<sup>20</sup> These options are likely to gain in popularity and make it administratively easier for families to keep up with premium payments. Some states, such as Alabama and North Carolina, allow families to pay a single, relatively modest

annual enrollment fee, eliminating the need for monthly payments. (Note, however, that an annual enrollment fee likely needs to be set well below the annualized cost of monthly premiums because many low-income families will find it difficult to come up with a single, large payment).

It also is important to give families that miss premium payments an easy way to "cure" the non-payment and to re-enroll their children in the program. The CHIP law enacted in 2009 requires states to provide at least a 30-day premium payment grace period before terminating a child's coverage. Georgia's experience with a three-month "lock out" policy for families that failed to make a monthly CHIP premium payment highlights the risks of failing to do so. Within eight months of adopting its lock out policy, 80,000 children were locked out of PeachCare, almost 60 percent of whom had family incomes below 150 percent of the federal poverty level.<sup>21</sup>

## Conclusion

Given rising health care costs and the budget difficulties facing states, it is likely that Medicaid and CHIP programs will continue to experiment with changes to their premium and cost sharing policies in the years ahead. In doing so, states will need to continue to balance the challenge that cost sharing poses to low-income families with the need to keep Medicaid and CHIP costs under control. By keeping charges minimal, especially for the lowest-income families and those with extensive health care needs, and by setting up mechanisms to monitor and modify cost sharing policies as needed, states should be able to do so.

## Primary Resources

### Research on Cost Sharing in CHIP and Medicaid:

- L. Ku & V. Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005).
- S. Artiga & M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured (May 2005).
- J. Hudman & M. O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured (March 2003).
- Government Accountability Office, "Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries," (March 2004).

### Descriptions of Federal Medicaid and CHIP Cost Sharing Rules:

- E. Herz, "Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)," Congressional Research Service (January 25, 2007).
- J. Solomon, "Cost-Sharing and Premiums in Medicaid: What Rules Apply?," Center on Budget and Policy Priorities (February 28, 2007).
- State Medicaid Director Letters from the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, (June 16, 2006 and August 15, 2007)
- J. Guyer, C. Mann, & J. Alker, "The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families," Center for Children and Families (March 2006).

Table 1: Federal Cost Sharing Rules for Children in Medicaid and CHIP

	MEDICAID			CHIP		
	Mandatory Children <sup>a</sup>	Other Children 100-150% FPL	Other Children >150% FPL	Children <100% FPL	Children 100-150% FPL	Children >150% FPL
<b>AGGREGATE CAP</b>	5% of family income	5% of family income	5% of family income	5% of family income	5% of family income	5% of family income
<b>PREMIUMS</b>	Not allowed	Not allowed	Allowed (no upper limit)	Up to \$19 per month depending on family size and income	Up to \$19 per month depending on family size and income	Allowed (no upper limit)
<b>DEDUCTIBLES</b>	Not allowed	Up to \$2.10 per month	Up to \$2.10 per month	Up to \$2.10 per month	Up to \$3.15 per month	Allowed (no upper limit)
<b>COPAYMENTS/ COINSURANCE<sup>b</sup></b>						
<b>Preventive services</b>	Not allowed	Not allowed	Not allowed	Not allowed	Not allowed	Not allowed
<b>Outpatient services (including managed care services)</b>	Not allowed	Up to 10% of payment	Up to 20% of payment	Up to \$3.40 or 5% of payment	Up to \$5.50 or 5% of payment	Allowed (no upper limit)
<b>Institutional services</b>	Not allowed	Up to 50% of payment for first day of care or 10% of payment	Up to 50% of payment for first day of care or 20% of payment	Up to 50% of payment for first day of care	Up to 50% of payment for first day of care	Allowed (no upper limit)
<b>Emergency services</b>	Not allowed	Not allowed	Not allowed	Not allowed	Up to \$5.50 in hospital setting; 5% of payment in clinic or non-hospital setting	Allowed (no upper limit)
<b>Non-emergency use of ER<sup>c</sup></b>	Up to \$3.40 or 5% of payment	Up to \$6.80 or 5% of payment	Allowed (no upper limit)	Up to \$3.40 or 5% of payment	Up to \$10	Allowed (no upper limit)
<b>Prescription drugs</b>	Up to \$3.40 or 5% of payment for non-preferred drugs	Up to \$3.40 or 5% of payment	Up to \$3.40 or 5% of payment; or up to 20% of payment for non-preferred drugs	Up to \$3.40 or 5% of payment	Up to \$5.50 or 5% of payment	Allowed (no upper limit)

<sup>a</sup> Mandatory children include children under age six with family income below 133% FPL and children ages six to 17 with family income below 100% of the FPL. (For purposes of the cost sharing and premium provisions of the Medicaid law, 18-year olds are treated as adults.) The rules that apply to mandatory children also apply to children (without regard to age) for whom Title IV foster care or adoption assistance is being provided.

<sup>b</sup> If their families cannot pay the copayment or coinsurance charge, children in this group still must be provided with the service or prescription drug.

<sup>c</sup> Federal law allows states to impose cost sharing for non-emergency use of an ER only if a beneficiary has been provided with an appropriate referral to an alternative provider, such as a community clinic or doctor's office.

**Table 2: Federal Cost Sharing Rules for Parents<sup>a</sup> in Medicaid**

	<b>Parents &lt;100% FPL</b>	<b>Parents 100- 150% FPL</b>	<b>Parents &gt;150%FPL</b>
<b>AGGREGATE CAP</b>	5% of family income	5% of family income	5% of family income
<b>PREMIUMS</b>	Not allowed	Not allowed	Allowed (no upper limit)
<b>DEDUCTIBLES</b>	Up to \$2.10 per month	Up to \$2.10 per month	Up to \$2.10 per month
<b>COPAYMENTS/ COINSURANCE<sup>b</sup></b>			
<b>Preventive services<sup>c</sup></b>	Up to \$3.40 or 5% of payment	Up to \$3.40 or 10% of payment	Up to \$3.40 or 20% of payment
<b>Outpatient services (including managed care services)</b>	Up to \$3.40 or 5% of payment	Up to \$3.40 or 10% of payment	Up to \$3.40 or 20% of payment
<b>Institutional services</b>	Up to 50% of payment for first day of care	Up to 50% of payment for first day of care or 10% of total cost of stay	Up to 50% of payment for first day of care or 20% of total cost of stay
<b>Emergency services</b>	Not allowed	Not allowed	Not allowed
<b>Non-emergency use of ER<sup>d</sup></b>	Up to \$3.40 or 5% of payment	Up to \$6.80 or 5% of payment	Allowed (no upper limit)
<b>Prescription drugs</b>	Up to \$3.40 or 5% of payment	Up to \$3.40 or 5% of payment	Up to \$3.40 or 5% of payment; or up to 20% of payment for non-preferred drugs

<sup>a</sup> Pregnant women and institutionalized individuals are exempt from almost all Medicaid cost sharing.

<sup>b</sup> If they cannot pay the copayment or coinsurance charge, adults in this group still must be provided with the service or prescription drug.

<sup>c</sup> Copayments and coinsurance are not allowed for family planning services.

<sup>d</sup> Federal law allows states to impose cost sharing for non-emergency use of an ER only if a beneficiary has been provided with an appropriate referral to an alternative provider, such as a community clinic or doctor's office.

## Endnotes

<sup>1</sup> See E. Herz, "Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)," Congressional Research Service (January 25, 2007); and J. Guyer, C. Mann, & J. Alker, "The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families," Center for Children and Families (March 2006).

<sup>2</sup> D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured, (January 2009); updated by the Center for Children and Families.

<sup>3</sup> *Ibid.*

<sup>4</sup> S. Artiga & M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured (May 2005); and L. Ku & V. Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005).

<sup>5</sup> L. Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities (May 7, 2003); and L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, 36: 471-480 (Winter 1999-2000).

<sup>6</sup> See G. Kenney, *et al.*, "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research*, 42: 2354-2372 (August 2007); B. Shenkman, "Healthy Kids Program Changes in State Fiscal Year 2003-2004: Associations with Enrollee Case-Mix, Health Care Expenditures, and Disenrollment; Tab O, Impact on Cost Sharing," A Report to the Healthy Kids Corporation (November 2004); G. Kenney, *et al.*, "Effects of Premium Increases on Enrollment in SCHIP," *Inquiry*, 43: 378-392 (Winter 2006/2007); J. Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," *Journal of Policy Analysis and Management*, 26: 237-255 (March 2007); Maryland Department of Health and Mental Hygiene, "Maryland Children's Health Program: Assessment of the Impact of Premiums, Final Report," (April 2004); J. Ferber, "Measuring the Decline in Children's Participation in the Missouri Medicaid Program: An Update," Legal Services of Eastern Missouri (September 2006); J. Miller, *et al.*, "Demographics of Disenrollment from SCHIP: Evidence from NJ KidCare," *Journal of Health Care for the Poor and Underserved*, 15: 113-126 (February 2004); RI Medicaid Research and Evaluation, "Results of Rite Care Premium Follow-Up Survey #2," (July 2004); and S. Kappel, "Effects of Medicaid Premiums on Program Enrollment: Preliminary Analysis," Vermont Joint Fiscal Office, (April 8, 2004).

<sup>7</sup> J. Boylston Herndon, *et al.*, "The Effect of Premium Changes on SCHIP Enrollment Duration," *Health Services Research*, 43: 458-477 (September 2007).

<sup>8</sup> T. Johnson, M. Rimsza, & W. Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health*, 96: 709-715 (April 2006).

<sup>9</sup> *Op. cit.* (6), Kenney, *et al.* 2006/2007.

<sup>10</sup> See RAND, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," (2006).

<sup>11</sup> *Op. cit.* (4).

<sup>12</sup> Health Care Not Welfare Project, "Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program," Submitted to the Oklahoma Health Care Authority (January 31, 2004).

<sup>13</sup> M. Rimsza, R. Butler, & W. Johnson, "Impact of Medicaid Disenrollment on Health Care Use and Cost," *Pediatrics*, 119: e1026-e1032 (May 2007).

<sup>14</sup> Health Care Not Welfare Project, "Beneficiary Attitudes Towards Paying Enrollment Fees, Copayments, and Premiums to Obtain Health Insurance Coverage Under an Expanded Medicaid Program," Submitted to the Oklahoma Health Care Authority (January 31, 2004).

<sup>15</sup> S. Kannel & C. Pernice, "What Families Think about Cost-Sharing Policies in SCHIP," National Academy for State Health Policy, (October 2005).

<sup>16</sup> Virginia Department of Medical Assistance Services memo, (May 15, 2002); see also, L. Summer & C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," The Commonwealth Fund (June 2006).

<sup>17</sup> *Op. cit.* (6), Shenkman, 2004 and *Op. cit.* (7).

<sup>18</sup> For example, see R. Braithwaite & A. Rosen, "Linking Cost Sharing to Value: An Unrivaled Yet Unrealized Public Health Opportunity," *Annals of Internal Medicine*, 146: 602-605 (April 2007).



<sup>19</sup> M. Chernew, *et al.*, "Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment," *Health Affairs*, 27: 103-112 (2008).

<sup>20</sup> See N. Kaye, C. Pernice, & A. Cullen, "Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs," National Academy for State Health Policy, (September 2006).

<sup>21</sup> A. Essig & T. Sweeney, "PeachCare Lockout: Who Suffers?," Georgia Budget and Policy Institute (May 2005).

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# Department of Health Policy

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## Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature

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### Introduction

One of the policy questions expected to receive considerable attention during the State Children's Health Insurance Program (SCHIP) reauthorization process is whether -- and if so, under what circumstances -- to permit states to use SCHIP funds to cover parents. In 2006, the average Medicaid income eligibility level for coverage of working parents stood at 65% of the federal poverty level, and 15 states and the District of Columbia set income eligibility levels for this group at 100 percent of the federal poverty level or higher.<sup>1</sup> In 2005, 8 states used some portion of their SCHIP allotment funding, in combination with federal waiver authority under §1115 of the Social Security Act, to extend coverage to parents of SCHIP or Medicaid-enrolled children who are not themselves eligible for Medicaid or SCHIP. In addition, five states extended assistance to pregnant women otherwise ineligible for SCHIP or Medicaid by covering their "unborn children."<sup>2</sup>

This analysis examines research published since 2000 that explores the relationship between public health insurance coverage of parents and the rate and effectiveness of coverage among children, as measured by insurance levels, coverage continuity, and appropriate use of pediatric health care. The analysis begins with a brief overview of current Medicaid and SCHIP coverage options for parents and children. It then summarizes key findings from the literature related to the impact of covering parents on children's insurance enrollment. The analysis concludes with a discussion of the implications of existing studies for the question of whether to expand state flexibility to use federal SCHIP allotments to cover parents.

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<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, 2007. *Health Coverage for Low Income Parents* <http://www.kff.org/uninsured/upload/7616.pdf> (Accessed April 28, 2007)

<sup>2</sup> Neva Kaye, Cynthia Pernice, and Anne Cullen, 2006. *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (National Academy for State health Policy, 2006). [http://www.chipcentral.org/Files/Charting\\_CHIP\\_III\\_9-21-6.pdf](http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf) (Accessed April 28, 2007)

## Overview

### *Coverage of Low Income Parents*

Like other low income persons, low income parents (family incomes at or below 200 percent of the federal poverty level) experience a high rate of uninsurance. The 10.9 million parents who were uninsured in 2005 comprised nearly a quarter of the more than 46 million uninsured persons that year.<sup>3</sup> Among 20.4 million low income parents, 37 percent lacked coverage, 36 percent had employer sponsored coverage, and 27 percent had coverage through Medicaid or another source of public financing.<sup>4</sup>

There is broad agreement that diminished health insurance coverage among non-elderly adults is a cause for concern, in view of the individual and community-wide effects of high uninsurance rates.<sup>5</sup> Both the President and Members of Congress have presented options for addressing the problem. In his FY 2008 Budget, the President proposed to revamp federal tax policy to place new limits on federal tax subsidies for employer-sponsored coverage while simultaneously creating a new tax subsidy arrangement de-linked from employer coverage and accessible to all individuals, including low income uninsured persons. Other policy makers have proposed to extend coverage to low income, non-elderly adults by expanding direct coverage under existing public insurance programs through the creation of health insurance subsidy options within existing public financing systems.

Numerous states have expanded public financing for low income adults, including parents, either through reforms in direct public coverage (e.g., Medicaid or SCHIP waiver expansions) or by creating other sources of funding for health insurance subsidies. Whatever form they take (i.e., individual payments or direct purchase through a publicly funded system), these subsidized arrangements typically involve enrollment in private coverage. Thus, regardless of whether effectuated through individual financing or direct, public insurance expansions under Medicaid or SCHIP, states actualize coverage by using market-based coverage strategies. As a practical matter therefore, the line between "direct" coverage and "coverage subsidies" has become increasingly blurred. What remains is a clear desire across the political spectrum to improve coverage of adults.

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<sup>3</sup> Kaiser Commission on Medicaid and the Uninsured, 2007. *Health Coverage for Low Income Parents* <http://www.kff.org/uninsured/upload/7616.pdf> (Accessed April 28, 2007)

<sup>4</sup> Id.

<sup>5</sup> Institute of Medicine, 2003. *A Shared Destiny: Community Effects of Uninsurance* (National Academy Press, Washington D.C.); Institute of Medicine, 2002. *Care without Coverage: too Little, Too Late* (National Academy Press, Washington D.C.); Jack Hadley, 2007. Insurance Coverage, Medical Care Use, and Short Term Health Changes Following An Unintentional Injury or the Onset of a Chronic Condition," *JAMA* 297:10 (March 14) 1073-1084; Kaiser Commission on Medicaid and the Uninsured, 2007. *Health Coverage for Low Income Americans: An Evidence-Based Approach to Public Policy* <http://www.kff.org/uninsured/7476a.cfm> (Accessed April 28, 2007)

For this reason, the fundamental policy question appears to be not *whether* to publicly subsidize coverage for low income parents but instead, how to finance and structure the subsidy (through tax expenditures or direct financing). Another question is how high up the family income range public subsidies – whatever form they take -- should reach. Those who advocate for the use of tax financing view this approach as one that brings equity to tax policy while promoting market efficiencies. Those who support public financing tend to focus on the natural and logical evolution of such an approach in light of current practice, as well as the greater ease by which direct spending policies can be used to create more broadly accessible and affordable health insurance markets. The Massachusetts health reform plan, which relies on direct public financing to make affordable care available through a mechanism known as the Connector, offers a good example of this hybrid strategy, which relies on direct public financing to create more widely available and affordable market options.

#### *Low Income Parent Coverage in a SCHIP Reauthorization Context*

Medicaid and SCHIP offer parallel pathways to expand public insurance coverage of low and moderate income children. In the context of SCHIP reauthorization, the question is whether to carry this parallelism where children are concerned into the parental coverage arena. The answer to this question lies at least part in a decision as to whether covering parents actually represents sound *child health policy*. Some have argued that coverage of parents is not only good for parents but furthermore, that extending coverage to parents promotes not only coverage of children but also the more effective use of coverage in terms of increased access to care and a greater use of appropriate care.<sup>6</sup>

It is because of this assertion regarding the *beneficial pediatric effects of family coverage* that the case for creating parallel parental coverage flexibility under both Medicaid and SCHIP has arisen.

The nation has a long history of approaching coverage in terms of families, not only children. It is the custom in the employer-sponsored market to offer family coverage. Furthermore, emphasizing family coverage under public insurance is of course not new to public insurance. From the time of its 1965 enactment, Medicaid has mandated coverage of family units consisting of impoverished “dependent children” and their “caretaker relatives” (as these terms historically were used in welfare policy).<sup>7</sup> Only during the past 30 years – since the first Medicaid child expansion proposals were introduced in 1977 by President Jimmy Carter<sup>8</sup> – has a child-specific expansion focus come to dominate national

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<sup>6</sup> Richmond, L.M. 2007. Panelists Debate Appropriateness of covering Adults Under SCHIP. BNA Health Care Daily Report. 12(71) ISSN 1091-4021

<sup>7</sup> Sara Rosenbaum and David Rousseau, 2001. “Medicaid at Thirty-Five” *St. Louis University Law Jour.* 45:7. 7-42

<sup>8</sup> Id.

Medicaid policy reform discussions. Furthermore, two notable Medicaid expansions – the welfare reform amendments of 1987 and 1996 – contain provisions to either ensure or permit the coverage of parents.

Medicaid's original emphasis on coverage of families was not the result of an evidence-based policy decision; instead, it reflected the value placed on family coverage generally, as well as underlying federal cash welfare assistance policy, as modified through subsequent welfare reform initiatives.

The question now is whether there exists an independent evidentiary basis to further align SCHIP coverage options with Medicaid policy, in this case, in a parental coverage context. The result of this expanded parallelism would be that state coverage of parents, as is the case with children, would be incentivized by means of enhanced federal payments

## **Methods**

Using standard literature search techniques aimed at both peer-reviewed studies and the more rapidly available “grey literature” that dominates much health services research linked to health policy, we identified 9 studies published since 2000 that expressly consider the child health effects of parental coverage through public insurance programs. Because the Medicaid parental coverage option was a feature of the welfare reform legislation of 1996,<sup>9</sup> it is not surprising that this research began to appear in 2000 and that the studies overwhelmingly focus on the effects of Medicaid parental coverage expansions. Several studies examine specific expansion efforts, while others use national or state-level survey data to consider the effects of parental coverage.

## **Findings**

Although varying in the source of data used and the specific questions posed, the studies tend to be quite consistent, showing positive effects on children when parents have coverage.

### *Effects on Coverage*

All studies measure the coverage effects on children of parental coverage. All studies show positive coverage effects on children – in some cases modest, and in some, substantial – from parental coverage. Gundelman and Pearl, Gundelman et. al., and Sommers et. al., also conclude that parental coverage improves the continuity of coverage in children and reduces the likelihood of breaks in coverage.

Parental coverage does not affect eligibility standards for children, in view of the fact that to begin with, children's eligibility standards typically are higher than

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<sup>9</sup> Id.

those used for adults. (Aizer and Grogger) At the same time, the studies uniformly show that parental coverage increases enrollment rates among eligible children.

Two studies address health insurance crowd-out and find that extending coverage to parents results in little if any crowd-out effect on children, in light of the low levels of access to privately sponsored coverage among low income families to begin with. (Aizer and Grogger; Dubay and Kenney)

There are no studies that suggest that covering parents diminishes coverage for children. Because the proportion of eligible but unenrolled low income children is so high, the issue is the *significance* of the coverage gains for children, not whether states that cover parents do so by diminishing coverage for children.

Sommers et. al. find that the positive effects of parental coverage on children's coverage are substantially lessened in states that administer separate SCHIP programs while requiring parents to secure coverage through Medicaid. Thus, for example, a state may set Medicaid parental coverage at 200 percent of the federal poverty level and children's Medicaid coverage at 100 percent of the federal poverty level while reserving SCHIP funds for a separate program for children with incomes between 100 and 200 percent of the federal poverty level. The Sommers study might support a conclusion that parental coverage might help boost eligibility levels for the poorest children (i.e., those who also obtain coverage through Medicaid) while having only a modest effect on enrollment rates among near-poor children. The authors attribute this finding to the confusing effects of requiring that families navigate separate programs in order to achieve coverage for themselves and their children.

*Effects on Access and Health Status as Measured by Use of Care, Use of Appropriate Care, Having a Regular Source of Care, and Other Measures*

Six of the 9 studies show that parental coverage has a positive effect on access to health care in terms of use of any care, use of preventive services, having a regular source of care, and having unmet health care needs. One particularly interesting study by Gundelman et. al. finds that parental coverage also lessens feelings of discrimination, suggesting the broader psychological value of family coverage in addition to its value in achieving higher levels of more appropriate health care use.

## **Discussion**

This review of studies examining the effects on children of parental coverage under public insurance program suggests that such coverage is associated with greater participation by children. The studies also support the conclusion that coverage tends to be more continuous and less interrupted and represents new, rather than substitution, coverage. Parental coverage also appears to be

associated with the *more effective use of coverage* among children, as measured by access to care, having a regular source of care, and using preventive services.

Making parental coverage possible also appears to be consistent with current employer coverage custom and practice, as well as with Medicaid's historical emphasis on family coverage. Over the past 30 years, particular attention has been paid to the coverage of children. At the same time, federal legislative policy dating to Medicaid's original enactment and continuing through the welfare reform laws enacted by Congress in the 1980s and 1990s have traditionally emphasized the importance of family coverage.

Offering coverage for parents – especially low income parents who are extensively uninsured and who may have significant unmet health needs – appears to operate as an incentive for families to both seek and use coverage. Low income parents who are uninsured have significantly reduced rates of health care use; coverage of parents appears to offer an important strategy for increasing access to, and use of, appropriate health care. Like other parents, low income parents who enroll in coverage also seek benefits for their children.

The question becomes the meaning of these studies for SCHIP policy reforms. States already have an option to extend Medicaid coverage to parents, at regular Medicaid federal matching rates. Recent federal Medicaid flexibility amendments enacted as part of the DRA may further encourage states to combine Medicaid and SCHIP coverage reform strategies, by using Medicaid to extend coverage to more parents, who in turn might then be enrolled in the same benchmark plans available to SCHIP-eligible children. (In the case of Medicaid-eligible children enrolled in such plans, benchmark coverage would be accompanied by EPSDT “wraparound” benefits). At least one study reviewed here also suggests that such two-pronged strategies should take care to make such expanded coverage arrangements as seamless as possible, so that parents do not view the task of enrolling both themselves and their children as effectively having doubled in the degree of difficulty involved. The more that the enrollment process diverges by payer source, the less may be the beneficial impact on children's enrollment of a family coverage strategy.

Given the state of current policy, therefore, the question is whether to expand SCHIP/Medicaid parallelism by adding parental coverage flexibility. Whether to expand this parallelism approach depends on the degree to which policy makers believe that *enhanced federal matching funds* should be preserved only for child health expansions and that expansion of coverage for parents should take place only at the regular federal matching rate.

Several SCHIP reauthorization measures introduced to date seek to incentivize states to use their allotments to reach uninsured children with moderate family incomes, as well as to streamline the eligibility determination and enrollment



process for all eligible children. One option might be to allow states that meet child coverage milestones to apply their remaining SCHIP allotment funds toward parental coverage. In this way, children would remain the principal beneficiaries of reform, while states that wish to do so could apply the balance of their allotments toward expanded coverage of parents at a preferred federal rate.

The benefit of this approach would be that it would result in parental coverage while also acting as a further enrollment incentive for children. Its limitation would be that once invested in parental coverage, federal SCHIP would not be available for re-allocation to states that had not yet met national child health coverage targets or whose federal allotments fall short of reaching actual need. Similarly, allowing the use of SCHIP funds to reach parents might lessen the level of federal funding available to invest in strengthening and improving pediatric coverage levels as well as the quality of pediatric health care.

Since the issue is not whether parental coverage is good for children but how much the federal government should be willing to pay to achieve family coverage, a logical response might be to permit the parallel use of SCHIP allotments when national child health coverage benchmarks are met. At the same time, the FY 2008 Conference Agreement reached on May 16 appears to set a proposed funding commitment tied to the number of children who are currently eligible but not enrolled in either Medicaid or SCHIP. Thus, bringing parental coverage parallelism to SCHIP policy might be expected to result in little if any parental coverage if the SCHIP reauthorization also contains expanded child coverage benchmarks. There simply would not be sufficient funds to cover all currently eligible children, meet expanded child health coverage benchmarks, and cover parents.

One additional option that might be considered is to permit the use of SCHIP allotments for parental coverage by states that achieve national children's coverage benchmarks through Medicaid expansions at the regular federal matching rate. Medicaid and SCHIP offer states parallel means of covering low and moderate income children and parents. Since the evidence shows that parental coverage is more costly than coverage of children, SCHIP's enhanced federal contribution formula ultimately might prove to be a more valuable financial incentive where adult coverage is concerned. This approach would give states an additional pathway toward improved family coverage while maintaining national children's coverage goals. The approach makes particular sense in states such as States such as Minnesota, Rhode Island, and New Mexico, whose regular Medicaid coverage policies for children had already reached enhanced levels (300 percent, 250 percent, and 185 percent of the federal poverty level respectively). Where a state already has made a child health investment at the regular Medicaid matching rate, it may make particular sense to permit the state to invest its allotment in parental coverage in order to avoid penalizing the state for having invested in children at the regular Medicaid financial contribution rate.

**Studies Examining the Effects of Parental Coverage on Children's Health Insurance Coverage(C), Access (A), and Health Status Through Appropriate Health Care Use (H)**

Study	Year	Issues	Summary
1. Ku, L., and M. Broadus. 2000. <i>The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms.</i> (Center on Budget and Policy Priorities. Washington, DC.);	2000	C, A, H	<p>Assessment of expansion implementation in 3 states in 1994, which produced the following results:</p> <ul style="list-style-type: none"> <li>• A 16 percentage point increase in Medicaid participation rates among low income children under age six compared to a 3 percentage point increase among young children in states that did not enact similar expansions.</li> <li>• Improved use of health care among both parents and children in expansion states, showing greater use of preventive services, more continuity of care, and fewer unmet health needs.</li> </ul>
2. Lambrew, J.M. 2001. <i>Health Insurance: A Family Affair.</i> (The Commonwealth Fund, New York).	2001	C	<p>Examination of the relationship between health insurance coverage of children and parents, showing the following:</p> <ul style="list-style-type: none"> <li>• 90% of low-income children with insured parents are covered through some form of health insurance, compared to 48% of children whose parents are uninsured.</li> <li>• Despite Medicaid/SCHIP eligibility, 95% of uninsured children with family incomes below 200% FPL remain unenrolled. Nearly 75% of uninsured children have at least one uninsured parent.</li> <li>• States that expand Medicaid to parents show uninsured rates among low income children that are over 40% lower.</li> </ul>

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Study	Year	Issues	Summary
3. Aizer, A., and J. Grogger. 2003. <i>Parental Medicaid Expansions and Health Insurance Coverage</i> . (NBER Working Paper 9907).	2003	C	<p>Using data from the March annual demographic supplement of the Current Population Survey to examine Medicaid eligibility expansions for parents from 1996-2001, the authors analyze the effects of expansion on insurance status and find the following:</p> <ul style="list-style-type: none"> <li>• Parental eligibility expansions did not expand eligibility for children, because the expansions reached a group of parents with family income levels below those already established for children.</li> <li>• However, parental eligibility expansions increased the <i>likelihood of Medicaid coverage</i> for both minority parents and children (Hispanic: 4.8% for mothers and 6.7% for children; Black: 7% for mothers and 8% for children)</li> <li>• Parental eligibility expansions increased the <i>likelihood of any kind of coverage for minority parents and children</i> ( Hispanic: 4.2% for mothers and 3% for children; Black: 4.4% for mothers and 6.3% for children)</li> <li>• Among White non-Hispanic parents and children, parental eligibility expansions slightly decreased the likelihood of coverage among parents while slightly increasing coverage of children.</li> </ul>
Davidoff, A., L. Dubey, G. Kenney, A. Yemane. 2003. <i>The Effect of Parents Insurance Coverage on Access to Care for Low-Income</i>	2003	C, A, H	<p>Using data from the 1999 National Survey of America's Families, the authors examined the correlation between uninsured parents and children's coverage and access to health care and found the following:</p> <ul style="list-style-type: none"> <li>• In 1999, almost 90% of uninsured, low-income (family income below 200% FPL), children had an uninsured parent.</li> <li>• Low income children with uninsured parents are 6.7% less likely to</li> </ul>

Study	Year	Issues	Summary
Children. Inquiry 40, (254-268)			<p>have well child visits and 6.5% less likely to have any physician visit. Low income uninsured children are 9.6% less likely to have a usual source of care (compared to children covered by Medicaid). Uninsured children are 22.3% less likely to have any physician visits and 28.3% less likely to have well child care when compared to insured children.</p> <ul style="list-style-type: none"> <li>• Low income insured children, with an uninsured parent are 4.1 % less likely to have any physician visit and 4.2% less likely to have a well child visit.</li> <li>• There is only a marginal effect of parental insurance on the rates of care for children.</li> <li>• If a parent is uninsured, then there is an effect on the child's use of health care and a positive spillover effect on children in general.</li> <li>• Expanding care to parents has a small but meaningful gain in access for children who are already insured.</li> </ul>
4. Dubay, L., G. M. Kenney. 2003. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid". <i>Health Services Research</i> . 38(5).	2003	C	<p>Using data from the 1997 and 1999 National Survey of America's Families, the authors examined whether public health insurance coverage expansions for parents increase child Medicaid participation rates and found as follows:</p> <ul style="list-style-type: none"> <li>• Extending coverage to parents increases participation in Medicaid among children and leads to lower overall uninsured rates among children.</li> <li>• Substitution effects (i.e., exchange of private for public coverage) are present but low because of the limited availability of private coverage for low income adults.</li> </ul>

Study	Year	Issues	Summary
5. Guendelman, S., and M. Pearl. 2004. "Children's Ability to Access and Use Health Care" <i>Health Affairs</i> . 23(2), 235-244.	2004	C, A, H	<ul style="list-style-type: none"> <li>• Expanding coverage for parents increases children's participation and utilization rates, even among children who are already insured.</li> <li>• States that do not provide family coverage have a lower percentage of poverty-related children participating in the Medicaid program (57.1%) when compared to states that do provide publicly financed family coverage plans (78.5%) as well as those that provide family coverage through Medicaid expansions (80.8%).</li> <li>• In a specific example, after its Medicaid expansion, Massachusetts saw a 21.3% increase in children's coverage compared to a 3.6% increase in other states. Overall uninsured rates among children declined at an 11% greater rate than in other states.</li> </ul> <p>The authors examine data from the National Health Interview Survey and found the following:</p> <ul style="list-style-type: none"> <li>• There exists a strong relationship between parents' and children's insurance status and type of coverage. Specifically, 84% of uninsured children have parents without insurance, 13% had parents with private insurance and 3% had a parent with public coverage. Conversely, 53% of publicly insured children have parents with public insurance, 16% have at least one privately insured parent and only 32% had parents who themselves had no health insurance. Similarly, 95% of privately insured children have at least one parent with private insurance, 1% have a publicly insured parent and 4% have uninsured parents.</li> <li>• Among families with child-only health insurance, the probability of breaks in coverage is 4% higher, while the probability of having a regular source of health care is 8% lower.</li> <li>• Extending coverage to parents is associated with continuous</li> </ul>

Study	Year	Issues	Summary
			<p>coverage and a greater likelihood of regular use of health care among children.</p> <ul style="list-style-type: none"> <li>Although the benefits to children that flow from parental coverage expansion are non-significant, parental coverage does appear to have some effect on reducing breaks in coverage and promoting continuity of care.</li> </ul>
6. Gifford, E.J., R. Weech-Maldano, P. Farley-Short. 2005. Low-Income Children's Preventive Services Use: Implications of Parents' Medicaid Status. Health Care Financing Review. 26(4), 81-94	2005	C, A, H	<p>Using data from the 1996 Medical Expenditure Panel Survey (MEPS), the authors examine the effect of parents' Medicaid status on health care utilization among young children and find as follows:</p> <ul style="list-style-type: none"> <li>Children's use of health services is related to their parents' use of health services, an important correlation in a health insurance context, since uninsured adults use 60% less ambulatory health care than insured adults.</li> <li>Extending Medicaid or SCHIP coverage to parents has a spillover benefit for children. While providing Medicaid to uninsured children results in a 14% increase in well-child visits, extending coverage to both children and parents increases well child visits by 24%.</li> <li>Having an uninsured parent reduces the probability of a well child visit by 3.5% among publicly insured children and by 11.8 % among privately insured children.</li> </ul>
7. Guendelman, L., M. Wier, V. Angulo, D. Omen. 2006. "The Effects of Child-Only Insurance Coverage	2006	C, A, H	<p>Using secondary data from the 2001 California Health Interview Survey (CHIS), the authors compared child-only coverage to family coverage with respect to health care access and utilization among low income children and find as follows:</p> <ul style="list-style-type: none"> <li>As in national estimates, there is an association between the</li> </ul>

Study	Year	Issues	Summary
<p>and Family Coverage on Health Care Access and Use: Recent Findings Among Low-Income Children," <i>California Health Services Research</i>. 41 (1), 125-147.</p>			<p>insurance status of children and parents. 72% of uninsured children had uninsured parents, 20% had privately insured parents and 8 % had publicly insured parents. Conversely, 66% of publicly insured publicly insured children had publicly insured parents, 14% of parents were privately insured and 20% had uninsured parents.</p> <ul style="list-style-type: none"> <li>• The absence of family coverage had a significant effect on access and utilization. Parents who lacked family coverage showed 6 times the odds of lacking consistent care, an increase in the rate at which they felt affected by discrimination, and had a lower probability of care in a timely fashion. Child-only coverage also increased the odds of breaks in insurance coverage, the likelihood of no usual source of care, the likelihood of seeking public care, and feelings of discrimination.</li> <li>• Providing insurance to both children and parents would be associated with a decrease in health disparities and a reduced incidence of breaks in health insurance coverage. Coverage of parents would also increase the likelihood of a regular source of care and would reduce feelings of discrimination.</li> </ul>
<p>8. Ku, L., M. Broadus. 2006. Coverage of Parents Helps Children, Too. Policy Priorities. Center on Budget and Policy Priorities. Washington, D.C.</p>	<p>2006</p>	<p>C, A, H</p>	<p>The authors summarize earlier research into parental coverage and conclude as follows:</p> <ul style="list-style-type: none"> <li>• Covering both parents and children creates an incentive for parents to obtain and keep coverage for their children and families. Covering parents also increases their knowledge of the system and thus informs them of their options for their children.</li> <li>• Covering parents affects children's access and utilization, improves child health, and improves the health of parents. Research suggests that increasing coverage to low-income parents will have a direct</li> </ul>

34x

Study	Year	Issues	Summary
9. Sommers, B.D. 2006. "Insuring Children or Insuring Families: Do Parental and Sibling Coverage Lead to Improved Retention of Children in Medicaid and CHIP" <i>Journal of Health Economics</i> . 25, 1154-1169.	2006	C	<p>effect on coverage of children</p> <p>Using the Current Population Survey, March Supplement (1999-2004), the author studied the drop out rates among children in Medicaid and SCHIP, comparing children with and without parental coverage.</p> <ul style="list-style-type: none"> <li>• Approx. 30% of children in Medicaid/SCHIP will not be enrolled in 12 months, and drop-out accounts for almost 50% of this figure.</li> <li>• Previous research suggests that covering parents with Medicaid increases children's Medicaid enrollment by 3-14%. Parental (mostly maternal) coverage is a predictor of (and protector against) child drop-out.</li> <li>• At the same time, States that administer SCHIP as a separate program from Medicaid show a 45% increased risk of drop-out, a result potentially associated with the greater complexities families encounter in navigating separate programs.</li> </ul>

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***Empowering People: Providers Shaping Policies***

**ABCD Testimony on the Proposed Comprehensive Waiver  
Before the Senate Committee on Health, Human Services and Senior Citizens  
June 6, 2011**

The Alliance for the Betterment of Citizens with Disabilities (ABCD) thanks the Chair, Senator Weinberg and the other members of the Senate Committee on Health, Human Services and Senior Citizens for the opportunity to provide comments about the proposed Comprehensive Waiver. I am Megan Ducoff, Policy Analyst for ABCD.

ABCD is a statewide organization representing member agencies that provide an array of community-based services to more than 15,000 people with complex physical and neurological developmental disabilities and their families. ABCD member agencies provide services to a range of individuals with multiple physical disabilities and neurological disabilities.

Our testimony today will focus solely on the areas of the Comprehensive Waiver which will impact people with developmental disabilities. We are generally pleased with the scope of the Comprehensive Waiver for people with developmental disabilities but still have a few questions.

When Governor Christie proposed his budget in February ABCD expressed in its budget testimony that it was intrigued by the Medicaid restructuring discussed in the Budget Summary. We explained that there was too little information to fully analyze its impact on Medicaid beneficiaries and on the Medicaid program. We stated that we supported the idea of more flexibility between Medicaid programs. Currently, if an individual needs services provided under one Home and Community-based Waiver they must dis-enroll from one waiver to go onto another one. A comprehensive waiver could provide flexibility and allow an individual to receive services regardless of their initial waiver. This would change the funding silo mentality of services to people with significant needs.

**Maximizing Federal Revenue**

ABCD expressed the need to maximize federal funds for home and community-based services. There are two options in the Affordable Care Act which New Jersey should explore as part of Medicaid restructuring. The first is the Community First Choice Option. This new option allows a State to include Medicaid home and community-based attendant services for people's long term supports as part of the Medicaid State Plan. The State, if it chooses this option, will receive 6% increased Federal Medical Assistance Percentage (FMAP) for home and community-based attendant services.

The second option is the Balancing Incentives Payments Program which will provide enhanced federal Medicaid matching funds to states that adopt strategies to increase the proportion of their total Medicaid Long Term Care spending to Home and Community-Based Services and implement delivery systems reform. With this program, New Jersey would receive a 2% enhanced FMAP.

Given the fact that the information related to Medicaid restructuring and other Long Term Care proposals in the budget demonstrate that the Administration is interested in moving away from funding nursing homes to serving people in the community, we believe that it is imperative that these two options are included in the discussion. It is incumbent upon New Jersey to use all federal funds which are intended to support policies to move to community-based services for seniors and people with disabilities. ABCD has performed a number of analyses on these and other options available in the Affordable Care Act and have shared that information with the Administration. We look forward to working with them to make these programs a reality so that there are enough funds to serve people in the community.

When the Concept Paper for the Comprehensive Waiver was disseminated in mid-May, ABCD was pleased to see that the Balanced Incentive Payment Program was included as a revenue stream. We were concerned that the Community First Choice Option was not included but have been informed by officials in the Department of Human Services it will be part of the Waiver as well. We look forward to working with the Department to ensure that all federal funds are maximized and that they are reinvested back into community services.

### **Managing Supports for Individuals with Developmental Disabilities**

The Concept Paper lays out a number of initiatives to change the system of supports and services to people with developmental disabilities. We are supportive of many of these initiatives and have actually urged the Division to make many of these changes over the years. For example, we are pleased that the Department plans to move forward with rate setting for providers. Currently, providers' rates are primarily based upon when they first started to provide the services. So, if an organization started up a new program 25 years ago, their rates are based upon that level and the small amount of annual contract increases provided over the years. It should be noted that this is the fourth year in a row that there is no contract increase. If an organization started up a new program in the last few years, their rates would be based upon the current amount of funds which each person with a developmental disability receives now; which is significantly higher than the funds received years ago. Hence, agencies are receiving funds to provide services to individuals with complex needs whom they have served for 20 years at a level far below the amount of funds that the Division currently contracts with agencies for individuals with lesser needs. We are pleased that the Division and Department plans to include in the Comprehensive Waiver changes to this rate system.

We are, however, concerned with a provision which states that the Department plans to eliminate the process of intake applications for children who will not enter the waiver system for three years or more. We have raised this concern at the Department and have been told that this would simplify the administration of the system since these children receive no services at the current time when applications are taken. We are concerned that the Department needs to ensure that children with developmental disabilities are known to the system. Eliminating the process of intake applications would hinder the ability for the Division to plan for the children who will need services in the future. We plan to discuss this further with the Department.

The Concept Paper explains that the Department will develop policies to manage the waiting list and ensure that individuals with greater needs are prioritized on the waiver to avoid serving them with State funds. ABCD has advocated for more than a decade that services should be based on the needs of individuals. For too long, individuals with complex physical and neurological developmental disabilities and their families have had to wait for services. We are pleased that the Department will prioritize the needs of individuals waiting for services. However, we are concerned that this is a significant change for the developmental disabilities community and want to ensure that all people are treated with equity and fairness. There are many concerns about the current assessment tool used by the Division of Developmental Disabilities to determine needed services. Two years ago a workgroup convened by the Division recommended the use of the Support Intensity Scale (SIS) which focuses on support needs and lends itself to the person-centered planning process. The SIS assesses the type, frequency, and amount of support time that person needs to accomplish living activities. The

SIS has been adopted by at least seven states and has been utilized in funding allocations. We urge the Division to adopt the recommendations of the workgroup and use the SIS rather than the current assessment tool in prioritizing the needs of individuals on the waiting list.

### **Family Support Services**

The Concept Paper explains that New Jersey will move forward to implement a new supports waiver to increase in-home supports for families currently funded by State-only money. For more than a decade ABCD has advocated for the State to maximize its federal funds in the Family Support program. Over the past two years ABCD has actively participated in a work group convened by the Division of Developmental Disabilities to develop a federal Home and Community-Based Services Waiver for Family Support.

ABCD, along with many other organizations and families in the developmental disabilities community, have long argued that all federal funds from waivers should be reinvested into community services. During the work group discussions on the Support Waiver it became clear to all of us that without full reinvestment of these new federal funds into the system, the waiver will fail. We urge the Administration and Legislature to ensure that all federal funds from the new support waiver in the Comprehensive Waiver be reinvested into community services for people with developmental disabilities.

We are pleased that the Concept paper includes the provisions developed by the Work Group related to Family Support. This change in the service system for Family Support will impact families and providers. Details still to be worked out relate to the changes for Family Support including how service dollars will be allocated to families, the amount of service dollars to families, and rates for providers. We look forward to working with the Division, other stakeholders and the Legislature on these changes.

### **Serving Individuals with Dual Diagnosis of developmental disabilities and mental illness**

We are very pleased that the Concept Paper includes the recommendations of the Dual Diagnosis Task Force report. In our budget testimony this year, ABCD expressed concern that the Governor's budget does not include funds to begin building a crisis response system for people who are dually diagnosed with developmental disabilities and mental health issues. We explained that New Jersey needs to make it a priority to create a system of care for people who are dually diagnosed.

Several years ago the Dual Diagnosis Task Force issued a number of recommendations, including a priority recommendation to begin building a crisis response system which would serve the needs of individuals with significant behavioral issues and their families. Such a continuum of services would be used to replace uncoordinated and dislocated services such as 9-1-1 and EMS assistance, ambulance transport to ER/Crisis Screening Center, unnecessary inpatient hospitalizations, inappropriate admission to State Psychiatric Hospitals, Developmental Centers, or out of state treatment and/or residential placements.

The Concept Paper explains that the final waiver proposal will be reliant upon the Dual Diagnosis Task Force Report as guidance. The Task Force report explored many options to maximize existing resources by drawing on federal Medicaid funds to ensure adequate funding for this new system of care. We look forward to working with the Administration and others to maximize this funding and to create a new system of care.

### **Conclusion**

The Concept Paper on the Comprehensive Waiver provides many changes to services for people with developmental disabilities which will promote efficient use of scarce resources and maximize federal benefits. There are still a number of questions related to the details of the proposal to be answered and we look forward to working with the Administration to resolve them.

**Testimony of Tom Baffuto, Executive Director, The Arc of New Jersey  
Senate Health, Human Services & Senior Citizens Committee  
Roundtable on Comprehensive Medicaid Waiver (CMW)  
June 6, 2011**

Thank you Senator Weinberg and the other Committee members for the opportunity to participate in today's discussion about the state's proposed Comprehensive Medicaid Waiver and the mandatory shift to Medicaid Managed Care for all "ABD" (aged, blind, disabled) Medicaid beneficiaries.

The Arc of New Jersey shares the concerns of many advocates as well as policymakers that we simply do not have enough detail at this time to properly evaluate the proposed Comprehensive Medicaid Waiver. While helpful in outlining the broad strokes, the "concept paper" that DHS has released is very light on details. This is a problem for several reasons:

- 1) We can't completely tell you what this comprehensive waiver will accomplish.
- 2) We can't assess how the savings will be realized. As this is expected to save between \$200-300 million, it's a little scary not to understand the math.
- 3) We can't identify potential problems, and thus can't begin working on solutions.
- 4) Most importantly, we can't guarantee that this will ultimately not be detrimental to people with intellectual and developmental disabilities and their families in New Jersey.

We are also concerned that there seems to be very limited opportunity for public input – especially given that the only thing available to comment on is the concept paper itself.

With all of that being said, both the Commissioner and the Deputy Commissioner of the Department of Human Services have given us assurances many times that people with developmental disabilities will not be hurt by this. We truly appreciate their intentions and are hopeful that it will play out that way. But without more information, it's just impossible to know right now.

With regard to some of the specific details that we do have, we have the following comments:

**Emergencies/Danielle's Law:** We are concerned about the \$25 copayment imposed on the "non-emergency use" of hospital emergency departments. We feel this will be particularly unfair to the individuals who are brought to emergency rooms as a result of staff fear of being in violation of Danielle's Law. This law, which had all the best intentions when it was passed, has

been plagued with implementation problems and routinely results in people being brought to emergency rooms when they do not need to be. It seems unfair to punish an individual who has little control over this situation.

**Provider Rates:** We are also concerned about the section that references revision to provider rates. To the extent that this section includes community providers for people with developmental disabilities, we feel that it is critical that providers are given the opportunity to be closely involved in the rate setting and that the ultimate rates are fair and equitable.

**Waiting List:** Additionally, we are concerned with the section that states that the implementation of the new "supports waiver" will essentially allow New Jersey to serve the majority of people on the current waiting list. We have absolutely no evidence of this fact and this assertion concerns us.

**Managed Long-Term Care:** We also have some general concerns about what this means in terms of possibly opening up the developmental disabilities system to managed long-term care. Is this part of the plan? What would that even look like? That would be a monumental shift in our service provider system and would require a very careful consideration before any decisions were made.

**Alternative Residential Options:** There is a point in the concept paper that has to do with expanding "cost-effective" residential alternatives. Expansion of services is certainly good, so long as quality remains and the "alternatives" supported are in line with our current value system in terms of how to best support people with developmental disabilities in their communities.

**Dual Diagnosis Task Force Recommendations:** On the other hand, we are very supportive of the Department's plans to implement the recommendations of the Dual Diagnosis Task Force. We fully support the need to do more in this area.

**Flexibility:** We also support the need to offer more flexibility in terms of people being to access different waivers at the same time.

With regard to the mandatory shift to Managed Care, The Arc of New Jersey does not oppose the state's proposal to shift all "aged, blind and disabled" Medicaid beneficiaries into managed care. We do, however, have some concerns about the implementation of this change.

**Timeframe:** First and foremost, we are concerned with the speed with which this is being done. Families have only recently begun receiving letters about this change and are going to be given a very short timeframe in which to do their research and select an HMO that best meets their loved one's needs. On a positive note, in response to our concerns, DHS has already taken some steps to try to alleviate this problem. First, they split the people that will be transitioned into managed care into two groups, who will be moved in sequentially. Additionally, just this week, they announced that they were moving back – by one month – the date for the first group to go into managed care.

While we are really appreciative that the Department has taken these steps, we do continue to have concerns about the speed with which this is occurring. And our office is receiving calls daily from families expressing frustration and anxiety because they do not understand what is happening with these changes to Medicaid and how to ensure their loved one will still be covered for all needed medical services within the managed care system.

**Care Management:** We see “care management” as a key element to making managed care work for people with developmental disabilities. In the limited experiences we have had so far with care management, it is clear that it is a wonderful service that can truly make the difference for a lot of people. However, we have also found that many people are not aware that care management exists or do not know how to access it. Also, with the large influx of new people into managed care, we don’t yet know if the HMOs are planning to bring on additional care managers to ensure that everyone will be served. During this transition, it is critical that people are told about care management, that it is easily accessible, and that the HMOs have enough care managers in place to handle the new enrollees.

**Adequacy of Networks/Exemption:** Additionally, we are not at all confident that the networks are adequate to handle people with developmental disabilities who have very complex medical needs. While we have been given assurances that they will be adequate (eventually), and that people will be ensured “continuity of care” in the meantime, we continue to worry about some people falling through the cracks. Some examples of the types of providers that may not be in-network in sufficient numbers are:

- pediatric specialists;
- dentists with expertise in caring for people with developmental disabilities;
- neurologists;
- mental health providers that have expertise in working with people with developmental disabilities;
- physical, occupational and speech therapists; and
- specialized durable medical equipment providers that have seating clinics to customize the equipment for the individual.

In light of this concern about the adequacy of the networks, we have asked DHS to consider implementing a short-term exemption process for a very limited number of people with complex medical needs who the HMOs are not yet ready to handle. We understand that the ultimate goal needs to be to get the networks to a place where everyone can get the care they need so an exemption would no longer be necessary. However, until those networks are in place, we believe that some exemption process needs to be made available.

**Anticonvulsants:** We have also been very concerned about the inclusion of anticonvulsant medications in the pharmacy benefit carve-in. Specifically, we are greatly concerned about people who have difficult-to-control seizures and may lose access to their current anticonvulsant regimen. The bottom line is that for some individuals, the reliability of the brand name drug is essential and they may not be guaranteed to continue to be able to receive the brand under the new proposal. We feel that it is essential that our consumers who have seizures have access to whatever anticonvulsant medications are medically necessary and we urged DHS to address this issue. I am happy to report that we were told late last week that DHS has now agreed to

grandfather in any consumers currently on an anticonvulsant regimen, ensuring that they would not lose access to their current anticonvulsant medications. We are truly grateful for this decision.

At the end of the day, the Department has certainly been working with us on our concerns and we appreciate that. However, with such a short timeframe for such major changes to be implemented, and knowing the medical complexity of some of the individuals we represent, we will continue to be concerned about this transition until we can be sure that everyone will be able to continue to get the medical care they need.

Thank you for the opportunity to provide testimony on these important topics and for your commitment to people with intellectual and developmental disabilities throughout the state.



*NAMI NEW JERSEY*

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Chairman Weinberg, members of the Health, Human Services and Seniors Committee, my name is Phillip Lubitz. I am the Associate Director of NAMI NEW JERSEY, the National Alliance on Mental Illness. NAMI NEW JERSEY is a statewide organization founded by the families of persons with a serious mental illness. We are the state's largest grassroots organization dedicated to improving the quality of life of individuals who have a serious mental illness and their families. I would like to thank you for the opportunity to speak today.

We appreciate the opportunity to share some thoughts on the Department of Human Services plan to seek a comprehensive Medicaid waiver as well as the immediate plan to move Medicaid managed care individuals receive Medicaid as a result of being blind, aged or having a disability.

We support the Departments efforts to:

- Consolidate New Jersey Medicaid and CHIP under a single-waiver authority
- Commit New Jersey to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- Promote increased utilization of home-and-community based services for individuals in need of long-term care
- Integrate primary, acute, long-term care and behavioral health care
- Promote efficient and value-added health care through Medicaid accountable care organization pilots.

We support the objective of the comprehensive waiver to rebalance or shift away from the reliance on institutional and acute emergency services toward preventive and home and community-based care where an individual's health is improved and they can remain an active member of their community to the extent that a system where inpatient care is available when appropriate.



In order to ensure that the HMOs can meet the needs of the elderly and physically disabled populations, we ask the state to require that each HMO describe how they will meet specified requirements, their experience elsewhere, describe their network completely and will not be allowed to enroll individuals with long-term care needs until a readiness review is successfully completed. HMOs must also submit plans for delaying and/or preventing their aged, blind, and disabled members who do not currently meet at risk-of-institutionalization criteria from reaching that level of care criteria.

We are most interested in the Departments plan to move behavioral health services for adults assessed to have low mental health and/or substance abuse symptoms/needs to have their care managed by a HMO to ensure:

- Integrated care coordination
- Integrated predictive modeling
- Promotion of co-located service delivery
- Integrated medical record and electronic medical record initiatives

We encourage the Department to provide incentives for integrating physical health and behavioral health for adults with major mental health and substance abuse disorders and/or serious mental illness. There is some evidence that those who have voluntarily enrolled into Medicaid managed care plans previously have experienced greater access to health care providers, particularly dental care, and have had positive experiences with the management of complex medical needs.

Although we support these goals, we remain concerned about plans to bifurcate mental health treatment. The comprehensive waiver proposes different approaches for managing behavioral health services (inclusive of mental health and substance abuse services unless otherwise specified) for adults and children.

Adults with moderate and intensive behavioral health needs will be supported through a non-risk model of managed care under contract with an Administrative Services Organization contract beginning January 1, 2013. A similar model has been in use in the children's mental health system for the better part of the past eight years and although it has not been without its "bumps" it has added some rationality to the allocation of resources based on evaluation and data driven decision making.

We are concerned regarding plans to carve adults with less severe needs into managed care beginning January 1, 2012 for behavioral health services. This seems to be a step back from the objective of having a truly integrated mental health system. Mental illness unlike some other illnesses can be exceedingly labile. It is unclear how developing a two track system can accommodate individuals who may exhibit wide range of acuity over time. A for profit manage care company under the proposed system would have an incentive to shift high users to the ASO rather than providing more intensive mental health services.

As we now have an opportunity to design a unified system we would be better served by incorporating all behavioral health services under the Administrative Services

Organization as has been proposed for the children's system. We may want to also consider having a single ASO manage behavioral health for both children and adults in order to achieve additional administrative savings.

The Comprehensive Waiver proposal calls for the Division of Mental Health and Addiction Services within DHS to undertake a series of tasks in addition to developing the Administrative Services Organization Request for Proposal. Prior to this process DHS should specify how system stakeholders, including families and individuals who live with serious mental illness, will be included in planning and oversight of the Request for Information (RFI), Request for Proposal (RFP) and Contracting process; and indicate how it will incorporate advocate recommendations, priorities and feedback.

We conceptually support the Department undertaking the following tasks:

- Work with DMAHS to promote integration of services with HMOs for the highest-cost members (top 5%) across the two systems including data sharing
  - Work with health homes and accountable care organizations to promote integration
  - Fully integrate addiction and MH services within a single division
  - Engage stakeholders in improving the community infrastructure including the network of providers and emergency department triage
  - Develop screening tools to determine an individual's required level of care.
  - Seek enhanced federal matching funds for integration of physical and behavioral health at community behavioral health provider sites allowed under Section 2703 of the Accountable Care Act
  - Rebalance behavioral health provider rates to incentivize more cost effective care
- Assure adequate inpatient capacity is available to meet the needs of those who require that level of care.

The newer second generation antipsychotic medications that have played such an important part in the recovery of persons with a mental illness are proposed to being placed under managed care for the first time. Because these medications have not been covered under Medicaid and ABD managed care plans in the past it is unclear if this proposal will interfere with access to proper medications or whether cost considerations will override clinical indications. It is our recommendation that the Legislature take a close look at this proposal to assure that medication decisions are based on clinical decision and efficacy rather than on short sighted cost considerations. To that end we may want to create a reimbursement for Board Certified psychiatrist to consult with general practitioners who are prescribing psychiatric medications.

We likewise believe that the use of emergency psychiatric services should be excluded from any plan to disincentivize the individuals from seeking acute mental health services by charging a \$25 co-pay until the access to adequate diversionary mental health services have been assured.

Our experience with past efforts to move individuals who receive Medicaid as a result of being blind, aged or having a disability (ABD) into managed care suggest that we should exercise caution when disrupting the insurance coverage that has tied these often fragile individuals to essential medical care. Sufficient outreach must be provided to these individuals and their caretakers before their system of care changes. Extreme care must be taken to see that a selected plan offers as little disruption to an enrollee's provider network and medication regiment as possible. The Department of Human Services should assure a comprehensive plan for the inclusion of stakeholders into the planning and execution of this initiative.

I want to thank you for your attention. We look forward to working with the Department of Human Services as this proposal advances and this committee's continued interest. I remain available for any questions that you may have.

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*NAMI NEW JERSEY is the National Alliance on Mental Illness of New Jersey. We are a statewide coalition of self-help support and advocacy groups composed of families, friends and persons with a serious mental illness. With chapters in all twenty-one counties we are New Jersey's largest grassroots organization dedicated to improving the quality of life of individuals with a serious mental illness and their families.*

# PEDIATRIC AFFILIATES, P.A.

SPECIALIZING IN INFANTS, CHILDREN AND ADOLESCENT MEDICINE

June 5, 2011

Senator Loretta Weinberg, Chair  
Senator Joseph Vitale, Vice Chair  
Senate Health, Human Services and Senior Citizens Committee  
125 West State Street  
Trenton, NJ 08625

RE: Proposed Medicaid Comprehensive Waiver / Transition From FFS to Managed Care

Dear Senators,

It is with great concern to the health and medical welfare of my patients that I write this letter. As the cost for medical insurance continues to rise, a significant percentage of my patients were forced to forfeit their insurance coverage and opt for Medicaid coverage. For the most part, Managed Care serves the needs of our pediatric population. However, there is a margin of children to whom Managed Care was a tremendous compromise in care and they therefore have been exempt from joining. This includes chronically ill children who 1) need specialists in their field out of state, or 2) need medications or medical supplies which are not covered by Managed Care.

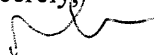
For example, patients with Spina Bifida, Hirschsprungs or other rectal malformations who are under the care of Dr. Pena at Cincinnati Children's Hospital - the innovator and leader in reconstructive surgery and Malone procedure which allows these children to lead independent lives. Boston Children's Hospital is often recommended by Managed Care specialists for their second opinion, and often for procedures and surgeries with outstanding results. Boston is used in several areas, including cleft palate, complex gastro issues, vascular malformations, severe cardiology issues and orthopedic issues. Most Metabolic Diseases which are detected from newborn screenings requires close follow up with Metabolic Specialists and researchers nationwide and their blood work must be tested in specialized labs. Many complex cardiology issues are cared for at Columbia's Babies Hospital in NYC, with unparalleled results. Many rare diseases require close follow up with specialized clinics or researchers in their disease; ie. MSUD, Familial Dysautonomia, DeGeorge Syndrome, Neurofibromatosis, Prader-Willi, etc. Extremely medically fragile children had their dental work done at Hospital of the University of Penn., the closest place able and willing to operate on these children. Many patients on growth hormones were unable to have their needs met by Managed Care.

My experience in attaining authorization from Managed Care for these medical needs is terrible. On the most part there is no chance for negotiation. Specialists and hospital personnel out of state are hardly able to come to a reasonable agreement with Managed Care. In a few cases authorization was given, and then was rescinded after the appointment / surgery date, leaving the parents with the bill. These experiences have left me unable to trust an authorization even when it was given.

For the chronically ill, the need to receive medical supplies through Managed Care has been a nightmare as well, as their vendors and covered benefits changes often. The quality of the supplies provided by Managed Care pales in comparison to Medicaid and impedes on the care given.

Limiting our chronically ill and disabled population to Managed Care is in the best of scenarios a compromise and to some a death sentence. I anticipate your understanding of the awesome medical responsibility we carry for these disabled and medically challenged children. Your favorable response will stand in your good stead.

Sincerely,



Robert A. Shanik, MD

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<input type="checkbox"/> <b>TOMS RIVER</b> 40 BEY LEA RD • ST B203 TOMS RIVER, NJ 08755 TEL: 732.341.0720 FAX: 732.244.6842	<input type="checkbox"/> <b>LAKEWOOD</b> 400 MADISON AVENUE LAKEWOOD, NJ 08701 TEL: 732.364.7770 FAX: 732.364.9292	<input type="checkbox"/> <b>MANAHAWKIN</b> 1616 RT 72 WEST MANAHAWKIN, NJ 08050 TEL: 609.597.6200 FAX: 609.978.1229	<input type="checkbox"/> <b>HOWELL</b> 3508 RT. 9 S • SUITE 200 HOWELL, NJ 07731 TEL: 732.905.9166 FAX: 732.905.9380	<input type="checkbox"/> <b>BRICK</b> 218 JACK MARTIN BLVD • E1 BRICK, NJ 08724 TEL: 732.458.0010 FAX: 732.458.9329	<input type="checkbox"/> <b>LAKEWOOD (S)</b> 870 RIVER AVE (RT 9S) LAKEWOOD, NJ 08701 TEL: 732.367.3700 FAX: 732.367.3727
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June 6, 2011

**Statement to the New Jersey Senate Committee on Health, Human Services and Senior Citizens**

Good afternoon, Committee Chair Weinberg, Vice Chair Vitale and members of the committee. Thank you for your interest and for allowing me the opportunity to communicate our concerns with the proposed changes to Medicaid.

My name is Yaakov Friedman. I am CEO of First Healthcare Management Company. We operate three adult medical day care centers in central and north Jersey. It is very gratifying to be in this field where we help people every day by providing quality care in a home and community based setting helping to keep the individuals we serve alive, healthy and in the community. All this with the added benefit of saving the system money by providing care management and preventative interventions.

**Copay**

Our first concern with the proposed changes is with the proposed three dollar copay. Copays are inappropriate for this service. NJAC 8:43F-1.1 under Scope and Purpose defines adult day care purpose is to provide preventive, diagnostic, therapeutic, and rehabilitative services. A copay is inappropriate for preventative care. We should not be setting up barriers to preventive care, preventive care should be encouraged. In addition, our clients are Medicaid beneficiaries living in poverty. They cannot afford a copay. This will cause a tremendous obstacle in access to care. A copay will not save the system money. Rather it will defeat the entire purpose of the program which is to provide preventative care to those who need it in order to prevent them from deteriorating and becoming an even bigger cost to the system.

**Managed Care**

My first comment is that we are not opposed to Managed Care per se. We applaud the efforts of the state to explore new ways to achieve efficiencies and to ensure the smart spending of Medicaid dollars.

Our concern however is with the hasty and haphazard implementation of Managed Care. As you all surely know, there is a tremendous amount of confusion in the state, the provider community, managed care companies, and most importantly the beneficiaries. According to the state's consulting firm, Mercer Consulting, the transition to managed care should take eighteen months to two years to vet out and complete.

In fact, The DHSS released a report in April 2009 titled Managed Long-Term Care in New Jersey. This report also recommends a three to five year transition time-line including three years of pilot programs. However, the Departments of Human Services

and Health and Senior Services are aiming to complete this in a matter of months. In fact the DHS has already mailed letters to beneficiaries to announce the change before they received CMS and legislative approvals. There are many outstanding issues, such as, oversight, rates, provider enrollment requirements, access issues for beneficiaries, appeals processes and fair hearings, covered services, and many more important issues. Each of these items needs to be addressed and it will take time to sort through. We are very concerned if this process isn't done in a minimally responsible way it will result in a catastrophic mess with interrupted services and huge costs to the system. We can be sure that we will certainly not achieve any efficiencies in an environment of chaos. We are dealing with the health and lives of many thousands of the state's neediest and most vulnerable individuals. This is the kind of thing that must be done with care and not rushed.

Specifically, we have a concern with the structure. Under the proposed structure, the MCOs are responsible for hospital care and community care such as home health care and adult day care, but are not responsible for nursing home care. This is problematic because in this structure the MCO is incentivized to ignore the individual's health and allow the patient to deteriorate into a nursing home where the cost is borne by the state in Fee for Service. The idea of Managed Care is for the MCO to be responsible for ALL of the individual's costs and that is the way the state saves money. This point is noted in the state's own report. Page 19 of the report notes "Giving plans no risk for nursing stay gives them a perverse incentive to admit high cost members to nursing homes".

Another concern is the rate. Typically MCOs will use trial and error in the marketplace to determine rates. With our vulnerable population, the stakes are simply too high to allow a trial and error process to determine rates. The DHS/legislature should require a rate floor of the current Medicaid rate that is supported by the cost study recently done by the department. Page 19 of the state's report notes that the purpose of managed care is to change utilization patterns, not to reduce Medicaid rates. The report recommends protecting existing Medicaid rates encouraging plans to focus their cost reduction efforts on avoiding high-cost services such as nursing homes.

We are being told by the department that they are ready. But the confusion clearly demonstrates that they are not. Today is June 6. We are but three weeks away from July 1<sup>st</sup>. There isn't even a contract for providers to sign to enroll in managed care networks. In addition, there has been back and forth on the effective dates; first it was July 1, then the department delayed implementation for dual eligibles and other groups until "the fall", and then due to erroneous communication to beneficiaries the state further delayed the effective date to August 1. Now we have three implementation dates July 1, August 1, and September or October 1. All of this clearly demonstrates the irresponsible haste that this program is being implemented with.

I urge the committee to require the department to follow the recommendations in their own report, and abandon this reckless rush for a July 1<sup>st</sup> implementation. Instead, let us begin working on a well thought out comprehensive managed care program for all services, and roll it out in an orderly fashion to ensure a smooth transition where we may

all benefit from the improvements, flexibilities, and efficiencies managed care has to offer.

In closing, I would like to once again thank the committee for providing an opportunity to address the concerns of the industry relative to the proposed Medicaid changes include in this coming year's budget. Thank you.

Yaakov Friedman  
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**JAMES**  
*Keeping Members Informed*

**Testimony of Dr. Kevin Saluck, CWS, FACCWS  
Vice President of Clinical Operations and Business Development for  
Central Medical Supply, Flanders and Cherry Hill, NJ  
Before the Senate Health, Human Services and Senior Citizens Committee  
On  
Medicaid Comprehensive Waiver  
June 6, 2011**

I am Dr. Kevin Saluck and I am the Vice President of Clinical Operations and Business Development for Central Medical Supply Group. Our corporate office is located in Flanders, New Jersey with a branch location in Cherry Hill.

Central Medical Supply Group is a member of the Jersey Association of Medical Equipment Services (JAMES), and I am currently serving as the President of the association, as well as the Chairman of the Legislative Committee. I am here today representing the homecare community – specifically the home medical equipment sector. My goal is to explain why the proposal to mandate managed care for the remaining fee-for-service aged, blind and disabled Medicaid population will not achieve the desired outcomes.

The Jersey Association of Medical Equipment Services (JAMES), established in 1978, disseminates information related to the delivery of Home Medical Equipment (DME) to providers of these services. It is the goal of the organization to keep its members informed of industry changes and related information necessary to maintain quality of care in providing home medical equipment, supplies and services to the patients who rely on us. Our membership covers the entire state, and consists of small through large service providers.

Home medical equipment companies provide a valuable service to thousands of patients who are in need of medically necessary supplies and equipment that include recurring, monthly orders for medical supplies, complex rehab mobility equipment and clinical respiratory services, such as life-sustaining patient ventilation. Having such a robust arrangement of diverse home medical equipment companies throughout the State of New Jersey allows for the timely discharge of patients from acute-care hospitals and sub-acute facilities. These companies are an integral part in the continuum of care as they allow these patients to enjoy a seamless and timely transition from the in-patient facility to their home environment. As the home environment is the preferred setting for the patient to convalesce or manage their disease state, the home medical equipment companies are a critical component in helping to decrease the length of stay and prevent in-patient readmissions.



While reviewing the State of New Jersey's Section 1115 Demonstration Comprehensive Waiver Concept Paper, we are concerned with portions of the paper. Under section V,

titled, "Delivery System Innovations", found on page 8 of the document, concerns are raised by our association with the proposal to move the dual eligible and aged, blind and disabled populations from the fee-for-service model to managed care. This move would place a high needs population into a care arena that, from what we have seen, typically does its best to reduce expenses by significantly limiting provider participation. This reduction in providers will cause problems in several key areas defined below:

#### **Reduced choice for recipients**

This population tends to be high-volume users of durable medical equipment and supplies, and due to on-going medical issues typically have an established relationship with a DME provider of their choice. As a part of the continuum of care, these patients rely on their DME providers to monitor their supply quantities and delivery schedules, stock appropriate levels of quality medical equipment and supplies to service their needs in short time-frames, including emergency situations, and communicate with the other medical professionals involved in their care. Interrupting this delicate cycle could prove harmful to patients as they re-establish themselves with new medical providers who must assess their conditions and needs, and then provide necessary medical documentation to new DME providers who will have to obtain authorizations to dispense medical supplies and equipment.

#### **Proximity of participating network providers**

Considering there will be a large reduction in the amount of DME providers permitted to service New Jersey Medicaid recipients through this waiver, these individuals who are accustomed to dealing with their local providers will be forced to deal with unfamiliar providers that may be 50-75 miles from where they live. If the beneficiary wants to come in to a retail showroom to look at a product or compare an assortment of products to determine what is best for their individual needs, the lack of proximity will prevent this. Additionally, people prefer to deal with local providers, and be given the choice to maintain the long-term provider/patient relationships they have formed throughout the years. With mandatory managed care, these options and choices will be eliminated, and recipients could have to cope with delayed access due to a lack of proximity of participating providers. If a patient's supply of diabetic test strips, diapers, or enteral nutrients depletes earlier than anticipated due to an unforeseen illness, the option of going to pick up an emergency order is no longer available. Family members or caregivers, who are used to obtaining repairs to equipment while they wait, will no longer have that option available. Decreased safety in complex rehab mobility devices and increased risk of patient injury will occur in situations where the DME provider who supplied the equipment is not in the managed care network. This could lead to the inability to utilize the wheelchair, restricting the patient to bed-confinement and subjecting them to secondary complications. DME providers that are participating in the managed care network may be unwilling to perform repairs on equipment not initially provided by their company. In the case of complex rehab mobility, hospital systems and facilities are concerned that their qualified providers for this type of equipment are currently not participating in the Medicaid managed care networks. We are concerned with the volume a move to managed care for these recipients will place upon limited "qualified" providers, once again presenting a scenario of delayed access for the patient to endure.

### **Delivery methods utilized may delay access**

Patients used to picking up their monthly supply orders may no longer have that option if forced to deal with an out-of-area provider. Orders that are usually delivered by the local DME provider's delivery vehicle may be delivered in alternative methods that include common carrier shipments, ultimately delaying the delivery timeframes the patients are accustomed to.

### **Timeliness of transition**

Clinical respiratory patients who often take from several weeks to a couple of months to safely transition to another provider will be subject to this process almost overnight due to this proposal. This will create much undue stress and anxiety on the patient, family members and caregivers. These patients are ventilator dependent and have been on service with their current providers for many years, and in most instances have maintained a continuous relationship with the same physician. This continuity of care should be encouraged and designed to continue. Under this proposal, this continuity of care will be severely disrupted and DME providers of clinical respiratory services believe there is not enough time afforded to them, the patient, the nursing service or the prescribing physician to collaborate together to establish a safe transition protocol, or even to allow the DME provider to contract with the chosen Medicaid managed care organization. Patients currently in need of complex rehab mobility products are finding their prescriber's written orders cannot be submitted for required prior authorizations due to the short time frame under which this proposal is set to occur. There is simply not enough time to obtain the prior authorization and build the complex rehab mobility products according to the necessary specifications for the individual's condition.

### **Inclusion of all providers and facilities in the network for patient's continuity of care**

As detailed above, clinical respiratory patients require several medical professionals to coordinate their care. A mandate to the managed care environment where some, or possibly all, of the current medical providers are not participating with the managed care plan could present situations where the patient is delayed access to care simply because they are required to establish themselves as a patient with new medical providers. Many physicians and prominent hospital systems do not participate with the Medicaid managed care organizations.

### **Ongoing requirements for maintenance, service and repairs**

There are concerns over the practices of some managed care organizations using providers that are a significant distance from the patient's home environment. If a clinical respiratory patient's DME provider is not located within a close proximity, the only option is for the patient to be transported to the emergency room in the event of equipment malfunction. Complex rehab mobility patients will lose the benefit of their clinicians selecting qualified providers close to their home environments, thereby eliminating transportation options for them to expedite the frequent maintenance and repairs that are needed for the type of equipment that allows them to participate in their activities of daily living, and all aspects of their lives. We are also concerned with the reimbursement policies of some managed care organizations when it comes to frequently serviced equipment – ventilators, and bi-level positive airway pressure devices, with or without artificial airways (Bi-PAP), for example. We have noticed a trend in the managed care arena that promotes “capping” the rental of this equipment into a purchase, when in actuality it is

equipment that requires on-going maintenance and attention by a clinical professional. The State of New Jersey's Board of Respiratory Care, the licensing board for respiratory care practitioners, clearly prohibit testing and exchange of these devices by unlicensed assistants in their current regulations. Once this equipment is capped and considered patient-owned, how does the patient secure this clinical professional at the appropriate intervals to maintain safe use of the equipment? Additionally, who is then responsible to assist the patient in the event of an emergency when the 24 hour, 7 day per week emergency service component from the DME company has been removed when the title of equipment ownership transfers to the patient? This practice is one that could jeopardize patient safety, and ultimately lead to an emergency room visit and subsequent hospital admission. We believe this is a practice that this very waiver is trying to prevent, yet it will also potentially increase the frequency of this occurrence with the proposal for mandatory managed care for these Medicaid recipients.

Three of the four Medicaid managed care organizations have closed provider networks at this time for DME providers. The fourth Medicaid managed care organization that is accepting providers for the DME network is only operational in 10 counties throughout the State of New Jersey.

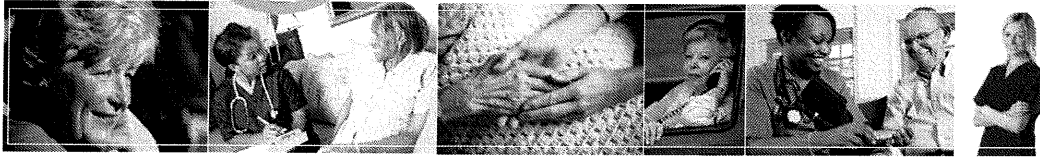
With the economic conditions less than desirable over the last few years, many DME providers have seen an increase in those eligible for Medicaid. Many DME providers are now servicing a significant amount of Medicaid patients. The loss of the option to continue to serve that patient base, combined with declining Medicare reimbursements over the past few years, will place many DME companies at financial risk. This will promote job loss and possibly business closure throughout the State of New Jersey, in addition to presenting Medicaid recipients with many challenges to overcome to continue to receive the medically necessary equipment and supplies they have come to depend upon.

We have a strong concern for a population of children and adults with severe developmental disabilities and cognitive impairments, as well as dually-eligible Medicare and Medicaid beneficiaries, who are incapable of navigating the additional procedural complications inherent in a managed care system. I am very concerned that the health and well-being of these populations will be severely and negatively impacted in a private managed care system.

Thank you for the opportunity to provide this testimony.

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### **Transferring Fee for Service to Managed Care The Impact on the Personal Care Assistance Program June 2011**

We need to ensure continuity of care and a seamless transition for fee-for-service Medicaid patients to managed care. There are 30,000 Personal Care Assistance (PCA) recipients in the State. PCA Services are one of the most cost effective means to keep frail elderly clients at home.

- When will Medicaid recipients need to enroll?
  - The managed care organizations are supposed to take over from the State on July 1, 2011; however, it is unrealistic to expect this to happen on time.
  - There are 30,000 patients that must enroll with an HMO and 178 providers that need to negotiate contracts before the end of this month.
  - Medicaid recipients were only mailed letters from the State about this change on April 28, 2011. The letter notified the recipient that they must choose an HMO by June 10, 2011 or they will be automatically enrolled with an HMO for their PCA services to continue. Estimates are that only 1 in 6 will read the letter due to disability or language barriers.
  - There was a glitch in the Department's letter providing an incorrect enrollment deadline causing additional confusion to an already complicated process.
- When will recipients transfer? Clients and providers are trying to figure out what applies to them.
  - The Department of Human Services is providing clients and providers information about the transfer; however, it is confusing and inconsistent.
  - As of right now, PCA clients are due to transfer July 1, 2011.
- How will care be authorized? How does a new patient get service?
  - The Department sent conflicting information to providers about covering new patients. Some information from the Division of Disability Services indicated new service request would halt as of May 30, 2011, and a more recent communication said that they will review new cases until July 31, 2011.

*Jean Alan Bestafka, RN, CEO*

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- How can providers assist clients to choose an HMO?
  - There are 178 unduplicated providers trying to get contracts with HMO's. So far, none of the HHSSA NJ members have received a signed Ancillary Provider Agreement.
  - Provider agencies want to help their clients enroll with an HMO that will ensure continuity of care, however, without contracts, it is impossible to advise clients.
- How will Providers be paid?
  - Currently providers are paid \$15.50 an hour with 90% of the cost being caregiver payroll costs. Companies make between 2 and 7 cents per hour.
  - Timely payments are of utmost concern; however securing signed contracts with the four HMOs must occur first.

**With all of this confusion and inability to ensure clients are enrolled with an HMO and that providers will have contracts in time to provide continuity of care we ask that you postpone the start of the transfer for the PCA program until September.**

*Jean Alan Bestafka, RN, CEO*

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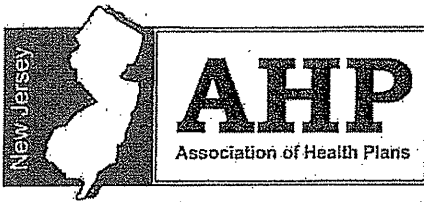
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**Transferring Fee for Service to Managed Care**  
**The Impact on EPSDT and CRPD**  
**June 2011**

- EPSDT and CRPD are programs that provide RN's and LPN's for up to 16 hours a day, 7 days a week, 365 days a year for skilled nursing care to severely disabled children and adults. These patients usually have tracheotomies, gastronomy tubes, ventilators, or other high tech needs which can only be provided by a nurse. Parents are trained to provide the care when there is no nurse.
- EPSDT and CRPD patients are also being included in the mandatory transfer to HMO's. There can be no gaps in their care as might happen if the transfer process is rushed and does not allow for continuity.
- Some parents have not yet received enrollment packets, and some of those that have do not understand them.
- Parents and providers need to verify that other providers such as Respiratory Therapy for ventilator is also in the HMO.
- The issues presented regarding PCA also exist for EPSDT and CRPD, but the patients are much sicker and need higher level of care every day.
- It seems that the initial problem with HMO's requiring only Medicare Certified agencies (who do not provide shift nursing, also called PDN) has been resolved. However, agencies still have not been provided with credentialing packets or agreements to provide these services and it is dangerously close to the date required for transfer. Recent frequent phone calls and emails to one HMO have not produced any response.

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**Wardell Sanders**  
President

**Sarah McLallen**  
Vice President

**Testimony of the  
New Jersey Association of Health Plans  
For the  
Senate Health, Human Services & Senior Citizens Committee  
June 6, 2011**

Chairwoman Weinberg and Members of the Committee,

The New Jersey Association of Health Plans ("NJ AHP") is a non-profit association representing leading health care plans in the state which cover nearly seven million New Jersey residents. Our members include Aetna, AmeriGroup, AmeriHealth, CIGNA, Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare. We represent the largest three Medicaid managed care organizations (MCOs) in New Jersey.

Thank you for your invitation to participate in this roundtable discussion on the transition of certain Medicaid services and beneficiaries from fee-for-service care to managed care. In addition to our comments below, we have included a copy of the most recent HMO Performance Report for New Jersey.

**Success of Medicaid Managed Care**

Since the inception of the Medicaid Managed Care program in the 1990s, NJ AHP's Medicaid Managed Care Organizations (MCOs) have partnered with the State to improve access to health care for Medicaid/NJ FamilyCare beneficiaries and to effectively manage state Medicaid dollars. MCOs ensure quality and cost-effective care, in part, by emphasizing prevention and coordination of care. In addition, care and case management programs ensure that beneficiaries have continuity of care and receive care that is appropriate for their condition. Our MCOs also currently provide additional services such as language translation services, 24-hour nurse help lines, community outreach programs, and health literacy and education programs to facilitate communication and access to care that are not routinely available via the Medicaid fee for service program. At the same time, the State has noted that "Managed Care clients represent 75% of the total members, yet expenditures to Managed Care Companies represent only 28% of the total program cost."<sup>1</sup>

Medicaid health plans understand what Medicaid beneficiaries need to live healthier lives:

- Medicaid is a program with numerous challenges. In comparison to the general population, Medicaid beneficiaries have much higher rates of poor health, fewer resources, and lower rates of health literacy.

<sup>1</sup> Commissioner Jennifer Velez, 1/7/11 slide deck presentation on federal health care reform.

- Medicaid beneficiaries need integrated systems of care that promote access to necessary services and improve health outcomes.
- Medicaid beneficiaries benefit from outreach efforts that assist them in making and attending medical appointments and obtaining needed care on an ongoing basis.
- Medicaid beneficiaries with chronic conditions require focused programs that provide tailored clinical and care management strategies.
- Medicaid beneficiaries often benefit from assistance with non-health related needs that can improve their health and well-being.

NJAHP's MCOs know this population and their needs well, and provide services to meet these needs.

### Medicaid Care Carve-Ins

NJAHP's MCOs are focused on a smooth transition from fee for service to managed care. By that, we mean: (1) no interruptions in services to our clients; (2) additional outreach to assist clients with the transition; and (3) timely payments to providers. Plans are investing significant financial and staffing resources to ensure a smooth transition. Of highest priority to the MCOs is ensuring that beneficiaries have an extended continuity of care period so no current services are interrupted and each beneficiary is evaluated with a health assessment to ensure they are receiving all current and any anticipated medically necessary services that will ensure a quality outcome.

NJAHP has worked with the Division of Medical Assistance and Health Services (DMAHS) since 1995 through various administrations and several changes to these public programs. Commissioner Jennifer Velez, Medicaid Director Valerie Harr and their staff have been working with the MCOs and NJAHP to ensure a successful transition of Medicaid beneficiaries. Additionally, DMAHS has done a great deal to support the transition, and that important work continues with the MCOs and all stakeholders to succeed in this transition. NJAHP and our member MCOs have attended several meetings sponsored by the Department to prepare for the transition, including quarterly Medical Assistance Advisory Council meetings, monthly Contract Issues meetings, Medicaid MCO CEO Roundtable meetings, and various stakeholder and workgroup meetings including: Home Health Workgroup, Division of Developmentally Disabled Work Group, Adult/Pediatric Medical Day Workgroup, and Dual Eligible Clients Workgroup.

It should be noted that the MCOs already serve a number of members with complex health care needs and have a proven track record of improving care by making available care coordination and a wider network of high-quality providers than are available in the Medicaid fee for service program.

### Expanding Managed Care Provider Networks

All of our MCOs are currently contracting with additional providers to serve their new members and the new services for their current members. Health plans are experienced at building networks and are held to rigorous provider network standards set forth by both the Department of Banking and Insurance and the Department of Human Services, including standards for mileage from provider offices, provider office compliance with the Americans with Disabilities Act appointment availability standards, expedited complaint and appeal processes, and stringent prior authorization standards. Our plans are currently on schedule with preparing for the July 1st transition and do not anticipate any problems.

### Comprehensive Waiver Application

While we are still studying the waiver application and awaiting final details, we support certain concepts and ideas put forth within the proposal, such as:



- Promoting Primary and Preventive Care through Medical Home Model and Accountable Care Organizations for High-Utilizers;
- Managing and Integrating Behavioral Health Services; and
- Transitioning to Managed Long Term Care Services.

Again, we look forward serving the state and the NJ FamilyCare beneficiaries as we have for over 15 years here in New Jersey. We are committed to providing a smooth transition to managed care, with no interruptions in service for the beneficiaries and prompt payments for providers.

Thank you again for the opportunity to participate in your roundtable discussion and for your consideration of our comments.



NEW JERSEY HOSPITAL ASSOCIATION

Elizabeth A. Ryan, Esq.  
President and  
Chief Executive Officer

DATE: May 31, 2011

TO: Chief Executive Officers  
Chief Financial Officers  
Chief Operating Officers  
Government Relation Officers  
In-House Counsel

FROM: Elizabeth A. Ryan, Esq.  
President and Chief Executive Officer

**RE: Section 1115 Demonstration Comprehensive Waiver –Medicaid Program**

The New Jersey Department of Human Services (DHS) and Division of Medical Assistance and Health Services (DMAHS) has released its concept paper for a Section 1115 Demonstration Comprehensive Waiver for the state's Medicaid program.

Under the SFY 2012 budget proposal, the departments of Human Services and Health and Senior Services have booked a total of \$300 million in savings through the restructuring of the Medicaid program. Until now, few details were made available to stakeholders; this concept paper is the first step in achieving CMS approval of the 1115 Waiver from the Centers for Medicare and Medicaid Services.

DHS is currently accepting comments on this paper, and will be meeting today with CMS to discuss the proposal with the goal of submitting the final application to CMS by June 30, 2011. The department will also discuss the concept paper at a MAC meeting June 13, and Commissioner Velez has committed to meeting with industry representatives during this process.

According to the concept paper, the goal of the waiver is to provide broad flexibility to manage all programs across the continuum more efficiently by encompassing all services and eligible populations under a single authority. Pervasive throughout the paper is an underlying theme to move nearly all Medicaid beneficiaries from fee-for-service to managed care.

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The waiver would also commit to making improvements to the Medicaid eligibility system, promoting increased utilization of home and community based services and generally promoting balanced eligibility and flexibility in the administration and implementation of our healthcare services. Lastly, the paper emphasizes that Medicaid should be the “payer of last resort” and that the role of program and its sister agencies should be redesigned to meet this objective.

As we continue to digest the details laid out in the concept paper, here’s a snapshot of provisions that would affect our industry.

### **Provider Payments**

Included in the waiver is a request to allow more flexibility in “defining covered services and adopting limits on the amount, duration and scope of services as well as imposing copayments and other cost sharing.” Although the waiver does not propose specific rate reductions to providers, the downstream effect of shifting more patients to managed care and requiring hospitals to collect ED co-pays may result in cuts to our facilities. The state’s goals include rebalancing the service delivery system toward primary care, providing equity in payments to in-state and out-of-state hospitals, incentivizing payment reforms between HMOs and hospitals and finally participating in the Affordable Care Act provider payment reform demonstrations which test both global payments and bundled payments.

#### **Specific Provisions Include:**

- *\$25 Co-Pays for Visits to the Emergency Department* - The waiver will seek authority to impose a \$25 copayment to correct the inappropriate use of hospital emergency departments. There are significant concerns with requiring a co-pay for poor patients who may not be able to afford the payment. Furthermore, there is ambiguity surrounding the determination of “inappropriate use” of the ED and the responsibility of the hospital to collect the payment. At an Assembly Budget Committee earlier this week, Commissioners Velez and O’Dowd testified that they wanted to change the behavior of patients by implementing this co-pay, yet it is unclear how the behavior will be changed if care must be rendered under the state’s charity care law.
- *Out-of-Network Payments for Emergency Services* – The waiver would require non-contracted hospitals providing emergency services to beneficiaries enrolled in Medicaid managed care to accept 95 percent of the Medicaid fee-for-service rate as payment for services rendered. Currently, non-contracted hospitals are required to accept the full fee-for-service rate as payment in full for emergency services, and there are only two hospitals that do not currently contract with all four Medicaid managed care payers.
- *Increased Payments to Primary Care Physicians* – The proposal would phase in an increase in Medicaid payments to primary care physicians to 100 percent of the Medicare rate. New Jersey proposes a phase- in to full implementation in 2013 when an enhanced federal match will be available. The increase would be paid from savings garnered from the waiver, but would be limited by the amount of funds available. While NJHA applauds the planned increase in payment, the more robust network should be demonstrated prior to implementation of the co-pay to ensure that the patient has access to care outside of the ER.

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- *Medicaid Global Payment System* – The concept paper references the state's interest in establishing a demonstration project in coordination with the CMS Innovation Center that would allow the state to adjust its current payment structure for safety net hospitals from fee-for-service to a global capitated payment structure. We are not sure if this demonstration would truly require participating safety net hospitals to bear risk but will be seeking additional insight going forward.
- *Fairness in payments to in-state and out-of-state providers.* In addition to rebalancing, New Jersey will also seek changes in payment rates that are designed to achieve fairness specifically when making payments to out-of-state providers. Specifically, the waiver proposes to pay out-of-state providers the lesser of the New Jersey Medicaid rate or the servicing state's Medicaid rate when the service is available and the member has access to an in-state provider. The waiver also proposes to coordinate with neighboring states and establish uniform payment rates for select facilities that provide specialty services.

### **Eligibility & Enrollment**

To correct a lack of accessibility to primary care, New Jersey will request broad flexibility for managing eligibility, enrollment and benefits. According to the waiver, the goal would ultimately be to reduce the utilization of hospital emergency departments, outpatient hospital clinics and inpatient beds. The waiver would restrict eligibility requirements, as well as increase the patient's cost-sharing responsibility.

#### **Specific Provisions Include:**

- *FamilyCare Enrollment* – The proposal would freeze enrollment for all adult parents in the expansion population for all parents with incomes up to 133 percent of the federal poverty level (FPL) and restrict eligibility to only new applicants who qualify for Aid to Families with Dependent Children. The reduction of eligibility for this program will result in more uninsured patients that will have no choice but to utilize hospital EDs as their primary source of care.
- *Eliminate Prior-Quarter Coverage for New Medicaid Beneficiaries* – The waiver proposes to eliminate prior-quarter coverage for services rendered to a patient who enrolled in Medicaid after receiving care at a facility. Currently, Medicaid would pay for services rendered shortly before the individual enrolled in the program. This proposal will make Medicaid effective on the day the application is accepted. This elimination will affect hospitals that have already rendered services to patients that qualify for Medicaid, and instead will be forced to classify these patients as charity care.
- *Benefits Reductions and Cost-Sharing* – The proposal would eliminate wraparound benefits for those who enroll in commercial plans under the Health Insurance Premium Payment program. The proposal would also permit premium increases for parents with incomes over 100 percent FPL.

### **Program Integrity**

New Jersey will also include in its waiver initiatives to promote the integrity of the Medicaid program. Specifically, the proposal would revise managed care contracts to “place additional responsibilities on HMOs for reporting fraud and abuse to DMAHS and the Medicaid Fraud Division of Investigation.” NJHA believes that the state should utilize its Medicaid Inspector General to perform audits of Medicaid providers.

### **Post-Acute Care**

Effective July 1, 2012, New Jersey will transition all long-term care services including home-and community- based services and nursing facilities for the elderly and physically disabled to managed care. HMOs must conduct a “readiness review” before enrolling patients into managed care, but it is unclear what benchmarks and standards will be used for the “readiness review” to be completed with the HMOs seeking to manage the long term care services/populations.

The proposal also promotes case management and supports coordination for long-term care services provided directly by the HMO or via contract with other organizations like Area Agencies on Aging. We believe that there is a potential for a conflict of interest when an HMO both authorizes/pays for long term care and also provides ongoing/chronic care management. CMS will require “conflict- free care management” for many of the ACA programs that states can participate in and receive enhanced federal matching funds. This important function must preserve access and provide appropriate quality safeguards for enrollees.

### **Behavioral Health**

The concept paper calls for a change in the delivery and payment to the state’s behavioral health system. Specifically, the waiver intends to “rebalance behavioral health provider rates to incentivize more cost effective care” and also “recommend rate revisions to promote community behavioral health capacity.” We will seek clarification if the language could translate into rate reductions to facilities currently providing services to this population. The paper also calls for training direct care workers who manage behavioral health issues, but does not specify if this applies to all settings, including long-term care and acute settings.

### **Conclusion**

The waiver process is a series of negotiations between the state and the federal government. As required by federal law, the state must conduct a series of public hearings before the waiver is accepted by CMS. NJHA will remain involved in the discussions of the waiver as the process moves forward, and will continue to update you as more details emerge.

# NJPCA

New Jersey Primary Care Association, Inc.

Katherine Grant-Davis  
President & CEO

May 26, 2011

Jennifer Velez  
Commissioner  
Department of Human Services  
State of New Jersey  
222 South Warren Street – 6<sup>th</sup> Floor  
P.O. Box 700  
Trenton, New Jersey 08625-0700

Dear Commissioner Velez:

The New Jersey Primary Care Association (NJPCA) is pleased to offer comments on the Department of Human Services Concept Paper on the Section 1115 Demonstration Comprehensive Waiver. The concept paper details the DHS request to the Centers for Medicare and Medicaid Services (CMS) for a waiver that will:

- ✓ Consolidate New Jersey Medicaid and CHIP under a single-waiver authority
- ✓ Commit New Jersey to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- ✓ Promote increased utilization of home-and-community based services for individuals in need of long-term care
- ✓ Integrate primary, acute, long-term care and behavioral health care
- ✓ Promote efficient and value-added health care through Medicaid accountable care organization pilots
- ✓ Provide flexibility to promote primary and preventive care access by balancing eligibility and enrollment for services, the benefits received and the rate of payment for services
- ✓ Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
- ✓ Promote healthy behaviors and member responsibility for their health care

The NJPCA represents the Federally Qualified Health Centers (FQHCs) in the State of New Jersey and we have a great deal of interest in this waiver. Our comments are focused on those issues and/or proposals that directly impact FQHCs.

First and foremost, the FQHCs are of course concerned with the proposal to freeze enrollment for all adults in the FamilyCare program over a certain income level. We do understand that children will continue to be covered. However a family of 3 would have to make no more than approximately \$7,000 per year in order for any adults to qualify. Right now, our understanding is that a family of 3 can make \$24,600 and qualify. Based on the testimony at the Assembly Budget hearing on May 24<sup>th</sup>, it is anticipated that 23,000 adults will no longer qualify. This of course is going to strain the FQHCs and the hospitals even further. We would be interested in seeing any cost analysis that was done that provides concrete evidence that freezing parents will not add costs to the system. Not having a regular source of care, based on many studies, suggests that lack of coverage does lead to higher costs overall since many adults do suffer from chronic diseases, which may go untreated for long periods of time. Of course, the FQHCs will try to ensure that care is provided but these centers are already strained since the reimbursement received from the State of New Jersey does not equate to the cost of treatment. The centers are also suffering from fiscal woes due to costs not being covered under any change of scope for new sites, new services, and providers for the last seven years. We would hope that CMS will review this issue carefully to ensure that a safety net is indeed in place for any adults who may not be eligible for coverage.

Another issue of concern is the amount of services and populations that will now be under the administration of New Jersey's HMOs. FQHCs have been partners of the HMOs in this State since 1996. For the most part we have worked well with our HMO partners. In some areas, the FQHCs are one of the largest networks contracted with the HMOs. Back in the beginning of managed care in New Jersey, there were nineteen (19) HMOs. We are now down to just four (4). The concern of course is in ensuring that the system is not overloading these four managed care companies and that all providers and enrollees receive high quality and efficient care. As an example, HMOs are now taking up to six months to credential physicians. If that is happening now, how will the HMOs ensure that the provider networks are adequate? Denial of claims is a **major** issue. Recently the FQHCs documented for the NJ Medicaid agency, the reasons that so many claims are denied by the HMOs. As an example, if Dr. A is at one site in the morning and then at another site in the afternoon (FQHCs have multiple sites) then the HMO incorrectly denies the claim. Now that more agencies such as home health, personal care, etc., are also going to be part of the HMO system, how do we ensure that claims are processed on time? This has been such a nightmare for such a long time and adding more provider and agencies will serve to only exacerbate the problem.

The concept paper states that the NJ Medicaid will eliminate the requirement that coverage be approved prior to the date of a Medicaid application. Our understanding is that this does not pertain to presumptive eligibility for pregnant women and/or children. Can your office confirm that this is indeed the case?

The concept paper states that new enrollees may change their HMO without cause within 90 days. After the 90 day period, plan changes **for cause** will be allowed; changing HMOs will be possible thereafter once a year during an open enrollment period. We ask that you elaborate on what constitutes cause?

Cost sharing will be implemented with the primary target being non emergent use of hospital emergency departments with the intent to change behavior. It is hoped that individuals will go to a more appropriate setting if they are charged a co-pay. The anticipated co-pay is \$25.00 to be collected by the hospital emergency room. While we do agree that non-emergency cases should not present at an emergency room, there are quite a few issues that need to be addressed. It is far more involved than just charging a co-pay. We believe that some very good lessons were learned from the recent ER

*ldox*

diversion program co directed by DMAHS, HRET and NJPCA. Excellent practices were put in place that (1) allowed the hospital and a FQHC to link computer systems for ease of scheduling appointments; (2) provided patients with very helpful literature regarding when to use the ER/when to call their primary care provider; (3) expanded the hours of the FQHC to coincide with the hours of heaviest usage at the ERs; and (4) allowed for tracking of diagnoses to see why certain groups used the ER versus calling their assigned provider. Will DHS and DMAHS help providers continue these promising practices? If not, just by charging a co-pay **will not** provide the desired result. As an example the brochure of when to use an emergency room was very well done. DMAHS should be working with providers, HMOs, and hospitals to produce this document in mass – patient education is key when trying to change behaviors. The charging of a co-pay alone, without supporting activities, will not change behavior but will instead leave the hospital with more debt if patients do not pay.

The concept paper states that adjustment of payment rates will be rebalanced to push the delivery system more towards primary care. We believe that is indeed an appropriate action to take. Primary Care has been underpaid for quite some time now. It is stated that *"the State will invest some of the savings achieved through other measures for an early implementation of increased payments to primary care providers up to 100% of Medicare rates. New Jersey proposes to phase this in up to full implementation when an enhanced federal match will be available (phase in based on what New Jersey can afford.)"*

The obvious question is what can New Jersey afford and what are the targets of additional primary care providers from 2011 – 2013? Can those targets be made available by county? Will dentists be included in this push for more primary care providers? We also have been advised that the PPS rate currently paid to the FQHCs will not be adjusted. Would your office please confirm that fact?

The concept paper states that specialists will be encouraged to participate since primary care providers need them for referrals. This is a major issue for the FQHCs since the specialty networks are not adequate. Can you define what "encouragement" will be provided to the specialists?

It is stated that prospectively Medicaid managed care capitation rates will be reduced to reflect the expectation that HMOs must further reduce unnecessary emergency department utilization of its members. When will that process begin and will reduced rates be passed onto the provider network thus putting more providers in a poor cash flow situation?

The concept paper states that ACOs will be piloted within a managed care framework. Will these pilots follow the track of the current bill this is pending (focused on fee for service) or will a new model be proposed? The waiver also states that HMOs will be required to pilot health care homes. Are these pilots part of one of the models under the ACA and if so, under which authority. FQHCs are currently involved in developing medical homes and seeking NCQA status so we need to make sure that our activities are aligned with the activities of the Medicaid agency.

We fully support the proposed member reward and responsibility program since that will be a partnership between DHSS, DMAHS, and the NJPCA/FQHCs. This proposal will hopefully serve as a way to incentivize patients to take an active part in achieving goals for healthier living. We do note that this part of the waiver is based on funding from CMS. Were savings projected from this pilot since it is very unclear if New Jersey will be one of the ten States to actually receive funds?



It is also mentioned that effective January 1, 2012 behavioral health services for adults accessed to have low mental health and/or substance abuse symptom needs will have their care managed by a HMO to ensure amongst other issues – promotion of co-located services. The FQHCs in New Jersey are currently piloting an integrated model of primary care/mental health/substance abuse. In fact, DMAHS is on the steering committee. How will your plans to co-locate align with models already in place or being formed? How will the HMO/ASO/provider network be linked to ensure that a cohesive model is developed?

The concept paper states that a series of tasks will be undertaken including "Seek enhanced federal matching funds for integration of physician and behavioral health at community behavioral health provider sites allowed under Section 2703 of the ACA. A review of Section 2703 states the following "Section 2703: States may provide Medicaid assistance to persons with chronic conditions who designate a provider or a team of professionals as their health home; a health home could include a rural clinic, a community health center, a physician, a clinical practice, or a clinical group practice."

Furthermore the ACA states:

Section 2703

*State option to provide health homes for enrollees with chronic conditions*

A state may provide medical assistance to individuals with chronic conditions who designate a provider or a team of professionals as their health home. Planning grants will be awarded to states developing a plan amendment under this section; total funding will not exceed \$25,000,000. States plan amendments shall include methodology for tracking avoidable hospital readmissions and calculating savings and a proposal for use of health information technology.

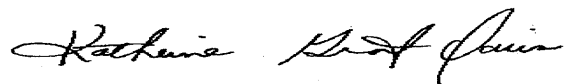
Designated providers include rural clinics, community health centers, physicians, clinical practices, or clinical group practices. A team of professionals may include professionals based at a hospital, community health center, or rural clinic. There may be opportunities for small rural practices to participate in innovative approaches to treating individuals with chronic conditions.

We question if additional pilots are going to be included in the waiver that correspond to this Section of the ACA since it would seem to be a great opportunity to better manage individuals with chronic diseases. Uncontrolled asthma or diabetes is a huge cost driver in the State of New Jersey. Please also define a community behavioral health provider. Are these community mental health programs or is there a broader definition.

Lastly, language in the waiver states that there are just a few expenditures that would not operate under the demonstration. Based on previous discussions with the DMAHS Director, PPS payments for FQHCs are not to be readjusted or changed under this waiver. Please confirm that fact for the FQHC industry.

Thank you for the ability to comment on this concept paper. We trust that our comments have been helpful and we look forward to further dialogue with you and your staff.

Sincerely,

A handwritten signature in cursive script, appearing to read "Katherine Grant-Davis".

Katherine Grant-Davis  
President and CEO

KGD:DVZ

**Hemophilia Association of New Jersey**  
**197 Route #18 S., Suite 206 N.**  
**East Brunswick, NJ 08816**

Dear Chairwoman Weinberg and members of the Senate Health, Human Services and Senior Citizens Committee:

Thank you for the opportunity to provide comments on the proposed transition from Medicaid fee-for-service to managed care and its potential impact on New Jersey residents with hemophilia. I provide these comments on behalf of the Hemophilia Association of New Jersey which was founded in August 1971 by 10 concerned families, and offers assistance to persons with hemophilia and their families. HANJ's mission is to improve the quality of life for persons with a bleeding disorder by providing and maintaining access to highly qualified medical treaters and successfully proven medical regimens.

Many Americans have some chronic conditions that are not necessarily impairing, and while drug therapies may be prescribed, they very often do not require extraordinary care. There is, however, a smaller group of individuals whose lives and medical outcomes are dependent upon access to treatment modalities deemed necessary and appropriate by the treating physician. This is the case with hemophilia. Across the board reforms ignore the challenges posed by those individuals with the greatest need, and at the greatest risk.

Persons with hemophilia have been referred to as "the canaries of the blood supply". In the early 1980's, the blood supply was contaminated by the AIDS virus. As a result of this contamination, 50% of all persons with hemophilia were infected with HIV because of their dependence on clotting factor extracted from plasma. The infection rate was higher in persons with severe hemophilia because they transfused more often. 90% of persons in this category were infected. In the 1990's, safer synthetic products emerged at a significantly higher price, while plasma derived products remained on the market. The cost of plasma derived products is a fraction of the cost of recombinant products. However, they were responsible for widespread infection with HIV and HVC, as well as other virus and prions.

There are no generics for clotting factors. Clotting factors are not therapeutically equivalent and therefore not interchangeable. Restrictions on product access are not acceptable. Interference in clinical decisions made by a treating physician in consultation with a patient is not acceptable. Jeopardizing medical outcomes, and lives, in a desperate attempt to contain costs is simply not acceptable. Clotting factor concentrates are not recreational drugs that require higher and higher doses to satisfy the user. It is a treatment that is not an option for the person with hemophilia, it is an absolute need.

There is no question but that hemophilia care is expensive, but it is still a bargain when compared to the long-term medical, rehabilitative, psycho-social, and welfare cost of improper or inadequate care.

The number of NJ residents with hemophilia on Medicaid or FamilyCare is approximately 80-115 individuals.

Hemophilia has been exempted from Medicaid Managed care in the past and we believe that exemption should continue for the following reasons:

- There are no generic brands of clotting factor
- If Managed Care Companies are willing to accept capitated fees, for a patient with hemophilia, rest assured they will allow the use of only the cheapest products on the market. Cheaper, in this instance, means less pure.
- Fee for service is a safer reimbursement mechanism for persons with hemophilia.

I would be pleased to provide you with any additional information you require.

Thank you for your continued support of the hemophilia community in New Jersey.

Sincerely,



Elena Bostick  
Executive Director  
HANJ

**President**

James Vizzoni, R.Ph.

**CEO**

John A. Giampolo

**Executive Director of**

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### **Senate Health, Human Services and Senior Citizens Committee Testimony on the Proposed Fiscal Year 2011-2012 State Budget proposals for Medicaid by The Independent Pharmacy Alliance June 6, 2011**

Chair Weinberg and Members of the Senate Health, Human Services and Senior Citizens Committee. I am John Covello, Executive Director of Government and Public Affairs for the Independent Pharmacy Alliance, a trade group representing over 700 independently owned pharmacies in all size communities throughout New Jersey. And as this committee is well aware, a large number of IPA pharmacies - close to 300 - are located in poorer, more urban New Jersey communities that service a disproportionate number of Medicaid, PAAD/Senior Gold and AIDS patients. These stores are the backbone of a crucial healthcare delivery system providing needed prescription care and services that keeps New Jersey's most vulnerable citizens - children, poor, aged and disabled - managing their diseases and medical conditions, avoiding more intensive and expensive health care treatments from doctors, nursing homes and hospitals.

IPA fully appreciates the State's ongoing financial difficulties that the Administration faces in proposing another budget that needs to close a \$10 billion deficit. And we do understand the enormous challenge that will require difficult choices in finalizing the FY 2012 state budget. However, given your review today to examine how this proposal affects Medicaid, we must point out where the budget proposal for Medicaid is problematic for independent pharmacies and their Medicaid patients.

#### *Medicaid HMO Mandate for ABD and other Medicaid Patients is Troublesome*

The Administration's proposal is to shift the 27,000 Medicaid Aged, Blind and Disabled (ABD) population's prescription drugs to Medicaid managed care organizations (MCO) along with all Medicaid psychotropic drugs, all 11,000 DYFS clients' prescription drugs and over all 81,000 carved out dual eligible patients prescriptions with special needs to MCO. In total, the Administration's proposal claims to save \$36.4 million on this HMO mandate.

IPA believes preserving the Medicaid pharmacy access as a fee-for-service is a sounder way to provide this benefit than having it subcontracted to for profit PBM middlemen. To allow PBM's to dictate control over this benefit will jeopardize these patients needs and could see underserved areas lose pharmacies. That would result in health care cost increases as pharmacy patients seek the most costly and intensive health care alternatives of doctors' visits, nursing home stays and hospital emergency room services.

As the organization that successful convinced the state to reverse this type of HMO mandate for Medicaid SSI and ABD back in 2003, IPA questions both the savings determination for this proposal, the elimination of state control and oversight for these drug therapies and most important, the detrimental impact for Medicaid patients and their pharmacies.

It is crucial for everyone to understand this proposal to shift these 132,000 patients prescription services to the MCO does not mean all their health care needs get managed under one umbrella. As is the case now with NJFamily Care, few MCO directly administer the pharmacy claim; most subcontract out to a Pharmacy Benefits Manager (PBM) without any direct oversight or responsibility to the state program or the Legislature. Even with the federal requirement of drug rebates from these MCO to the state and federal government, the lack of direct control over the drug benefit by New Jersey would result in lack of accountability for the pricing charged to the state by the MCO for the Medicaid pharmacy benefit. Combine that with the PBM's administrative cost and their control under contract to the MCO – not the state – for the plan coverage raised questions as to how the proposal can save the state any money. More importantly, these Medicaid patients are atypical pharmacy patients. They are sicker, frail and more vulnerable than the general public. They typically are on multiple medications for various diseases. They do not fit the model for managed care because they have more serious needs that require pharmacy access and state administration. PBM's always look to shift patients to mail order, change their drug regiment and therapies. Under this HMO mandate, all these decision will be shifted from the state to the PBM's, without state control or oversight. **It is especially important for New Jersey to retain that control of Medicaid prescriptions given the fact that in recent years it there have been over many documented cases of \$371 million settlements in other states of Medicaid waste, fraud and abuse by PBM's.**

These points were proven when IPA successfully convinced Medicaid to revoke the last Medicaid prescription HMO mandate in 2003. And while the SSI population was shifted to the Medicare Part D program in 2006, the federal program is designed to avoid the greatest harm to patients – it allows patients and their pharmacy to build their prescription coverage needs to the best plan and preserves the patient's choice of pharmacy. Still, even under this model, patients do not always get their drug plan choice right to properly cover all their prescription needs. Even more troubling, these Part D plans are now finding ways to coerce and even force Part D patients into mandatory mail-order.

The point is these ABD and other Medicaid fee for service patients have great pharmacy service needs that are not well equipped to be served under the managed care model. And from both a fiscal and program management perspective, turning over control of this drug benefit to for-profit PBM's under a subcontracting arrangement with the MCO eliminates all government control and oversight over this critical safety net program. This Medicaid pharmacy managed care proposal does not prevent the HMO's from excluding pharmacies from providing specialty drugs and compounded prescriptions. All that will do is allow the HMO's and the PBM's to provide those items, which are very profitable directly from the mail order operations. Also, the shift of Medicaid Durable Medical Equipment (DME) from fee for service to Medicaid managed care, if simply added to the current MCO contracts, will not ensure that pharmacies that currently are approved Medicaid DME providers will be included in every HMO DME provider network. This will be harmful to Medicaid patients if this proposal will simply limit their access to critical diabetic supplies and other DME items – or creates an incentive to coerce the patient to seek these supplies

through mail order. Usually, these patients have disease states for they have prescription needs. This shift of Medicaid DME and their prescription services to managed care will jeopardize these patients overall care.

The Legislature needs to challenge these policy shifts, ask tough question of the underlining assumptions and calculations of how this change of coverage to PBM's will save the state money and yet preserve pharmacy services to a very needy Medicaid population that will prevent more costly ER and nursing home visits. This change cannot simply turn the current Medicaid services over to the HMO's under the existing contracts which allow for subcontracting to PBM's for pharmacy services. If the Legislature does not remove this mandate, clear principles must be included in the budget to protect patients and allow pharmacies to continue to serve these very vulnerable patients. To that end, the NJ Retail Pharmacy Coalition has requested the attached principles for Medicaid managed care for pharmacy to be included as budget language. While IPA fully agrees with all these principles, IPA believes the most fundamental requirement missing is the direct oversight and accountability of the PBM's to the state Medicaid program. Such oversight is required under ACCA for the State Health Insurance Exchanges and should be required for Medicaid managed care if it remains in the FY 2012 final budget agreement. I have included at the end of the Pharmacy Coalition's proposal IPA's requested budget language (in bold) for PBM accountability and oversight to the state Medicaid program.

Medicaid Waiver must ensure access to all pharmacy providers.

While there is much to be supported in the state's Medicaid concept paper for its global waiver for the program, there are several provisions that are of concern to IPA as it relates to independent pharmacies being able to continue to serve the General Assistance population.

Accountable Care Organizations (ACO's): While IPA endorses the notion of we fully support the concept of ACO's, we do have concerns that these entities, which are likely to be large organizations, should not be permitted to limit the pharmacies that can participate. We have a freedom of pharmacy choice law in New Jersey to which any ACO must adhere.

Rewarding Medicaid recipient responsibility: It appears that the Medicaid personal and healthy responsibility behaviors incentive portion of the waiver is based on the disease adherence principles embodied in the "Ashville Project", which does pay pharmacies to enhance and maintain patient disease management and treatment adherence. That is an approach community pharmacy has long supported. However, **this waiver proposal claims these financial rewards, managed by the HMO's will only be given to certain designated pharmacies. Again, this approach will limit Medicaid patients' choice of pharmacies in violation of the state's Freedom of Pharmacy Choice law.** Given such incentives only to certain pharmacies could result in many urban pharmacies, which serve the majority of the Medicaid GA population, to seeing their patients directed to only certain pharmacies. This approach could lead some of these pharmacies to close and jeopardize these Medicaid patients access to Medicaid pharmacy care. IPA opposes the waiver proposals restrictions on designating only certain pharmacies in this patient behavior reward program

Use of extrapolation for claims challenges: IPA fully supports every effort by the State to pursue Medicaid fraud based on the evidence. These efforts should be focused on where claims should be questioned before authorization and system controls to prevent unnecessary and improper Medicaid prescriptions. While this waiver proposals use of data mining to discover Medicaid fraud is legitimate, the proposed use of extrapolated data for Medicaid fraud recoveries is an inappropriate application of Medicaid fraud efforts. The use of extrapolation assumes a certain amount of fraud based on a sampling, not actual claims investigation. This approach is patently unfair and an overreach of effort. It is based on a faulty assumption that a certain percentage of claims must be fraudulent based on statistics, not real program integrity efforts. IPA opposes the granting the power through this waiver to the HMO's to use extrapolation for Medicaid fraud and abuse actions.

#### Conclusion

The bottom line for community pharmacies is there is a shrinking bottom line. Before Medicare Part D, independent pharmacies generally were already small operating margins. That trend is only getting worse, and the stress of the system is shown by the changing nature of New Jersey independent pharmacy community. In New Jersey, since Part D started in 2006, over 116 independent pharmacies serving urban and suburban poor and elderly patients have closed – including 23 in just the past year alone. All totaled, since the state first tried to shift in 2001 of pre-Part D SSI and ABD eligible pharmacy patients from fee-for-service to managed care (a policy reversed in 2003), 229 independent pharmacies have closed their doors statewide. The proposal to turn over a significant Medicaid population to for profit PBM's "middlemen" without any controls will only make that situation worse, with no guarantees it will save the state money in the process.

For those independent pharmacies serving urban and rural areas, where so many pharmacy patients are covered by Medicaid, PAAD, Family Care, Senior Gold & ADDP, you will see these patients lose pharmacy care access (because chain stores are not there) and the state see health care budget costs increase, not decrease, as these pharmacy care patients seek other more intensive and expensive health care services. The shift to managed care without protections will jeopardize both patient care and the future of many independent pharmacies. Also the Medicaid waiver proposals' efforts to further limit pharmacy access for the remaining fee-for-service Medicaid patient would also hurt our members' patients who rely on their local pharmacy.

IPA appreciates the committee's interest in the impact of the proposed budget's Medicaid initiatives on the most vulnerable patients, and we stand ready to work towards a common ground that will help vulnerable Medicaid patients in underserved areas preserve their pharmacy access needs. Thank you.

Respectfully Submitted,



**President**

James Vizzoni, R.Ph.

**CEO**

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E-mail: [info@ipagroup.org](mailto:info@ipagroup.org)Web: [ipa-rx.org](http://ipa-rx.org)**FY 2012 Budget Proposal for Medicaid Carve for Pharmacy Benefit needs direct control over Pharmacy Benefit Managers**

The administration proposes shifting 27,000 of Medicaid Aged, Blind and Disabled (ABD) population's prescription drugs coverage from fee-for-service to Medicaid managed care organizations (MCO) along with all Medicaid psychotropic drugs. Also, there are another 81,000 ABD that are in NJ Medicaid HMO but not for prescription that would now be required to have their prescriptions through managed care. The plan now also includes shifting 11,000 children in DYFS from their FFS for drugs to managed care.

Shifting Medicaid prescriptions to managed care for these 27,000 ABD's, 11,000 DYFS and the 81,000 already in Medicaid HMO' but not for drugs does not mean all their health care needs get managed under one umbrella. Of the 4 current Medicaid HMO's for NJFamily Care, only 1 – Horizon Mercy – directly manages its prescription claims. The others subcontract out to a Pharmacy Benefits Manager (PBM) without any direct oversight or responsibility to the state program or the Legislature. **The state will lack accountability for the pricing charged to the state by the MCO for the Medicaid pharmacy benefit.** This is simply a privatization out to the PBM, with higher administrative costs than the fee-for-service prescription system, combined with the lack of direct control over the drug benefit and the rebates.

The point is these ABD and other Medicaid fee for service patients are not typical patients – they are sicker, frail and more vulnerable and have great pharmacy service needs that are not well equipped to be served under the managed care model. They do not fit the model for managed care because they have more serious needs that require pharmacy access and state administration. PBM's always look to shift patients to mail order, change their drug regiment and therapies. Under this HMO mandate, all these decision will be shifted from the state to the PBM's, without state control or oversight. It is especially important for New Jersey to retain that control of Medicaid prescriptions given all the documented cases settled in other states of Medicaid waste, fraud and abuse by PBM's.

While IPA agree with the provisions provided by the New Jersey Retail Pharmacy Coalition on the needs for principles for Medicaid managed care, IPA believes the most fundamental requirement missing is the direct oversight and accountability of the PBM's to the state Medicaid program. Such oversight is required under ACCA for the State Health Insurance Exchanges and should be required for Medicaid managed care. If the Legislature is not going to remove language to shift pharmacy from managed care, the following budget language should be added in addition to those listed in the Pharmacy Coalition's proposal (IPA's language is in bold at the end of those already submitted by the Retail Pharmacy Coalition):

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Notwithstanding the provisions of any other law or regulation to the contrary, and subject to any federal approval that may be necessary, the amounts hereinabove appropriated in the Managed Care Initiative account are subject to the following condition: Effective July 1, 2011, assuming receipt of any applicable federal approval, the following services, which were previously covered by Medicaid fee--for--service, shall be covered and provided instead through a managed care delivery system for all clients served by and/or enrolled in that system: 1) home health agency services for the Aged, Blind, and Disabled (ABD) populations as well as individuals who are dually eligible for Medicaid and Medicare; 2) medical day care, including both adult day health services and pediatric medical day care; 3) personal care assistant services; 4) prescription drugs for the ABD population as well as for individuals who are dually eligible for Medicaid and Medicare; and 5) rehabilitation services, including occupational, physical, and speech therapies.

A participating Medicaid Managed Care Organization (MMCO), and its Pharmacy Benefits Manager (PBM), which provides prescription drugs benefits for all individuals which were previously covered by Medicaid fee-for-service and enrolled or expected to be enrolled in the managed care delivery system during Fiscal Year 2012 shall: 1) not require any of these individuals to use mail order, to pay an additional fee or be subjected to any other penalty for failing to utilize mail-order pharmacy; 2) fully comply with the state's "any will provider" law (NJSA 17:48A-7i ) 3) allow any pharmacy that participates in the MMCO network to provide specialty drugs defined as drugs that would be covered under the medical portion of the MMCO's health plan; 4) require to have a dispute resolution process for generic drug maximum allowable cost (MAC) reimbursement formulas that result in below acquisition cost payment; 5) contract with any willing provider who in the long term care setting has the capacity to provide specialty packaging, IV medications, compounding services, alternative dosage forms, intramuscular injections, 24/7 service and delivery, and emergency services, boxes and logbooks; 6) cover in the long term care setting all medically necessary medications at all levels of care, have an appropriate transition process and an exceptions and appeals process which allows an appointed representative to act in the enrollees behalf in the event of impairment which precludes the enrollee from participating in coverage determination and appeals process. For purposes of subsections 5) and 6), long term care setting is defined as assisted living facilities, residential treatment facilities, group homes, hospice care, medical day care and PACE in addition to skilled nursing facilities, IMDs and ICF MRs; 7) require direct contracting of the pharmacy managed care benefit between the MMCO and the NJ Division of Medical Assistance and Health Services; 8) be required to report quarterly to the NJ Department of Human Services on their generic dispensing rate and substitution rates; 9) incorporate the following audit protections in conducting audits of a participating pharmacy: prohibit more stringent record keeping by a pharmacy or dispensing entity than is required by State and Federal law or regulation; prohibit the use of extrapolation or other statistical expansion techniques in calculating the amount of any recoupment or penalty resulting from an audit of a pharmacy or dispensing entity; to the extent that an audit results in the identification of any clerical or record-keeping errors in a required document or record, the pharmacy shall not be subject to the recoupment of funds by the PBM unless the PBM can provide proof of intent to commit fraud or such error results in actual financial harm to the PBM, the MMCO, or the Medicaid recipient; and 10) specify that MMCOs and their PBM acting on behalf of Medicaid have a fiduciary responsibility to the state to ensure that the MMCOs and their PBM operate solely in the interests of individuals participating in qualified health plans offered by the MMCO; **11) provide to NJ DMAHS all relevant contractual instruments executed between the MMCO, the PBM and NJ Medicaid); 12) require PBMs to confidentially disclose to the DHS Commissioner and the plans the following information: a) the aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these passed on to the plan sponsor; b) the average aggregate difference between the amount the plan pays the PBM and the amount that the PBM pays a retail pharmacy; 13) mandate that the MMCO's require PBMs that administer its prescription drug benefits to provide to pharmacies that contract with the PBM: a) the methodology and resources that the PBM utilizes to determine reimbursement (including to calculate the maximum allowable cost list); and b) timely updates to pharmacy product reimbursement benchmarks used to calculate prescription reimbursement.**

Thank you for considering IPA's recommendations to protect the state's interests and these vulnerable patients.

## **Medicaid Managed Care Principles**

The Plasma Protein Therapeutics Association (PPTA) represents the world's leading manufacturers of plasma-derived and recombinant biological therapies, collectively known as plasma protein therapies, and the collectors of source plasma. These critical therapies are infused or injected by more than 1 million people worldwide to treat a variety of rare, life-threatening diseases and serious medical disorders. PPTA members produce in excess of 80 percent of the plasma protein therapies used in the United States today and more than 60 percent worldwide.

Lifesaving therapies produced by PPTA members include clotting factor therapies for individuals with bleeding disorders, immunoglobulins (IG) to treat complex diseases in persons with compromised immune systems and neurological disorders, and therapies for individuals who have alpha-1 anti-trypsin deficiency, which typically manifests as adult onset chronic obstructive pulmonary disease and substantially limits life expectancy.

### **MEDICAID HEALTH MAINTENANCE ORGANIZATIONS (HMOs)**

Many states are considering enrolling fee-for-service recipients in Medicaid HMOs as a strategy for solving their budget problems. Medicaid HMOs are a way for states to spend money more efficiently while providing quality care to certain Medicaid recipients who currently don't have their care managed by anyone. The mistake for states would be taking Medicaid recipients from providers who currently manage their care well and placing them with Medicaid HMOs that don't have the experience in providing quality care for the Medicaid recipients with rare, chronic conditions such as hemophilia. PPTA would like to suggest that Medicaid recipients with hemophilia currently have their care managed, just not typically by a Medicaid HMO.

### **HEMOPHILIA TREATMENT CENTERS ALREADY MANAGE CARE**

Hemophilia is well managed medically at 141 federally-funded Hemophilia Treatment Centers throughout the United States. Created in 1973, this nationwide network of hemophilia diagnostic and treatment centers provide a multidisciplinary, comprehensive care approach for patients and families within one treatment facility.

Hemophilia Treatment Centers' are a highly successful disease management program. Mortality rates and hospitalization rates for bleeding complications from hemophilia were concluded to be 40% lower among people who received medical care in hemophilia treatment centers than among those who did not receive this care.

### **MEDICAID HMOs LACK EXPERIENCE IN THE TREATMENT OF HEMOPHILIA**

Because Hemophilia is a challenge to develop accurate capitation and already well managed by Hemophilia Treatment Centers, many Medicaid HMOs have not engaged

in managing Hemophilia like other diseases. HMOs do not possess general knowledge about hemophilia -- how to treat it and best practices for therapy.

PPTA supports patient access to all medically appropriate, life-saving plasma protein therapies, which because of important clinical and manufacturing differences, an individual patient may tolerate or respond to one therapy better than another in the same class. Because such therapies are not therapeutically equivalent, pharmaceutically equivalent, or bioequivalent, they are not interchangeable.

An individual with hemophilia should have access to the full range of FDA licensed clotting factor concentrates from the most medically appropriate provider. Specifically, the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF)—a leading patient organization for persons with bleeding disorders in the United States--has stated in its guideline #159

“Clotting factor therapies are neither pharmacologically nor therapeutically equivalent and vary based upon purity, half-life, recovery, method of manufacture, viral removal and inactivation processes, potential immunogenicity, and other attributes. The characteristics of each product and the resultant product choice for an individual patient require a complex decision making process with the ultimate product being agreed upon by the patient and their respective healthcare provider. It is critical that the bleeding disorders community has access to a diverse range of therapies and that prescriptions for specific clotting factor concentrates are respected and reimbursed.”<sup>1</sup>

In fact, the U.S. Food and Drug Administration (FDA) has approved the various clotting factor therapies [Factor VII, VIII, IX and X and von Willebrand Disease] for distinct clinical indications. The therapies are neither clinically nor therapeutically interchangeable. In addition, some therapies are derived from human plasma, while others are made utilizing recombinant DNA technology, created from genetically modified cell lines.

In each case, different therapies require different dosages and different regimens, and may be appropriate or effective only for specific populations or for particular individuals within those populations. Treating these therapies as interchangeable directly contradicts the determinations made under FDA guidelines, which have undergone years of review.

Because of the uniqueness of each therapy, PPTA opposes any limitation of access to plasma protein therapies based on comparative effectiveness models by government and private health insurance plans for patients who have chronic, life-threatening diseases and disorders.

## **HEMOPHILIA's UNIQUENESS HAS BEEN RECOGNIZED BY FEDERAL AND STATE GOVERNMENT PROGRAMS –**

79X

<sup>1</sup> MASASC Recommendation #159 (last visited August 14, 2008), available at <http://www.hemophilia.org/NHFWeb/MainPgs/MainNHF.aspx?menuid=57&contentid=179>

**MEDICARE** – The Federal government offers its only exemption in DRGs for hemophilia, therapies allowing hospitals to pass through costs for hemophilia therapies for inpatient visits. Hemophilia therapies are the only drugs afforded a furnishing fee in the outpatient setting due to the unique risk and management of the disease.

**MEDICIAD** – In addition to New Jersey, Florida, and Kansas currently exempt hemophilia therapies from its Medicaid Managed Care Pharmacy Benefits and pay for hemophilia therapies on a through fee-for-service. Florida revisited this policy during their recently completed 2011 Regular Session, and once again determined it to be good health policy.

**HEMOPHILIA STAND ALONE PROGRAMS** – Florida, Louisiana, and South Carolina created stand alone programs for its Medicaid Management of hemophilia therapies and have chosen not to include the class in any Medicaid Managed Care pharmacy benefit.

#### **HEMOPHILIA CAN BE CHALLENGING TO MANAGEMENT OF A CAPITATED RISK MANAGED CARE PLAN**

**INHIBITORS** - Approximately 30% of patients with severe hemophilia A develop an inhibitor in their lifetime. Occurrences are unpreventable and unpredictable, but the costs are generally high and can reach over \$1 million. Treatment is complex and remains variable, even among experts. Because the number of patients is low, risk may not be evenly spread among Medicaid managed care plans. Fully capitated HMOs cannot predict inhibitor development and would very likely seek an increase in risk adjustment from the state to appropriately care for these patients.

**COST SHIFTING** – Due to the low incidence of Hemophilia, Medicaid beneficiaries receiving treatment for hemophilia could potentially spread unevenly across a state's Medicaid Managed Care plans. The odds that a disproportionate number of hemophilia patients end up in one plan could put a plan at tremendous risk of unlevel cost sharing.

**Inhibitor rates:** <http://emedicine.medscape.com/article/210104-overview>

**How to treat an inhibitor:** <http://www.cdc.gov/ncbddd/hemophilia/inhibitors.html>

**Mortality for HTC treated patients:** <http://www.cdc.gov/ncbddd/hemophilia/data.html>



**STATE OF NEW JERSEY**  
**SECTION 1115 DEMONSTRATION "COMPREHENSIVE WAIVER"**  
**CONCEPT PAPER**

**I. Overview of the comprehensive waiver**

The State of New Jersey (State), Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) is seeking a Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses all services and eligible populations served under a single authority that provides broad flexibility to manage all programs more efficiently. The waiver will allow New Jersey flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategy. The comprehensive waiver will:

- Consolidate New Jersey Medicaid and CHIP under a single-waiver authority
- Commit New Jersey to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- Promote increased utilization of home-and-community based services for individuals in need of long-term care
- Integrate primary, acute, long-term care and behavioral health care
- Promote efficient and value-added health care through Medicaid accountable care organization pilots
- Provide flexibility to promote primary and preventive care access by balancing eligibility and enrollment for services, the benefits received and the rate of payment for services
- Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
- Promote healthy behaviors and member responsibility for their health care

This concept paper describes the specific actions New Jersey will undertake to improve management of its programs and manage within available funds if it is successful in obtaining the flexibility it seeks.

The initiatives that ultimately are included in the formal comprehensive waiver submission will be driven by in-depth analyses and informed by public input.

**II. Streamlined and efficient program administration**

Consolidation of New Jersey Medicaid under a single waiver with administrative flexibility

Currently, New Jersey DMAHS and its sister agencies (including Divisions within DHS, Department of Health and Senior Services (DHSS) and the Department of Children and Families (DCF)) administer Title XIX and XXI programs under multiple authorities including:

- A Medicaid State Plan
- A Title XXI CHIP State Plan

- Two Section 1115 demonstration waivers (one that covers parents and a second recently approved that offers the formerly State-funded general assistance population an ambulatory benefit package under Title XIX)
- A Section 1915(b) waiver that allows mandatory managed care for certain populations
- Five 1915(c) home-and-community based services based waivers
- 1915(j) State Plan authority for cash and counseling
- Multiple contracts with managed care organizations

The comprehensive waiver replaces these disparate authorities and seeks a single, unified federal authority that specifies the types of changes that New Jersey can make with streamlined Centers for Medicare & Medicaid Services (CMS) approval and limits the changes that require more extensive and lengthy CMS review. New Jersey seeks CMS partnership in responding to changes quickly, which may be necessary to administer the most efficient Medicaid and CHIP programs possible in a time of limited budget resources. New Jersey requests the following CMS approval process:

- Level 1 changes – Administrative changes such as contract requirements for managed care organizations or administrative services only organizations and processes and procedures under the waiver (e.g., new performance measures, network requirements, care coordination requirements, quality indicators and/or reporting requirements) – *CMS approval would not be required.*
- Level 2 changes – Changes in the service delivery system, cost-sharing, services covered and/or rate changes not otherwise approved through the waiver and amendments to budget neutrality terms and conditions – *CMS questions and Requests for Information in 30 days and approval within 45 days or the change would be deemed approved.*
- Level 3 changes – Eligibility changes not otherwise approved through the waiver and amendments to budget neutrality terms and conditions – New Jersey would seek public input, submit these changes 120 days prior to the implementation date and *CMS would have 60 days to request additional information or pose questions, 60 additional days to review and approve or the change would be deemed approved.*

As part of this proposal, New Jersey intends to streamline its internal program administration. For example, New Jersey intends to demonstrate streamlined, effective procurement processes for Medicaid contracts. DMAHS will seek State authority to pursue competitive bidding of managed care contracts during the demonstration and relief from lengthy State procurement requirements in order to implement the various components of this demonstration along the described timeframes.

Consolidation of programs under the comprehensive waiver also means that the nature of the relationship and roles of DMAHS and its sister agencies will be redefined and memorialized in interagency agreements.

### **III. Eligibility and enrollment**

Under New Jersey's current Medicaid program, eligibility and enrollment policies, benefit packages and provider payment rates are in need of rebalancing. While the current program has



expansive eligibility levels and enrollment policies and relatively generous benefits, it nonetheless pays rates to some providers that may serve as a disincentive to participation in the program and limit the accessibility of primary care. The goal would be to ensure that hospital emergency departments, outpatient hospital clinics and inpatient beds are utilized only when appropriate.

In order to correct this imbalance, New Jersey will request broad flexibility for managing eligibility, enrollment and benefits.

#### Eligibility and enrollment flexibility

New Jersey is committed to continue serving individuals presently receiving services under New Jersey Medicaid and CHIP programs today (NJ FamilyCare is New Jersey's CHIP program). New Jersey will not terminate the eligibility and enrollment of any individual (child or adult) now served under its State Plan and/or waiver programs. Further, there will be no impact on eligibility criteria for children.

While New Jersey has chosen not to eliminate coverage for anyone now served by the program to avoid the turmoil to these individuals and the providers who serve them, there are three eligibility processes that New Jersey proposes to change for Medicaid and CHIP applicants:

- Freeze enrollment for all adult parents in the expansion population currently authorized under the Section 1115 waiver for parents with incomes up to 200% of the Federal Poverty Level (FPL). Enrollment of higher income parents (those with incomes above 133% of the FPL) in NJ FamilyCare (NJFC) was already frozen in March 2010. New Jersey seeks to freeze enrollment for the remaining NJFC parents by eliminating the enhanced earned income disregard for new applicants under Aid to Families with Dependent Children (AFDC)-related Medicaid (the difference between the AFDC income level and 133% of FPL).
- Eliminate the requirement that New Jersey provide coverage prior to the date of a Medicaid application for certain groups of new applicants. New Jersey will continue to provide prior-quarter coverage for individuals who are retroactively determined eligible for Supplemental Security Income (SSI) and certain individuals at the institutional level of care including home-and-community based services waivers. New Jersey believes this request is consistent with similar requests that CMS has granted in other states under 1115 demonstration authority, preserves retroactive eligibility for those most in need, and is consistent with New Jersey's belief that care should be managed at the earliest point possible.
- Require new managed care enrollees to choose a Medicaid health maintenance organization (HMO) upon eligibility application (or within 10 days of the application) or be auto-assigned. Members will be allowed a 90-day period to change HMOs without cause. After the 90-day period, plan changes for cause will be allowed, changing HMOs will be possible thereafter once a year during an open enrollment period.

New Jersey continues to migrate its Medicaid and CHIP programs towards coordinated care provided in comprehensive managed care delivery systems. Each of the provisions above are consistent with this philosophy: A person's care should be managed from the earliest point in time.

In return for the requested Medicaid eligibility flexibility, New Jersey is committed to improving its performance throughout the Medicaid eligibility determination process. To this end, the State will endeavor to:

- Significantly reduce the time for processing long-term care applications.
- Obtain authority to use preadmission screening instruments for the elderly, physically disabled, those with developmental disabilities, and those with mental illness as the disability determination for social security income from the Social Security Administration which will allow the individual to be eligible for long-term care services under 42 CFR 435.210 (would be eligible for SSI if they applied) well before the regular SSI eligibility determination is completed.
- Automate the redetermination process using IRS, State tax, child support and all other sources of income, residency and eligibility information. In order for New Jersey to accomplish this task the Social Security Number (SSN) of beneficiaries will be mandatory and maintained electronically for all programs.

New Jersey understands that these performance improvement steps will require a significant investment of time and resources on its part, but believes that the benefits to members and potential cost savings to the State are significant. These proposals reflect New Jersey's commitment to a Medicaid program that operates more efficiently and under a cohesive vision of eligibility and coverage.

#### Medicaid as payer of last resort

Under Title XIX of the Social Security Act, Medicaid is intended to be the payer of last resort with few exceptions. Medicaid continues to be available, however, to individuals who are insured through commercial and employer-based insurance and/or Medicare. On the other hand, Title XXI which authorizes the State CHIP, is explicitly available only to the uninsured. Both Medicare and private insurers have avoided payment of millions of dollars in claims they should have rightfully paid.

#### *Commercial insurance*

States depend on beneficiaries to provide third-party insurance information. When so informed, third-party liability can be identified and Medicaid payments avoided. HMOs are also required to inform states of the availability of third-party liability. This does not occur as often as it should, however, and Medicaid programs are asked to pay bills that should have been the responsibility of a commercial plan through employer-based coverage or coverage purchased directly by individuals.

Today, states are permitted to have Health Insurance Premium Payment (HIPP) programs to determine if the commercial coverage is cost effective and allow Medicaid to subsidize the premiums in lieu of direct payment under Medicaid for services covered by the commercial plan. Under Section 1906 of the Social Security Act, however, HIPP programs must evaluate each individual's or family's commercial policy, thereby creating a significant administrative burden.

Additionally, under the HIPP program, states are required to offer wraparound benefits: those that Medicaid covers but the commercial plan does not. The cost of wraparound benefits is significant (two states reported that savings would increase by 72% if wraparound coverage were eliminated). In spite of these current HIPP requirements, states report significant savings for HIPP under both fee-for-service (FFS) and managed care. Savings would be higher if administrative costs associated with determining cost effectiveness were reduced and wraparound benefits were controlled. Pennsylvania, Iowa and Texas operate aggressive HIPP programs under both their FFS and managed care programs. All three programs have significant enrollment today and report that savings increased over time.

Under the comprehensive waiver, New Jersey requests authority to enhance the opportunities under HIPP in three ways:

- Determine cost effectiveness in the aggregate by eligibility category and managed care rate code
- Eliminate wraparound coverage for adults excluding the aged, blind and disabled and children
- Improve reporting and follow-up to identify availability of employer-based coverage, particularly for members with chronic conditions and high medical cost

#### *Retroactive Medicare Part B*

For well over 30 years, state Medicaid programs provided health care services to individuals who were eligible for Medicare but because of an error in eligibility determination by the Social Security Administration were categorized as eligible for SSI rather than Social Security Disability Insurance. The error is reflected in the eligibility category known by states as SSI without Medicare. States had observed that the SSI without Medicare population was growing at a rate far in excess of the elderly and disabled with Medicare. The error is acknowledged by CMS and the Social Security Administration.

The total amount paid by states was originally estimated at \$4.8 billion (state funds only). This figure is expected to increase. New Jersey's share is estimated at \$107.3 million. In response to the error, CMS originally stated that it could not pay the states because the Medicare program only pays providers. States were asked to recoup payments from providers and then ask providers to bill Medicare. Most of the Medicare claims submitted by providers would no longer be considered timely filed and would be denied, aside from the significant administrative burden it would place on providers and the states.

As an alternative, several states, including NJ, have proposed that CMS allow states to pursue a solution through a 1115 waiver, and to use the amount owed (using the Medicare 222(b)

authority) as the non-federal share of expenditures in their current programs. New Jersey is incorporating this proposal into this comprehensive waiver, understanding the final disposition will be negotiated on behalf of a number of states.

At the same time, this Medicare Part B error points to the difficulty states have in keeping the statutory philosophy of “payer of last resort.”

#### **IV. Benefits and provider payments**

##### Benefit and cost-sharing flexibility

New Jersey is requesting flexibility in defining covered services and adopting limits on the amount, duration and scope of services as well as imposing copayments and other cost sharing.

The comprehensive waiver will also seek authority to engage the population the State serves in using health care services appropriately. New Jersey will implement enhanced cost sharing including both premiums and copayments. Premiums for parents with incomes over 100% of FPL may be adopted but will not exceed 5% of family income as required under 1916(f) of the Social Security Act. In addition, New Jersey believes that copayments beyond those allowed under current federal rules for inappropriate use of services will change behavior. The primary target is non-emergency use of hospital emergency departments where New Jersey is seeking to impose a \$25.00 copayment with the intent of redirecting care to primary care settings. Section 1915(f) of the Social Security Act provides authority to the Secretary of Health and Human Services to approve copayments directed at inappropriate emergency department use.

##### Payment rates to providers

The comprehensive waiver includes components that revise payment rates to providers that are designed to achieve four objectives:

- Rebalance the service delivery system toward primary care
- Provide equity in payments to in-state and out-of-state hospitals
- Incentivize payment reforms between HMOs and hospitals
- Participate in the Affordable Care Act provider payment reform demonstrations testing global payments and bundled payments

*Rebalancing.* As noted above, the New Jersey Medicaid program is in need of rebalancing with regard to the rates paid to primary care providers and other providers in specialty settings. Physician FFS rates are approximately 47% of Medicare rates and are estimated to be less than 25% of usual and customary charges.

At this time, New Jersey wants to shift the focus of payment to promote primary care and improve network adequacy and quality. Toward that end, the State will:

- Invest some of the savings achieved through other measures for an early implementation of increased payments to primary care providers up to 100% of Medicare rates. New Jersey proposes to phase this in up to full implementation in 2013 when an enhanced federal match will be available. (Phase-in based on what New Jersey can afford.)
- Encourage participation of those specialists in ambulatory settings that primary care physicians need for referrals through implementation of an enhanced consult fee.
- Through its HMOs implement payments to health care homes as described in Section V below.

*Fairness in payments to in-state and out-of-state providers.* In addition to rebalancing, New Jersey will also seek changes in payment rates that are designed to achieve fairness specifically when making payments to out-of-state providers. Most states limit payments to out-of-state hospitals to the lesser of the average rate paid to in-state hospitals or the rates paid the hospital by the Medicaid program in their resident state. New Jersey will adopt a similar policy as follows:

- Pay out-of-state providers the lesser of the New Jersey Medicaid rate or the servicing state's Medicaid rate when the service is available and the member has access to an in-state provider
- Coordinate with neighboring states and establish uniform payment rates for select facilities that provide specialty services

*Incentivize payment reform between HMOs and hospitals.* While Medicaid is continuing to encourage HMOs to delink themselves from the FFS rates, it is still clear that FFS rates continue to influence HMO and hospital behavior. As Medicaid moves more of its population to managed care, at some point the FFS rates will no longer be maintained. For this reason, the State is proposing:

- Require that non-contracted hospitals providing emergency services to Medicaid or New Jersey FamilyCare members enrolled in the managed care program shall accept, as payment in full, 95% of the amount that the non-contracted hospital would receive from Medicaid for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS. This is consistent with the New Jersey Appropriations Act which, for many years, has included the following provision: "Non-contracted hospitals providing emergency services to Medicaid or New Jersey FamilyCare members enrolled in the managed care program shall accept, as payment in full, the amounts that the non-contracted hospital would receive from Medicaid for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS." Similar language appears in a Medicaid statute at N.J.S. 30:4D-6i.
- Continue setting Medicaid managed care capitation rates that reflect costs associated with an efficient/effective HMO as compared to rate development as a cost-plus calculation. Specifically, capitation rates will continue to include a low acuity non-emergent analysis,

which is a clinical-supported approach that targets inefficient/unnecessary emergency department utilization. New Jersey Medicaid managed care data shows that about 62% of all ED services were deemed low acuity non-emergent visits in SFY 2010 with 24% determined to be preventable, accounting for 9.6% of the SFY10 emergency department expenditures. Prospectively, Medicaid managed care capitation rates will be reduced to reflect the expectation that HMOs must further reduce unnecessary emergency department utilization of its members.

*Participate in provider payment reforms under the Affordable Care Act to pursue episodic pricing and linkages to outcomes.* There are two payment reform opportunities under the Affordable Care Act in which New Jersey will seek participation with its HMOs and hospitals:

- Integrated Care Around Hospitalization – Section 2704 establishes a demonstration project, in up to eight states, to study the use of bundled payments for hospital and physician services under Medicaid. The demonstration is effective on January 1, 2012, and ends December 31, 2016.
- Medicaid Global Payment System – Section 2705 establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five states that would allow participating states to adjust their current payment structure for safety net hospitals from a FFS model to a global capitated payment structure. The demonstration shall operate through 2012. The Affordable Care Act authorizes this program but does not appropriate any funding.

## **V. Delivery system innovations**

New Jersey will take steps under the comprehensive waiver that are specifically designed to provide integrated health care services, promote competition, support health homes for members, and pilot the Accountable Care Organization model.

Integrated primary, acute, long-term care and behavioral health care: Managing long-term care for seniors and persons with physical disabilities

New Jersey is in the process of transitioning most Medicaid and CHIP enrollees into capitated managed care for most services. This comprehensive waiver continues the evolution in the delivery system by supporting cost-effective managed primary, acute, long-term and behavioral health care.

Beginning July 1, 2011, and into the fall, the primary and acute care needs of most Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid HMOs. In so doing, New Jersey will also include services, such as pharmacy for the aged, blind and disabled, that have historically been carved out of managed care. The only population that will remain FFS for primary care but still under the comprehensive waiver will be General Assistance, who will receive an ambulatory benefit under Medicaid. (Some *services* for other populations will also be FFS such as behavioral health) for certain adults and children as described below in this section.) The General Assistance benefit

excludes inpatient and outpatient hospital care which will continue to be funded through New Jersey's Charity Care Program funded with disproportionate share dollars.

A principle objective of the comprehensive waiver is to rebalance or shift away from the reliance on institutional and acute emergency services toward preventive and home and community-based care where an individual's health is improved and they can remain an active member of their community.

Effective July 1, 2012, New Jersey will further amend its existing HMO contracts to manage all long-term care services including home-and-community based services and nursing facilities for the elderly and physically disabled. In order to ensure that the HMOs can meet the needs of these populations, the State will ask for each HMO to describe how they will meet specified requirements, their experience elsewhere, describe their network completely and will not be allowed to enroll individuals with long-term care needs until a readiness review is successfully completed. HMOs must also submit plans for delaying and/or preventing their aged, blind, and disabled members who do not currently meet at risk-of-institutionalization criteria from reaching that level of care criteria. Managed long-term care will include:

- Those at risk of long-term care (meet the level of care criteria administered by the State) will have integrated home-and-community based services, behavioral health and acute care
- The continuum of home-and-community based services will be expanded beyond current 1915(c) authority
- Cost-sharing, home maintenance of needs allowances and post-eligibility treatment of income will be standardized across populations
- Cash and counseling services now authorized under Section 1915(j) of the State Plan will be included under managed long-term care (HMOs will be required to continue participation of members already participating in cash and counseling and/or self-direction upon implementation of managed long-term care for a transition period)
- Self-direction will be offered through the HMO along with fiscal intermediary services for independent providers (the State will secure fiscal intermediary services through a competitive bid and make the fiscal intermediary available to HMOs to provide members the most cost-effective service that results from larger volumes of participants)
- Existing PACE programs will be blended with managed long-term care as possible participants in the HMO long-term care network
- HMOs will provide case management and support coordination either directly or through contracts with organizations such as Area Agencies on Aging
- HMOs will have authority to mandate the cost-effective placement whether home-and- or nursing facility; home-and-community based services can be more expensive for a short-term transition period post discharge from a nursing facility (this authority must be requested and approved by CMS)
- HMOs will be required to implement information systems to automate care planning and tracking functions and predictive modeling

While New Jersey has made significant progress in rebalancing its long-term care programs to move more of its seniors and disabled into home and community-based settings, New Jersey

anticipates qualifying for the enhanced federal matching share under the Balancing Incentive Payments to be available under the Affordable Care Act and will submit a competitive and successful proposal when the opportunity is announced by CMS. This has the potential to provide New Jersey with an increased federal match from two percentage points up to five percentage points on non-institutional expenditures between October 1, 2011, and September 30, 2015.

In implementing managed long-term care, New Jersey is committed to building the infrastructure required to monitor quality and HMO performance in managing long-term care. Defining quality measures in the home-and-community based services framework is a major undertaking. In addition, New Jersey will examine and consider legislation that maximizes the role of self-directed care givers. As part of this proposal, the State will also seek a waiver of the Preadmission Screening and Resident Review requirements. HMOs will make placement decisions depending on the most appropriate setting for care.

#### Additional managed care improvements and pilots

In addition to the changes described in the previous section, New Jersey will take steps under the comprehensive waiver that are specifically designed to promote competition, support health homes for members, pilot the accountable care organization model and take steps to integrate behavioral health and physical health care.

In order to accomplish the changes necessary and have the programs in place between July 1, 2011 and July 1, 2012, New Jersey will amend current HMO contracts initially for these changes. However, the State will seek necessary authority to streamline its contracts and competitively bid managed care in two to three years. The managed care changes for acute/medical services include:

- Pilot accountable care organizations within a managed care framework and share savings for these initiatives with the State, federal government, HMOs, the accountable care organizations and providers
- Require HMOs to implement, at least on a pilot basis, health care homes (and accountable care organizations) to obtain 90% federal matching available under the Affordable Care Act
- Implement a member rewards and responsibility program based on a partnership between Federally Qualified Healthcare Centers and HMOs, supported by program funding from the Medicaid Grants for Prevention of Chronic Disease
- Effective January 1, 2012, behavioral health services for adults assessed to have low mental health and/or substance abuse symptoms/needs will have their care managed by a HMO to ensure:
  - Integrated care coordination
  - Integrated predictive modeling
  - Promotion of co-located service delivery
  - Integrated medical record and electronic medical record initiatives
- Provide incentives for integrating physical health and behavioral health for adults with major mental health and substance abuse disorders and/or serious mental illness served



outside of the HMOs under an administrative services organization) (See *Managing behavioral health* below)

- Work with DHS to develop a framework for access to Applied Behavioral Analysis for children with autism
- Provide incentives for integrating physical health and behavioral health for children served outside of the HMOs under the Children's Initiative (See *Managing behavioral health* below).

New Jersey will also conduct a pilot of an accountable care organization for the General Assistance population who will not be under managed care. New Jersey will seek authority to use disproportionate share dollars to fund shared savings with the accountable care organizations, HMOs, and the State for reduced emergency department and inpatient use by General Assistance members. In addition, the State will seek Safe Harbor protection from penalties under the Stark Anti-Kickback requirements for providers participating in accountable care organization programs under the comprehensive waiver.

#### Managing services for the dual eligibles

Under the comprehensive waiver, New Jersey will enroll dual eligibles into Medicaid managed care on or about September 1, 2011 for primary and acute care. Effective January 1, 2012, New Jersey will contract with Medicare special needs plans that are also Medicaid managed care plans (HMOs). New Jersey seeks \$1 million in grant funding as a component of the comprehensive waiver for planning the redesign of the current system of fragmented care for individuals who are dually eligible for Medicare and Medicaid.

Through the comprehensive waiver, New Jersey will require that dual eligibles enroll in a single Medicaid HMO/Medicare Advantage Special Needs Plans for receipt of both Medicaid and Medicare benefits. However, it appears that CMS does not have the authority to waive freedom of choice under Medicare. In the absence of such authority, New Jersey requests the ability to auto-assign a member to the same Medicare and Medicaid plan with an opt out for Medicare and the authority to limit Medicaid payment of Medicare cost-sharing to only those Medicare providers that are within the Medicaid HMO's network, with the goal of encouraging dual eligibles to enroll in the same plan for the Medicaid and Medicare benefits.

The Department has long recognized that the dual eligibles have been a cost driver for New Jersey. CMS has also recognized this issue and has offered states the opportunity to support states' ability to make data driven decisions. To that end, New Jersey will take advantage of the recently announced US Department of Health and Human Services series of initiatives to facilitate access to Medicare data in order to help coordinate care, improve quality, and control costs for these high risk and high cost beneficiaries.

Finally, New Jersey seeks to streamline oversight requirements, and as such, will seek a single appeals process rather than the two processes – one under Medicare and one under Medicaid.

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### Managing behavioral health

The comprehensive waiver proposes different approaches for managing behavioral health services (inclusive of mental health and substance abuse services unless otherwise specified) for adults and children.

*Adults.* Adults with moderate and intensive behavioral health needs will be supported through a non-risk model of managed care under contract with an Administrative Services Organization contract beginning January 1, 2013. Adults with less severe needs will be carved in to managed care beginning January 1, 2012, as described in a previous section as will all adults requiring long-term care services. DHS will develop and issue a request for proposals in SFY 2012. DHS will work with the New Jersey Division of Purchase and Property to accomplish this procurement in a short time frame. Otherwise, an exemption from the existing procurement process will be required so that DHS and DMAHS can quickly conduct necessary procurements to make use of the flexibility granted the State under the comprehensive waiver.

Before the administrative services organization is operational, the Division of Mental Health and Addiction Services within DHS will undertake a series of tasks in addition to developing the Administrative Services Organization Request for Proposal including:

- Work with DMAHS to promote integration of services with HMOs for the highest-cost members (top 5%) across the two systems including data sharing
- Work with health homes and accountable care organizations to promote integration
- Fully integrate addiction and MH services within a single division
- Complete a state hospital closure and transition residents to the community consistent with the Division's Olmstead plan. DMHAS will seek to utilize Money Follows the Person for patients leaving the State and county hospital system
- Engage stakeholders in improving the community infrastructure including the network of providers and emergency department triage
- Develop screening tools to identify adults that will be served through the HMOs
- Seek enhanced federal matching funds for integration of physical and behavioral health at community behavioral health provider sites allowed under Section 2703 of the Accountable Care Act
- Rebalance behavioral health provider rates to incentivize more cost effective care

Once the contract is in place, the administrative services organizations will perform a number of tasks on a non-risk basis. These tasks include:

- Develop and conduct a uniform assessment of all adults seeking treatment that includes diagnosis and functional status to identify the most "at-risk" population for long-term behavioral health service needs
- Conduct predictive modeling
- Manage inpatient admissions for private and public psychiatric care and perform continuing-stay review
- Recommend and implement prior authorization requirements approved by DHS
- Build a provider network focused on network adequacy for community-based care

- Perform all utilization management functions
- Assist residents' transition to the community from State hospitals that are closed
- Identify individuals meeting the State's definition of serious mental illness
- Recommend rate revisions to promote community behavioral health capacity
- Pay claims
- Provide member access services including on-line and toll free numbers with appropriate languages available
- Design and recommend a member rewards program
- Provide behavioral health supports for individuals with intellectual and developmental disabilities and provide training for direct care workers who must manage behavioral health issues
- Implement the following to promote integration of behavioral health and physical health (most requirements apply to the administrative services organization and the HMO):
  - Establish a formal process for administrative services organizations communication with HMOs and primary care physicians regarding their members in care
  - Share all behavioral health claims/encounters with HMOs allowed by federal regulations and vice versa
  - Streamline access into behavioral health services
  - Accept performance measures for integration steps taken by administrative services organization (and conversely the HMO)
  - Develop a joint focus with HMOs to integrate care for top 5% most expensive across the two systems including integrated medical records
  - Educate members and providers in both systems
  - Participate in electronic medical record initiatives
  - Develop care coordination protocols for integration with HMOs
  - Promote integrated service delivery (e.g., co-located behavioral health and physical health services)
  - Promote integrated service delivery through accountable care organizations
  - Implement hospital emergency department triage
  - Educate members regarding the formulary

Children. Most of the behavioral health services for children with moderate and intense behavioral health needs are currently supported through a non-risk model of managed care under the DCF – Division of Child Behavioral Health Services' contract with an administrative services organization provider. The administrative services organization provides many functions including utilization management, prior authorizations, a single point-of-entry and coordinates a behavioral health needs assessment process for children. This administrative services organization model will be utilized to support all children accessing behavioral health (mental health and substance abuse) services for all levels of need. Children, more than adults, often move more rapidly back and forth from low-intensity need to high-intensity need. Therefore, a single management system through the established administrative services organization model will be utilized as the best model for ensuring coordinated, integrated care in an efficient and cost-effective manner. This transition will take effect in July 2012.

### Managing supports for individuals with intellectual and developmental disabilities

Consistent with the requirements of the Olmstead decision, a key objective of the comprehensive waiver is to reduce the use of institutional placement to care for people with intellectual and developmental disabilities and increase community placement and support for those individuals.

All developmental disabilities services under the supports waiver (which will be submitted to CMS) and the community care waiver, as well as State Intermediate Care Facility for People with Mental Retardation services for adults will be incorporated under the comprehensive waiver.

Before this occurs, New Jersey will seek enhanced federal match and aggressively pursue initiatives to:

- Obtain enhanced federal match under Balancing Incentive Payments to be available under the Affordable Care Act (two to five percentage points as described above)
- Implement the supports waiver to increase in-home supports and obtain federal match for Medicaid-eligible people for Medicaid-eligible services currently funded with State-only dollars
- Replace cost-based reimbursement with prospective rates
- Eliminate the process of intake applications for children who will not enter the waiver system for three or more years
- Expand the resource allocation levels for supports to include all adults served by home and community-based programs
- Expand the continuum of health-and-community based services and cost-effective residential alternatives
- Build the health-and-community based services provider network through reinvestments and incentives for community based services
- Integrate financial reporting systems
- Close a State developmental center and transition residents to the community using the Money Follows the Person grant support and using a portion of savings both to support individuals transitioned to the community and to reinvest in the home-and-community based services infrastructure

The Developmental Disabilities agency within DHS and DMAHS will also undertake initiatives designed to reduce the general fund dollars that are unmatched in the program but appear to be covered services for eligible adults and children under Title XIX. These initiatives include:

- Require a denial of Medicaid eligibility before State-funded programs are made available to both new and existing members
- Require SSN and adopt a common identifier for Medicaid and State-funded services to allow retroactive claiming for individuals determined eligible for Medicaid and submit a retroactive claim for services paid with state funds within the last 24 months (July 1, 2009-June 30, 2011)
- Enhance claiming federal match for out-of-state placements

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- Streamline eligibility policies and processes to reduce the amount of time before an adult is placed on the home-and-community based services waivers avoiding the use of state-funded services
- Develop policies to manage the waiting list and ensure that individuals with greater needs are prioritized on the waiver to avoid serving them with State funds
- Convert State-funded programs serving children to Title XIX

These initiatives taken as a whole also have a significant impact on New Jersey's ability to resolve the list of adults waiting to receive services. Once the supports waiver is implemented and reinvestments are made, New Jersey will be able to serve the majority of adults now on the waiting list.

Serving individuals with intellectual and development disabilities with dual diagnoses of mental illness and substance abuse disorders

New Jersey will implement an initiative that is specifically targeted to adults and children with a dual diagnosis of behavioral health and intellectual or developmental disability. New Jersey recognizes that some services currently funded largely through State funds (e.g., crisis intervention and advanced behavioral analysis) could be covered under Medicaid, and also recognizes that most if not all of the adults and children served are Title XIX or XXI eligible. As the initiative is designed, the State will maximize federal participation under Title XIX and XXI.

The potential savings to the State needs to be further refined, but the final proposal will be reliant upon the Dual Diagnosis Task Force Report as guidance. New Jersey proposes to examine mental health screening, in-home services, emergency and crisis intervention now provided with State-only dollars and develop a plan to incorporate the services into Medicaid. These services include:

- Adult mental health screening and emergency services
- Adult off-site crisis intervention
- Short-term emergency treatment
- Crisis stabilization/respite beds
- Specialist screening staff that work in conjunction with the Crisis Response System serving individuals with developmental disabilities and mental illness
- Supportive services that would allow for identification of needs at assessment and prior to the need for crisis intervention
- Applied Behavioral Analysis for children and young adults with autism spectrum disorder particularly those without mental retardation

In addition to screening, there are other mental health and substance abuse services such as individual and group therapy and medication administration that are provided through the community behavioral health system under contract with the Division of Mental Health and Addiction Services where rates of reimbursement are materially below cost. Payment rates for providers not under contract are higher. New Jersey recognizes that community behavioral health services are cost effective and will resolve the payment inequity as a component of the

intellectual and developmental disabilities/mental illness dual initiative. This initiative results in provider reimbursement rates that are prospective and not cost reconciled.

## **VI. Rewarding member responsibility and healthy behaviors**

Through the comprehensive waiver, New Jersey will also encourage all individuals receiving Medicaid to engage in healthy behaviors and accept additional responsibility for their health. New Jersey will engage its HMOs and the behavioral health administrative services organizations to develop a member reward initiative for healthy behaviors and/or compliance with a needed plan of treatment. HMOs would be given flexibility in the design of rewards programs and dollar incentives. The use of financial rewards would be restricted to health-related purchases through designated pharmacies. For example, members could be rewarded if they:

- Reduced or eliminated inappropriate emergency department use in favor of timely access to primary care
- Obtained age and condition-appropriate immunizations and preventive screenings
- Completed an outpatient substance abuse treatment program
- Participated in telemonitoring for diabetes, high blood pressure
- Quit smoking
- Had zero no-shows for scheduled appointments
- Completed follow-up appointments
- Were on time to appointments
- Lost weight according to a nutrition plan
- Exercised according to a treatment plan

As a complement to and funding source for the member rewards program, New Jersey has submitted a grant request under the Affordable Care Act Medicaid Incentives for Prevention of Chronic Disease. The Affordable Care Act authorizes grants of \$5 million to \$10 million to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. DMAHS has partnered with Federally Qualified Health Centers and HMOs in its grant proposal.

## **VII. Program integrity**

New Jersey will also include in its comprehensive waiver initiatives to promote the integrity of the program. These initiatives include:

- Refocus program integrity investigations to the managed care environment including managed care entities themselves and development of strategies for program integrity for managed long-term care
- Implementation of the Medicaid Recovery Audit Contractor specific to managed care
- Revision of managed care contracts to place additional responsibilities on HMOs for reporting of potential fraud and abuse to DMAHS and the Medicaid Fraud Division for investigation, including:

- Redefining the Special Investigations Unit required within each HMO as a data mining function staffed by analysts not investigators that monitors claims and encounter data for potential provider and member fraud or abuse such as billing for services not rendered, billing for services not medically necessary, up-coding, misrepresenting clinical information, duplicate billing, using a Medicaid card belonging to someone else, lending or altering a Medicaid ID including duplication and altering or forging prescriptions
- Reporting of suspected fraud and abuse identified through data mining for investigation by the Medicaid Fraud Division thereby providing the potential for greater recoveries through extrapolation from sample data which HMOs are not permitted to do, the tripling of overpayments and the imposition of sanctions;
- Imposition of sanctions if an HMO fails to report potential fraud and abuse
- Strengthening internal audit and compliance functions within HMOs for fraud and abuse and third-party liability identification
- Requiring routine criminal background checks of high-risk providers and excluded individuals and entities
- Strengthening reporting and collection from liable third parties by requiring third-party liability data matches within the same corporate entity
- Enhanced focus for targeted services on explanations of member benefits sent by HMOs to engage members in making sure they receive the services for which the State has paid
- More sophisticated data matches for redetermination of Medicaid eligibility which will be possible through the SSN of Medicaid applicants and enrollees that New Jersey proposes to require
- Development of a package of amendments to Medicaid, New Jersey FamilyCare and General Assistance statutes and regulations, with input from the Medicaid Fraud Division of the Office of the State Comptroller; amendments to other DHS, DHSS and Department of Banking and Insurance and State probate statutes, with input from relevant State agencies and amendments to the Rules of the Court to accomplish the following:
  - Clarify and enhance the ability of DMAHS, the Medicaid Fraud Division and/or the Medicaid Fraud Section in the Division of Criminal Justice to address fraud, waste and abuse; save and recover funds when third-party liability exists and obtain reimbursement of Medicaid funds from estates and special needs trusts
  - Provide DMAHS the authority to file liens against the property of living permanently institutionalized individuals and to issue "cease and desist" orders, with penalties for failure to comply
  - Provide DMAHS greater authority and flexibility to address fraud and abuse by beneficiaries

### **VIII. Budget neutrality**

Consolidation of programs under Section 1115 necessitates the negotiation of a "budget neutrality" agreement with CMS for most of the Medicaid and CHIP dollars and programs New Jersey administers. The concept of "budget neutrality" is that a 1115 demonstration program will not cost the federal government more than it would under existing Medicaid program rules

over the term of the demonstration. There continues to be a State/federal matching requirement and a state is "at risk" for the costs of continuing to serve populations and services if expenditures under the budget neutrality agreement are exceeded.

Under this proposal, there are just a few expenditures that would not operate under the demonstration:

- Services for individuals who are eligible for Medicare but do not receive a "full" Medicaid benefit because their income or assets are too high. These groups include Qualified Medicare Beneficiaries (QMB) Only, Supplemental Low Income Beneficiaries, Qualified Individuals (QI1s) and additional Qualified Individuals (QI2s). (The QMB Plus group does receive a full Medicaid benefit and are included in the comprehensive waiver.)
- Medicaid administrative expenditures claimed by schools.
- Medicaid administrative costs for DHS and its sister agencies. (Administrative costs are excluded from the tests of budget neutrality under Section 1115 waivers because CMS wants to ensure that the State has the infrastructure to administer the waiver.)
- FFS expenditures for emergency services-only populations.

All other program dollars and the disproportionate share hospitals allotment are proposed to be subsumed under the waiver. Disproportionate share dollars are to be included in this waiver for the following reasons:

- To redirect a portion of DSH dollars to incentivize hospitals and other providers for reduced emergency department and inpatient hospital use in the accountable care organization pilots.
- As a protection should it be needed to ensure that the state does not exceed budget neutrality. New Jersey will continue to pay disproportionate share hospitals under its current plan (with the three exceptions noted for General Assistance and health in this paper and the Affordable Care Act), unless it needs the DSH allotment to meet budget neutrality.

Most Section 1115 waivers are for a five-year period, which would encompass the Affordable Care Act 2014 implementation of new populations under Medicaid and a myriad of other changes. New Jersey could either shorten the waiver period or negotiate the terms under the Affordable Care Act.





# **MANAGED LONG-TERM CARE IN NEW JERSEY**

**APRIL 2009**

**JON S. CORZINE  
GOVERNOR**

**HEATHER HOWARD  
COMMISSIONER**

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## Introduction

New Jersey's Fiscal Year 2009 Budget included the following language:

On or before April 1, 2009, the Commissioner of the Department of Health and Senior Services shall report to the Governor, the State Treasurer, the President of the Senate and Speaker of the General Assembly on, the department's plan for the conversion of the Medicaid fee for service long-term care benefit to managed care. The report shall include but not be limited to timeframes for implementation per county, plan design, included and excluded populations and projected savings in related Medicaid expenditures relative to fee-for-service projections for Fiscal Year 2010 through 2014.

This report fulfills that requirement. In this report, we begin by describing the current state of re-balancing efforts in New Jersey. We provide a detailed overview of the major decisions that New Jersey must make regarding the rollout of managed long-term care. We survey the planning activities that have taken place to date and the decisions that the Department of Health and Senior Services has made based on those planning activities. We conclude with an estimated timeline for a pilot of managed long-term care.

Managed long-term care has been tried to varying extents in several Medicaid programs. It is a model with great promise but also with real risks for what is a particularly vulnerable group of Medicaid beneficiaries. Managed long-term care is still a relatively new phenomenon and in need of careful study.

New Jersey has already made significant progress in transforming long-term care from institutional to home and community-based settings, as detailed in the background section below. However, progress in "rebalancing" the long-term care system has been uneven, with some counties and some populations progressing faster than others. Our recommendation, therefore, is to proceed with a pilot managed long-term care program and to include a rigorous third-party evaluation of the program before making a decision on a statewide managed care model in New Jersey. This report lays out a plan for **a pilot of managed long-term care in a small number of**

counties, focusing on the elderly and those with physical disabilities. This would be a pilot of managed long-term care as a new delivery system for entire long-term care eligible populations, and we propose that enrollment into managed long-term care would be mandatory in the pilot counties. We also propose a focus on counties with a large Medicaid long-term care population in order to provide sufficient enrollment for participating plans.

There are multiple time-consuming administrative processes involved in establishing a pilot managed long-term care program. We anticipate these processes taking until SFY 2011—at which point a pilot program could begin enrollment.

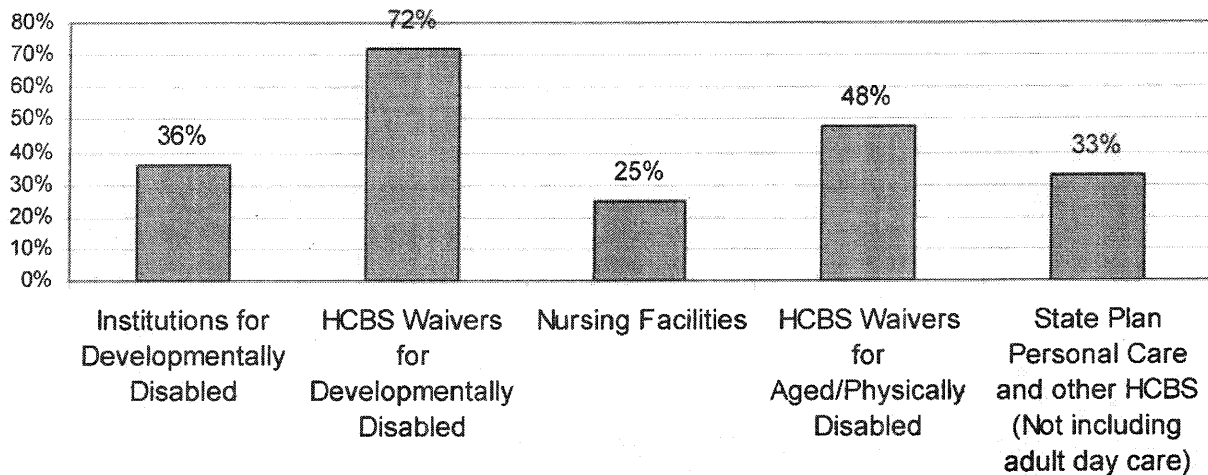
## **Background**

Medicaid long-term care benefits are delivered to a diverse set of beneficiaries, including most notably: the frail elderly; people with physical disabilities; people with developmental disabilities; and people with severe mental illness. The State of New Jersey has made substantial progress in shifting the delivery of long-term care from institutional to home and community-based settings. According to the AARP, between, 2002 and 2007 New Jersey spending on HCBS grew substantially faster than spending on institutional services.<sup>1</sup>

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<sup>1</sup> AARP, Across the States 2009. Because AARP does not count Adult Day Care in its calculations, growth in "State Plan Personal Care and other HCBS" is under-stated.

**Change in Medicaid Spending on Institutional vs. Home and Community-Based Services, New Jersey 2002-2007. (Source AARP)**



More recently, New Jersey has initiated a multi-faceted effort to rebalance long-term care for the elderly and physically disabled. On June 21, 2006, Governor Jon S. Corzine signed the Independence, Dignity and Choice in Long-Term Care Act to create a process to reallocate Medicaid long-term care expenditures and develop a more appropriate funding balance between nursing home care and other home and community-based care services (HCBS). The State is now legislatively charged with rebalancing its Medicaid long-term care system to include more community care and greater consumer choice, and to ensure that “money follows the person,” allowing maximum flexibility between nursing homes and home and community-based settings.

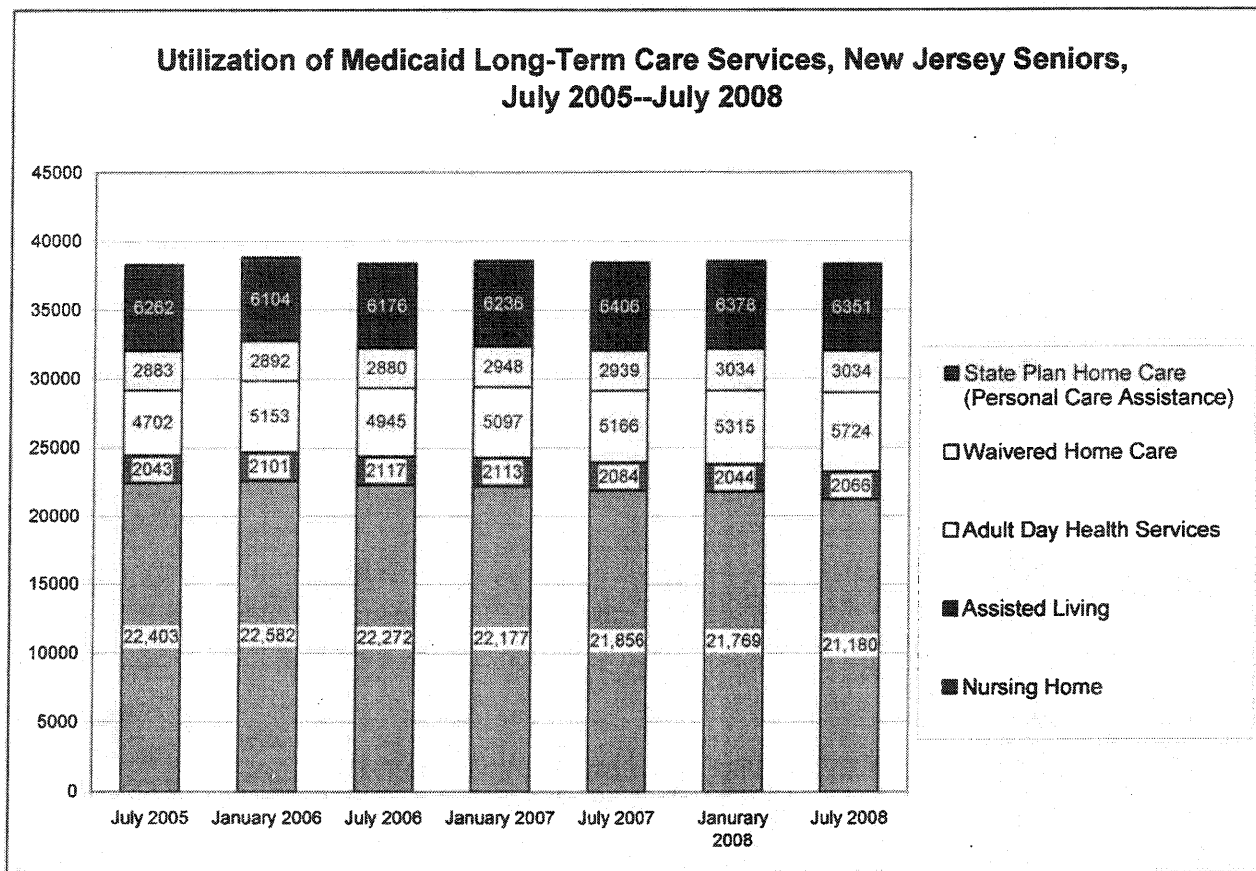
The centerpiece of this effort is the Aging and Disability Resource Connection (ADRC). ADRC, with a focus on community residents and consumer direction, was initially implemented in the pilot counties of Atlantic and Warren in 2007 and is recently expanded to seven counties. In the ADRC model, consumers are informed about appropriate long-term care options as part of a comprehensive assessment and care management approach administered at the county level. Based on their eligibility criteria, consumers are counseled on appropriate home and community based services. This model is paired with nursing screening and diversion programs that coordinate with the ADRC.

A number of other reforms have taken effect in parallel with the ADRC:

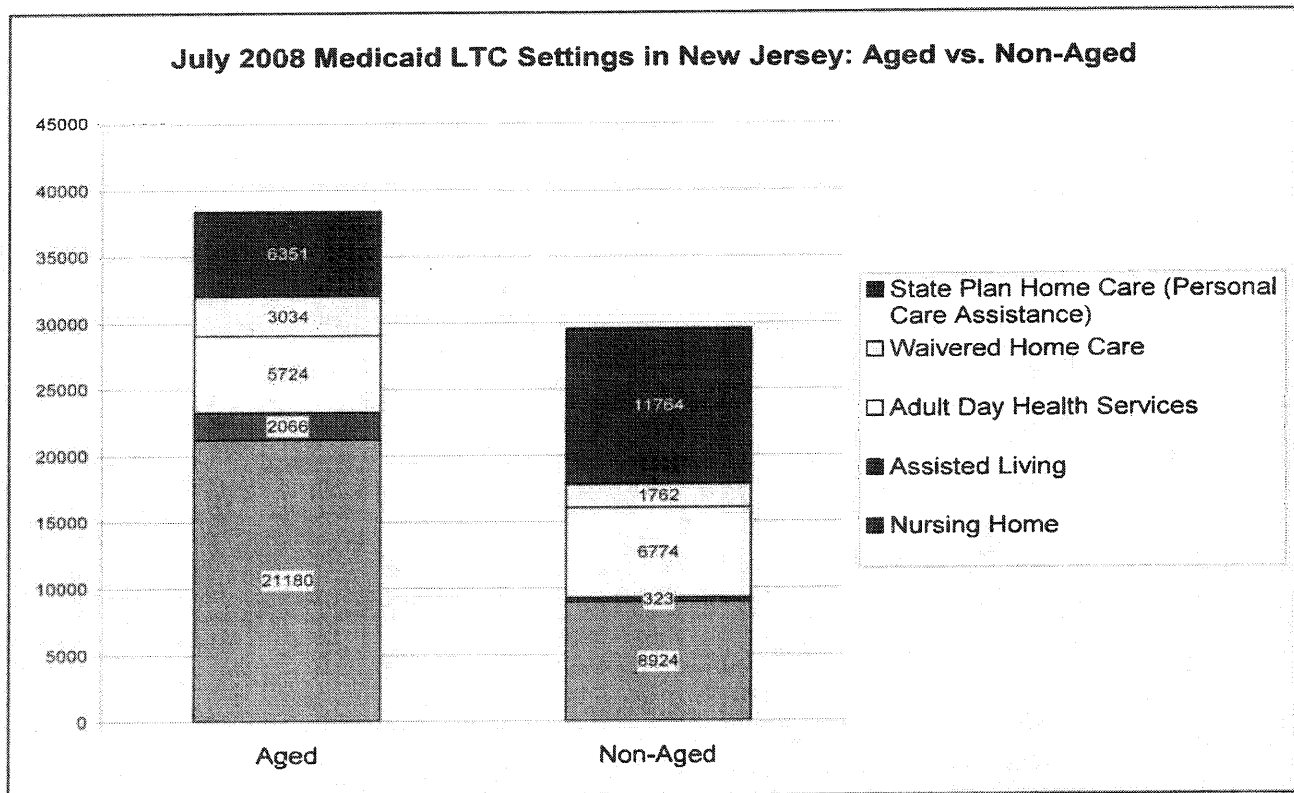
- Under a new Medicaid Eligibility Fast Track Determination (Fast Track) process available statewide, consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria can receive HCBS for up to 90 days while they complete the full Medicaid application and eligibility determination process.
- A Nursing Home Transition program has increased available funding, expanded HCBS options, and provided more flexibility for nursing home residents to control and direct their services.
- A new budget process is under development in the DHSS to support the rebalancing of the State's long-term care budget.
- The three Medicaid waiver programs for home and community-based services have been consolidated into one Global Options waiver and a web-based client tracking system is being implemented.
- New Jersey has begun operating the first of several anticipated PACE (Programs of All-inclusive Care for the Elderly) programs. PACE incorporates managed long-term care with Medicare managed care, using both funding streams to support an intensive care management model housed in a medical adult day center. PACE provides a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate.

These efforts have led to demonstrable results for long-term care delivery to elderly people. As shown in the chart below, despite growing populations of frail elderly and people with physical

disabilities, Medicaid nursing home use among the elderly has gone down steadily over the last three years while use of home and community-based services has increased.



However, progress in “rebalancing” the long-term care system has been uneven, with



some counties and some populations progressing faster than others. Although nursing home use is declining among the elderly, over 50% of elderly users of Medicaid long-term care are still in nursing homes in New Jersey, a number that is higher than the United States average.<sup>2</sup>

### How Managed Care Could Help to Rebalance Long-Term Care in New Jersey

Medicaid managed long-term care is similar to the existing Medicaid managed care program for primary and acute care in New Jersey (and most states) in that an insurance company receives a fixed monthly amount per person (a capitation) from the state in return for delivering a range of Medicaid services. However, managed long-term care involves capitation for Medicaid long-term care costs, typically including both nursing home care and home- and

<sup>2</sup> AARP, Across the States 2009.

community-based services ("HCBS"), rather than physician and hospital costs. In some states plans cover both Medicaid long-term care and conventional primary and acute care Medicaid benefits.

Beginning with a small pilot in California in the late 1980s and with Arizona's statewide system in the early 1990s, a number of states have employed capitation as a tool to encourage efficiency and in particular to encourage the substitution -- where possible -- of HCBS for nursing home care.<sup>3</sup> States also expect managed long-term care to provide comprehensive case management and coordination services. **Table 1** below summarizes the history of managed long-term care in Medicaid.

From the state's perspective, the primary objective of managed long-term care is to incentivize insurers to allocate resources cost-effectively and appropriately. Because HCBS are typically less expensive than institutional care, managed care organizations have an incentive to maintain people with disabilities in the community if possible.

Both fee-for-service and managed care Medicaid programs have two primary mechanisms for changing where a given consumer receives long-term care. The first is the authority to approve or disapprove a given service. The second is the capacity to work directly with consumers in a care management capacity to maximize their independence and well-being.

Managed long-term care can strengthen both of these mechanisms, because capitation gives plans a strong financial incentive to hold down the high cost institutional services. Managed long-term care plans can be expected to reduce nursing home utilization through the process of approving or denying services. Managed long-term care plans also have financial incentives to limit high cost services by investing in a care management program. Some states

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<sup>3</sup> "The Past, Present and Future of Managed Long-Term Care" Paul Saucier, Brian Burwell and Kerstin Gerst Thomson/MEDSTAT and University of Southern Maine, Muskie School of Public Service April 2005, Department of Health and Human Services.



have made a robust, "high-touch" care management program a specific requirement in managed care contracts. In New Jersey, where there are both state-level and county-level care management systems already in place in the fee-for-service system, managed long-term care could either replace those care management entities or work in concert with them.

Many of the established programs are still relatively small pilots, and the state with the most mature program, Arizona, has never had a Medicaid fee-for-service system as a basis for comparison. Medicaid officials in states such as Minnesota and Wisconsin believe strongly that managed care has been successful in their states. But a cautious, step-by-step approach in implementing managed care in New Jersey would be best for New Jersey.

<b>TABLE 1: Characteristics of Selected Managed Long-Term Care Programs<sup>4</sup></b>						
<b>Program</b>	<b>Implementation Date</b>	<b>Population Eligible</b>	<b>Voluntary/ Mandatory for Medicaid</b>	<b>Geographical Coverage</b>	<b>Medicaid Payments</b>	<b>Must enroll in Medicare Managed Care</b>
<b>PACE (includes "pre-PACE")</b>	1983 (On Lok)	55+ with NF-level LTC needs	Voluntary	40 urban programs in 17 states	Capitated primary, acute and LTC; rate structure varies	Yes
<b>Florida Frail Elder Option</b>	1987	Aged and disabled; NF-level LTC needs	Voluntary	2 urban counties in Southeast Florida	Capitated primary, acute and LTC; three rate cells	No
<b>Arizona Long Term Care System (ALTCS)</b>	1989	Aged and disabled; NF-level LTC needs	Mandatory	Statewide (urban and rural)	Capitated primary, acute and LTC; single blended rate	No
<b>Wisconsin Partnership Program</b>	1995 <sup>2</sup>	Aged and disabled; any LTC needs	Voluntary	6 counties (rural and urban)	Capitated primary, acute and LTC; multiple rate categories	Yes
<b>Minnesota Senior Health Options (MSHO)</b>	1997	All aged	Voluntary	Initially 7 urban and 3 rural counties, now expanding statewide	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Yes
<b>New York MLTC Plans</b>	1997	Aged and disabled with NF-level LTC needs (aged/ disabled varies by plan)	Voluntary	Multiple counties (rural and urban, but mostly urban)	Capitated LTC only (primary and acute FFS); multiple rate cells	No
<b>Texas Access Reform (Star) + Plus</b>	1998	All aged and disabled	Mandatory	Initially 1 urban county; now statewide urban expansion	Capitated primary, acute and LT (NF limited to 1 mo.; Rx not in cap); multiple rate cells	No
<b>Florida Diversion</b>	1998	Aged with NF-level LTC needs	Voluntary	25 urban and contiguous counties	Capitated primary, acute and LTC; single rate	No
<b>Wisconsin Family Care</b>	2000	Aged and disabled; NF-level LTC needs	Mandatory	Initially 5 counties, now expanding state wide	Capitated LTC only (primary and acute FFS); two rate cells	No
<b>Minnesota Disabled Health Options</b>	2001	All physically disabled	Voluntary	Initially 4 urban counties, now expanding state wide	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Yes

<sup>4</sup> Adapted from "Past Present and Future of Managed Long Term Care", DHHS 2005.

Mass Health Senior Care Options (SCO)	2004	All aged	Voluntary	Nearly statewide (rural and urban)	Capitated primary, acute and LTC; multiple rate cells	Yes
New Mexico (CLTCS)	2008	All aged and disabled	Mandatory	Initially 6 counties, expanding statewide	Capitated primary, acute and LTC, but mostly seniors who receive FFS Medicare	No

### Options for New Jersey:

There are several basic decisions that New Jersey must make regarding managed long-term care program design:

1. Which Populations: Medicaid long-term care benefits are delivered to a diverse set of beneficiaries, including most notably: the frail elderly; people with physical disabilities; people with developmental disabilities; and people with severe mental illness.
2. Relationship with Medicare and other Medicaid benefits: Managed long-term care has been combined with capitation for other Medicaid or Medicare services in some states. Texas has integrated managed long-term care with capitation of managed care organizations for the whole Medicaid benefit package including acute care costs, and has expanded the program on a mandatory basis to much of the state. Massachusetts has gone further, integrating the entire Medicaid benefit with Medicare managed care for dual eligibles.

Table 2 below lays out these options:

<b>Table 2: Options for Integration of MLTC and Other Managed Care Benefits</b>	<b>Medicaid Long-Term Care Only</b>	<b>All Medicaid</b>	<b>Medicaid-Medicare</b>
<b>Contractor at risk for:</b>	<b>Medicaid HCBS and Nursing Home</b>	<b>Medicaid HCBS and Nursing Home</b>	<b>Medicaid HCBS and Nursing Home</b>
		<b>Medicaid Primary and Acute</b>	<b>Medicaid Primary and Acute</b>
		<b>Medicaid Rx</b>	<b>Medicaid Rx</b>
			<b>Medicare Primary and Acute</b>
			<b>Medicare Rx</b>

3. Starting in one county, a group of counties, or statewide: Although managed long-term care has a great deal of promise, it also requires careful evaluation, which indicates that a pilot in a small number of counties is advisable. However, it is also important to have enough Medicaid enrollment in the pilot to support managed care operations. As described below, these considerations lead us to recommend a pilot in a small number of high-Medicaid counties.

4. Mandatory v. Voluntary enrollment: Voluntary enrollment can be a way to mitigate the impact of managed care during a pilot phase. States that have made managed long-term care voluntary for Medicaid beneficiaries generally see most of their LTC users stay in the fee-for-service system. However, voluntary enrollment also leads to intense pressure on plans to “cherry-pick” low-cost individuals. Long-term care costs are predictable and if plans can select favorable risks, managed long-term care will cost Medicaid more than fee-for-service. The issue of mandatory enrollment is also partly tied to the earlier question of whether to integrate with Medicare managed care for dual eligibles. The federal government has long ruled that Medicare managed care (Medicare Advantage) enrollment cannot be mandatory for dual eligibles.

5. What is Covered: Medicaid long-term care incorporates a mix of regular Medicaid benefits, such as nursing home care, personal care assistance, and medical day care and

special HCBS waiver benefits. Although we have flexibility in which of these benefits are covered by managed care, it is important not to leave major gaps through fee-for-service carve-outs in what managed care plans are at risk for. Because different long-term care services can substitute for each other, if managed care plans do not have to pay for a service they will be strongly incentivized to shift care into that service as a way to shift costs back to fee-for-service Medicaid.

Another question with regard to scope of managed care coverage is how much plans are at risk for residential or institutional placements—that is, nursing home and assisted living. Having plans fully responsible for institutional costs can be problematic, because many residents of nursing homes and assisted living begin their stay as private pay and then spend down to Medicaid eligibility. In this circumstance, there is often very little a plan can do to manage for a long-time resident of a facility. Plan finances could become dominated by whether or not they enroll these “spend-down” cases. However, if plans are not at-risk for any residential placements, they will have no incentive to avoid them, which undermines much of the potential benefit of managed long-term care. Most states that have implemented managed long-term care have given plans financial responsibility for only the first 2-6 months of nursing home care.

6. Insurance Regulation: The Department of Banking and Insurance currently regulates private long-term care insurers, but private insurers offer a much simpler long-term care benefit than Medicaid. The state will have to develop new regulatory standards for multiple areas in order to properly regulate Medicaid managed long-term care plans. These include:

- How provider groups could qualify for taking insurance risk as an organized delivery system;

- How the state will define an adequate network of providers: Network adequacy is a particularly important concern given the wide acceptance of Medicaid fee-for-service among long-term care providers and the importance of a local service provider for many users of long-term care.
- Utilization management: A strong system for the state to monitor whether plans are allowing for adequate levels of service is critical for a new program that focuses on a vulnerable population.
- Appeals and grievances: As with regular Medicaid managed care, the state has an important obligation to provide a transparent and consumer-friendly process for appealing plan decisions, beginning within the plan and then moving to a fair hearing process -- when necessary. The process should be open to providers as well as consumers. Given the high level of cognitive disability in Medicaid LTC, plans must establish procedures for appeals and grievances that include assistance for people with cognitive limitations and their surrogate decision-makers.

7. Types of plans: The type of managed care organizations has varied among MLTC states. In some states, managed long-term care has been dominated by long-term care agencies or community-based organizations who started their own plans. In other states, MLTC plans are administered by more traditional insurance companies. It is important to note that whether delivered by conventional insurance companies or by provider-based plans, managed long-term care is a labor-intensive business involving face-to-face care planning.

8. Capitation rates: States have varied widely in their approaches to rate-setting for managed long-term care monthly capitation rates, and some states have only minimally conducted risk adjustment of rates. Because long-term care costs are more predictable than

medical costs, there is a major risk of cherry-picking of low-cost enrollees in managed long-term care unless plans receive the appropriate rate for members with different risk profiles.

Furthermore, the state and its county partners have now developed a robust assessment and screening process that could be utilized in scoring new enrollees for risk adjustment purposes.

9. Provider rates: Managed care organizations often negotiate rates with medical providers on a contract by contract basis. Some states have structured their managed long-term care program with existing Medicaid fee-for-service rates as a floor for managed care rates. This places an emphasis on reducing costs by managing utilization rather than by reducing rates.

#### **Planning activities and decisions to date**

As noted above, the 2009 budget directed the Department of Health and Senior Services to develop a plan for the implementation of Medicaid managed long-term care in New Jersey. Almost from the point the NJDHSS received this directive, we began a series of public discussions with major Medicaid provider, insurer and consumer groups regarding the possibility of managed long-term care. With support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, a major Medicaid managed care consulting firm and think-tank located in New Jersey, has been working with the Departments of Health and Senior Services and Human Services on an intensive consultation program regarding both regular Medicaid managed care and managed long-term care. The long-term care program has focused on lessons learned from other states with managed long-term care and related programs, including Minnesota, Wisconsin, New Mexico and Washington State.

Based on these efforts as well as our analysis on where change is most needed in long-term care delivery, we would make the following recommendations for managed long-term care in New Jersey:

- Start with a pilot program: Managed care has promise for long-term care, but it also is a relatively new model nationally. Our recommendation is to proceed with managed long-term care on a pilot basis and to include a rigorous third-party evaluation of the program before making a decision regarding managed care's utility in New Jersey more broadly.

- Focus initially on the elderly and physically disabled: As demonstrated above, frail elderly and people with physical disabilities still receive most of their long-term care in nursing homes, although significant progress has been made. Indeed, New Jersey is slightly below the national average in the balance of institutional vs. community-based care for these populations. Given the potential power of managed care to drive rebalancing efforts, it makes sense to pilot managed care with these populations.

- Make enrollment mandatory or mandatory with an opt-out provision: Although voluntary enrollment may seem less risky, in a number of ways it is more risky from a policy perspective. Voluntary enrollment also leads to intense pressure on plans to "cherry-pick" low-cost individuals. Long-term care costs are predictable and if plans can select favorable risks managed long-term care will cost Medicaid more than fee-for-service. Moreover, the purpose of the pilot program will be to evaluate the effectiveness of managed long-term care organizations as a new delivery system for long-term care, an evaluation that will be difficult in a voluntary program.

- Risk-adjust capitation rates: States have varied considerably in the degree to which they vary capitation rates based on the individual risk profile of the individual consumer.



We recommend engaging an actuarial firm to develop an effective risk-adjustment system for setting MLTC rates. Such a system will minimize pressures to cherry-pick low-cost enrollees.

One attractive option is to utilize New Jersey's existing screening and assessment infrastructure to conduct risk measurement at the onset of managed long-term care enrollment and on an ongoing basis. New Jersey is now implementing a uniform screening and assessment tool as part of its ADRC effort, and this tool could be used by county staff to support risk measurement and rate-setting. In this model county staff would conduct an assessment and assign a risk score for each new member of a managed long-term care plan, which would then be a factor in the plan's reimbursement. The county assessment would also serve as a guide to quality monitoring activities.

- Separate managed long-term care from Medicare managed care: Managed care plans may be better able to coordinate care if they cover the entire Medicare and Medicaid package with one plan for dually eligible people, and PACE programs have achieved strong results integrating these two funding streams. However, there is at least one significant downside to tying Medicaid managed care to Medicare managed care. It is not possible to cover an entire population with Medicare managed care because it is against federal law to mandate enrollment in Medicare managed care, which is a voluntary program. It is also notable that the Obama Administration has made clear that it intends to make significant changes in Medicare managed care, possibly in the next two years.

- Pilot MLTC in two or more counties with high Medicaid enrollment: Both other states that have tried managed long-term care and managed care organizations have indicated that if plan enrollments are too small it is difficult to have critical mass to support the intensive

care management and insurance functions involved. Therefore, even in a pilot it is important to have enough Medicaid enrollment to support managed care operations.

- Put plans at-risk for all long-term care services: If managed care plans do not have to pay for a service they will be strongly incentivized to shift care into that service as a way to shift costs back to fee-for-service Medicaid. We recommend that comprehensive long-term care capitation to managed long-term care plans include the following services :

- i. All Medicaid para-professional home care services including those covered by the Global Options 1915(c) waiver and the regular Medicaid personal care assistance benefit,
- ii. Adult Day Health services,
- iii. Assisted Living,
- iv. Adult Family Care,
- v. Nursing Home.

Managed care plans also have the flexibility to offer additional value-added benefits including home modifications, tele-monitoring, and other services. In each case, payment to plans and regulation of plans must focus on ensuring adequate levels of service, with a particular emphasis on adequate levels of home care services.

We recommend that the following services be carved out of managed long-term care, at least in the pilot phase:

- i. Consumer-directed para-professional home care services, whether through the Personal Preference Program or through the Global Options Waiver. Consumer-direction means that consumers receive a monthly cash allowance and work with a consultant to develop a plan regarding the services they need

and the individuals and/or agencies they can hire to provide those services.

This structure is an alternative to managed care in New Jersey's long-term care strategy.

- ii. Nursing home spend-down cases and long-term nursing home stays: As noted above, giving plans no risk for nursing stays gives them a perverse incentive to admit high cost members to nursing homes. However, giving plans total risk for nursing home costs can lead to a risk of forcing plans to cut back on necessary nursing home care. Moreover there is little to be gained from plan enrollment of long-term nursing home residents after they spend-down to Medicaid eligibility; the state should avoid having plans compete to avoid such enrollments. We recommend leaving in fee-for-service both long-term nursing home stays and spend-down cases who have been long-term nursing home residents.

- Pass through some or all Medicaid fee-for-service rates: The purpose of managed long-term care is to change utilization patterns, not to reduce Medicaid rates. Long-term care providers are sometimes heavily dependent on Medicaid and particularly sensitive to Medicaid rate changes. In this pilot program, we recommend protecting some or all existing Medicaid rates for long-term care, encouraging plans to focus their cost reduction efforts on avoidance of high-cost services in general and nursing home care in particular. (As detailed above, we recommend that New Jersey engage an actuarial firm to develop an effective risk-adjustment system for setting the monthly rates that MLTC plans receive.)

- Administer a three year pilot: This will allow for two years of program operation before an evaluation in year three.

- Pay for a third-party evaluation: Managed long-term care has not had a strong history of rigorous evaluation. If New Jersey is going to make an informed decision regarding managed long-term care, evaluating the pilot is vital to future expansion across populations and across the state. This evaluation should be selected via RFP to include a robust methodology for quality assurance performance, as well as an examination of cost-effectiveness.

## **Timeline**

**Develop/Finalize Program Design:** As an important preparatory step the New Jersey Department of Health and Senior Services will establish an interdepartmental committee comprised of representatives from the Departments of Health and Senior Services, Human Services and Banking and Insurance to develop and finalize the program design. Through a Robert Wood Johnson Foundation grant, the Center for Health Care Strategies, Inc. will provide technical assistance to the committee by researching other states' managed long-term care programs, soliciting stakeholder input regarding key program design issues, and determining federal/state authority options. It is anticipated that the planning phase will require between eight and 12 months to complete the program design and to develop and release a Request for Information to determine interest/ideas of potential contractors.

**Implementation Planning Process:** The committee will work with actuaries to get a high-level idea of rate structures, draft managed long-term care insurance regulations, and determine whether there is a state or federal public notice requirement. The timeframe to complete this phase will require between three to six months.

**Medicaid Waiver(s) Approval:** Following the two phases, we will initiate three time-consuming administrative processes involved in establishing a pilot managed long-term care program in New Jersey:

1. Applying to the federal Centers for Medicare and Medicaid Services (CMS) for approval of a Medicaid waiver.
2. Developing an approved contract format and rate structure with CMS.
3. Establishing a new regulatory framework for a new type of managed care organization

**Identify/Address Infrastructure Needs:** The Interdepartmental Committee must identify and resolve necessary changes to the State's Medicaid Management Information System (MMIS). To modify the system will require extensive programming, so we anticipate this activity to will take between 12-18 months to complete. This activity will be initiated as part of the program design phase.

We anticipate these processes taking until SFY 2011 – at which point a pilot program could begin enrollment.