Section 1115 Demonstrations: NJ Comprehensive Waiver

Public Comments

Title	Description	Created At
For youth in the System of Care, will commercial insurance be pursued so that these youth are not disfranchised in favor of Medicaid status	Commercial insurance in light of the parity act should be sort to cover youth commercially insured youth so that those biologically occuring mental health issues are covered as if they were physical illnesses.	2012-10-14 09:41
Somehow there needs to be scrutiny of Commercial Insurers to keep them accountable for delivery of Pairty Act benefits		2012-10-13 12:38
I have grave concern for the TBI Waiver and the manner in which it is being included in the Comprehensive Waiver.	I strongly recommend that DHS in NJ reaches out to individuals served by current HCBS waivers and the service providers in order to best determine how to proceed with the Comprehensive Waiver. Not enough has been done to ensure seamless transition and guarantee the provision of services, which leaves an already vulnerable group of state residents even more vulnerable.	2012-10-04 11:44
Please keep the Case Managers so we can maintain a personal touch not the HMO.	Do not leave our cases to impersonal HMO's - maintain the case managers who know and understand their clients.	2012-06-21 17:12
Moving LTC Back Home	There needs to be more post-eligibility income that can be devoted to maintenance of the home while a person is on Medicaid in a nursing home. Currently, you are only allowed $150 post-eligibility deduction for the first six months of a nursing home stay for maintenance of a home. That is not enough money, and it forces those in facilities to sell their homes when they might otherwise come home after a longer period of nursing home care. My suggestion would be to raise that amount to equal the current New Jersey Shelter Standard (for the community spouse) of $551.63, and allow the six month period to be renewable with a doctor's letter or affidavit as to the resident's desire to eventually return home with community supports. It probably wouldn't be enough in every case to keep the house or apartment going, but it could be of great assistance, and instill the message that even though a person is in a nursing home in New Jersey, the state does not expect that that would be their final destination, even if they go on Medicaid.	2012-06-08 13:01
See AARP Comments on: Reinvestment of Savings, Quality Monitoring, and more below.	AARP's mission is to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. Following the submission of the Section 1115 Demonstration Comprehensive Waiver in September, we have worked to review and assess its impact on behalf of the 1.3 million New Jersey residents who are AARP members. We do want to restate our support for many of the positive proposals incorporated in the waiver request. The State's proposals to increase utilization of home and community-based services (HCBS) for long-term care (LTC), to expand eligibility through the spend- down provisions of the medically needy standard, to streamline the eligibility process, and to	2012-05-27 17:53

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	incorporate innovative models for service delivery are all goals that AARP continues to support However, there are still areas of great concern to AARP about the design and implementation of this1115 waiver. 1. Medically Needy Standard. We believe a workgroup should be established to research and make recommendations to further improve the standard. This workgroup should be comprised of appropriate stakeholders, including consumers, and seek to further demonstrate the goal of eligibility expansion and access to appropriate and necessary care. 2. Streamlined Eligibility. Our concern relates to the idea that the streamlined system, as currently described, will consider the physical and cognitive challenges of only some older adults, not all. Additionally, the streamlined process has the potential to result in inappropriate service denials, an outcome that should be avoided. 3. Level of Care Determination. We continue to strongly object to having the managed care organizations (MCOs) performing level of care (LOC) determinations for LTC services, because of the tremendous potential for conflicts of interest. Given the MCOs financial interest in the outcome of all LOC determinations, we believe this conflict of interest must be addressed. Ma 4. Plan of Care Development. This is an additional area where there is a potential conflict of interest in having the MCO determine what services an individual will receive. As the MCO will receive a set amount of money to provide services for each individual, there is an inherent financial incentive to provide fewer services. An individual plan of care should be developed by a neutral third-party, someone who has no vested interest in the plan other than to ensure that necessary services are provided to the individual. Transition to Managed Care and Choice of Provider 1. Transition Period Needs to be Revised. The intended implementation of this proposal is January 1, 2013. Given this date, we believe that there is an inadequate amount of time to educate and enroll individuals into LTC managed care. The State should consider implementing these changes in a staggered time frame, so that all individuals are not transitioning at the same time. Although plans for outreach and education have been designed, this population, their families and other non-paid caregivers need to have more opportunities to receive education on the process, to ask questions about the changes, and to determine how the changes will affect the individual receiving services. AARP recommends that the State phase in the implementation of managed care for this population. We would suggest that two or three counties be chosen for initial implementation, perhaps beginning with only new enrollees in those counties. After a three to six month period, there should be an assessment of the implementation before adding additional populations and additional counties. Again, these enrollees need the most support and rely on family and friends to ensure health and welfare. Thus, a measured and deliberate implementation schedule is vital to the success of the program. 2. Adequate Provider Networks. Most MCOs do not have experience providing HCBS. The State needs to ensure that there are sufficient and well-trained in-home caregivers to meet the needs of the expected	

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	expanded number of individuals receiving care at home. There also needs to be strong oversight to ensure high quality service delivery. 3. Continuity of Care. As individuals transition to MCOs, it is vital that there be continuity of care for those who receive LTC services and that the services are delivered by providers trusted by the individual and family. 4. Auto-Assignment of Dual Eligibles. AARP continues to have concerns about auto-assigning dual eligibles to the same Medicare and Medicaid plan with an opt out for Medicare, particularly due to the non-payment of Medicaid providers who are not currently enrolled with a Medicare MCO. This is particularly important for recipients of long-term services and supports where there is a high prevalence of individuals with multiple chronic conditions, which may make the selection process very difficult. Pre-enrollment notice provisions should include information on MCO options, details on provider networks, and objective quality and credential data on the MCOs and their provider networks. This notice should also list the health care providers the prospective enrollee has used during the preceding 12 months, based on Medicaid and Medicare data, and indicate whether each provider is part of each MCO's network. If any current and recent health care providers are not part of a MCO network, the notice should state that the enrollee in that MCO will not be able to use that provider after a certain date. 5. Readiness Review Process. AARP believes the State should involve consumer representatives in the readiness review process. 6. Consumer Involvement and Transparency. AARP urges NJ to follow CMS's recently finalized 1115 transparency regulations. While New Jersey submitted this proposal before the regulations were finalized, adherence with the new language is beneficial for both the State and for the consumers. Consumer advocates and other stakeholders should be able to review proposed MCO contract language, as well as the State's implementation and communication plans. Engaging consumers and their advocates throughout the process of development and implementation can help improve the likelihood of success of this new program delivery model by ensuring these changes and options are clearly and appropriately communicated and explained to individuals and their families. Quality of Care and Adequate Provider Networks 1. Providers with Experience Serving LTC needs. It is essential that the State look very closely at the adequacy of MCO networks to serve individuals receiving LTC. As mentioned above, while many MCOs have experience with nursing facilities and home health, few have experience delivering home care support to individuals needing assistance with activities of daily living and instrument activities of daily living. 2. Complaint Structures. Each MCO should have a complaint process that is known to all enrollees, as well as toll-free numbers for people to call if care is not adequate. The State should ask all MCOs to log each call or inquiry, categorize them and report the resolution of those complaints on a periodic basis to the State or a designee. The MCO should also report on any system changes it has made in response to complaints to the State. The complaint categories and resolutions should also be made available to the public.	

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	3. Quality Monitoring. The State needs to have suffiecient staff with the appropriate level of training, to include quality metrics and measurement, to monitor the quality of service delivery by the MCOs. We applaud the State's requirements regarding the quantity of data that will be required of the MCOs. 4. National Committee for Quality Assurance (NCQA) Accreditation. AARP continues to advocate for a State requirement that all MCOs obtain NCQA accreditation. 5. Advisory Committees. In order to ensure success, the State and the MCOs must commit to regularly meet with consumer representatives to share information and concerns. Reinvestment of Savings AARP believes it is very important that savings from this managed care implementation be reinvested in the LTC system, rather than redirected to other areas. New Jersey residents will continue to need LTC services in greater numbers as the years progress and the State must invest in new and existing home and community-based care delivery systems and ensure the quality of those and other LTC services to meet those needs. We believe that the State should commit publicly to using these savings as a supplement to current State expenditures in order to further develop and strengthen LTC delivery systems, including home and community-based care. By reinvesting in these programs, both the State and consumers will benefit while continuing to ensure access to the necessary and invaluable care that home and community-based services and other long-term care services and supports can provide. As always, AARP is ready to assist in any way to help ensure that New Jersey has the most appropriate, accessible and quality Medicaid LTC program for its resident	