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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 disproportionately 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.

**PHILLIP LUBITZ:** 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)**