1	MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
2	New Jersey State Police Headquarters Complex Public Health, Environmental and Agricultural
3	Laboratory Building 3 Schwarzkopf Drive
4	Ewing Township, New Jersey 08628
5	October 19, 2017
	10:09 A.M.
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7	FINAL MEETING SUMMARY
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9	Members Present:
10	Deborah Spitalnik, PhD, Chair Sherl Brand
11	Mary Coogan Theresa Edelstein
12	Dorothea Libman Beverly Roberts
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13	<u>Members Excused:</u> The Honorable Mary Pat Angelini
14	Christine Buteas Wayne Vivian
15	Members Unexcused:
16	Mary Lund
17	State Representative:
18	Meghan Davey, Director Division of Medical Assistance and Health Services
19	
20	Transcriber, Lisa C. Bradley
21	THE SCRIBE 6 David Drive
	Ewing, New Jersey 08638
22	(609) 203-1871 The1scribe@gmail.com
23	
24	Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at
25	http://www.state.nj.us/humanservices/dmahs/boards/maac.

1	Attendees in Perso	nc
	Mark Warthur	AbbVie
2	Cheryl Reid	Aetna Better Health New Jersey
	Daniel Keating	Alliance for the Betterment of Citizens
3	_	with Disabilities
	Cathy Chin	Allman Group
4	Brian Atkisson	Association of New Jersey Chiropractors
	Matthew Minnella	Association of New Jersey Chiropractors
5	Shabnam Salih	Camden Coalition of Healthcare Providers
-	Tara Porcher	Centers for Medicare & Medicaid Services
6	Cheryl Golden	Cumberland County Board of Social
U U	0110292 002001	Services
7	Lisa Upshaw	Essex County Welfare Agency
1	Liza Grundell	Family Resource Network
8	Karen Brodsky	Health Management Associates
0	Chris Czvornyek	Hospital Alliance of New Jersey
9	Carol Katz	Katz Government Affairs
9		Member of the Public
10	_	Mental Health Association of New Jersey
10	Cynthia Spadola Lori Price Abrams	
1 1	Khanah Lao	NJ Association of the Deaf
11		
1.0	Wardell Sanders	NJ Association of Health Plans
12	Debra Wentz	NJ Association of Mental Health and
1 0		Addiction Agencies
13	Mary Abrams	NJ Association of Mental Health and
1 4		Addiction Agencies
14	Kevin Casey	NJ Council on Developmental Disabilities
1 E	Dennie Todd	NJ Council on Developmental Disabilities
15	Grace Egan	NJ Foundation for Aging
	Crystal McDonald	NJ Health Care Quality Institute
16	Selina Haq	NJ Primary Care Association
	Kim Higgs	NJ Psychiatric Rehabilitation Association
17	David Drescher	Office of Legislative Services
	Robin Ford	Office of Legislative Services
18	Karen Shablin	Optum, Inc.
	Sonia Delgado	Princeton Public Affairs Group
19	Catherine Mabee	Riker, Danzig, Scherer, Hyland &
		Perretti, LLP
20	Jennifer Farnham	Rutgers Center for State Health Policy
	Kathleen Lockbaum	Salem County Board of Social Services
21	Arturo Brito	The Nicholson Foundation
	Raquel Jeffers	The Nicholson Foundation
22	Shirley Samuels	Unknown
	Zinke McGeady	Values Into Action NJ
23	Deborah Brown, DMI) WellCare
	John Kirchner	WellCare
24	Lisa Knowles	WellCare
	Nancy Tham	Wellcare
25	-	

1	Hannah Good	NJ Treasury, Office of Management and
		Budget
2	Graham Ruff	NJ Treasury, Office of Management and Budget
3	Kelli Rice	NJ Division of Developmental Disabilities
U	Freida Phillips	NJ Division of Family Development
4	Marie Snyder	NJ Division of Family Development
-	Chris Cheethom	NJ Medicaid Fraud Division
5		NJ Medicaid Fraud Division
0	Kay Ehrenksantz	NJ Medicaid Fraud Division
6	Stefanie Muzgai	NJ Department of Health
0	Laura Otterbourg	NJ Division of Aging Services
7	Julie Cannariato	NJ Division of Medical Assistance and
/	Surre cannarrates	Health Services
8	Linda Edwards	NJ Division of Medical Assistance and
0		Health Services
9	Meghan Davey	NJ Division of Medical Assistance and
-	2	Health Services
10	Carol Grant	NJ Division of Medical Assistance and
		Health Services
11	Marc Gonzer	NJ Division of Medical Assistance and
		Health Services
12	Roxanne Kennedy	NJ Division of Medical Assistance and
	4	Health Services
13	Phyllis Melendez	NJ Division of Medical Assistance and
	4	Health Services
14	Maribeth Robenolt	NJ Division of Medical Assistance and
		Health Services
15	Cynthia Rogers	NJ Division of Medical Assistance and
		Health Services
16	Heidi Smith	NJ Division of Medical Assistance and
-		Health Services
17	Steven Tunney	NJ Division of Medical Assistance and
		Health Services
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Attendees by Phone:

20	AT&T Caller Data	
	Total Number of Calls:	13
21	Breakdown by Area Code:	
22	Area Code	

	<u>Area Code</u>	<u># of Callers</u>	
	215		2
23	518		1
	609		8
24	732		1
	973		1
25			

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1	DR. SPITALNIK: Good morning. I'm Deborah	1	DR. SPITALNIK: And now I'd like to ask the
2	Spitalnik, and it's my pleasure to welcome you to the	2	people on the phone to identify themselves.
3	October 19th meeting of the Medical Assistance Advisory	3	(Participants via phone introduce themselves.)
4	Council (MAAC). We have sign language interpretation	4	DR. SPITALNIK: So the way that the MAAC
5	available today in the auditorium. If that's	5	functions, and we have been proud to be able to do
6	something that you need to utilize, please join the	6	this, is that we don't just reserve an isolated period
7	interpreters in front of the podium.	7	for public comment. We discuss each issue. We ask
8	I also want to mention that if people do	8	that the members of the MAAC ask questions first, and
9	need accommodations, please let Phyllis Melendez know	9	that would also include Theresa on the phone. Then
10	prior to a meeting so we can make sure that everyone	10	we'll open that to the members of the public. We ask
11	can fully participate.	11	that people make questions, not statements, and that
12	I want to welcome everybody to this meeting.	12	people are as succinct as possible. When you do make a
13	We will do introductions. I will explain some things	13	statement, please identify yourself by name for the
14	about how we function. We'll look at minutes. We have	14	benefit of our record reporter so we have an accurate
15	an informational update, a series of presentations, and	15	record. We've never had to limit that kind of dialog,
16	more additional updates.	16	and we hope to continue to live up to that.
17	It's my responsibility to let you know that	17	So our first piece of business is to turn to
18	the procedures in the unlikely event of an emergency	18	the minutes of our last meeting, which was July 20th,
19	that if the fire alarm sounded or an evacuation	19	and I will ask for any additions or corrections from
20	announcement was made, you need to quickly leave the	20	members of the MAAC or a motion for approval.
21	building via the nearest exit, go to Lamp Post No. 9 in	21	MS. BRAND: Motion to approve.
22	the parking lot, and then we'll check off your names on	22	DR. SPITALNIK: Thank you.
23	the attendance list.	23	Second?
24	I have to let you know that pursuant to New	24	MS. ROBERTS: Second.
25	Jersey's Open Public Meeting Act, adequate notice of	25	DR. SPITALNIK: In favor?
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1	the schedule of this meeting was posted according to	1	(MAAC members vote by a show of hands.)
2	State requirements.	2	DR. SPITALNIK: The minutes of July 20th
3	Our custom is that the members of the MAAC	3	are approved.
4	introduce themselves, then I ask the members of the	4	Our first business is a presentation from
5	public who are in the auditorium to introduce	5	Valerie Mielke from the Division of Mental Health and
6	themselves. We also have people participating by	6	Addiction Services (DMHAS).
7	phone, so at the end of that, I will ask them to	7	Welcome, Valerie. We're delighted to see
8	identify themselves, and that does include one MAAC	8	you.
9	member today.	9	And as Valerie is making her way to the
10	Prior to introductions, I am pleased to	10	podium, let me remind people that the slide that are
11	announce two new appointments to the MAAC: Christine	11	being shown today are posted on the Division's web site
12	Buteas and The Honorable Mary Pat Angelini have been	12	to ensure access at: Http://www.state.nj.us
13	appointed to the MAAC. Unfortunately, they are not	13	/humanservices/dmahs/boards/maac/.
14	able to be with us today, but they plan to be with us	14	Valerie, welcome and good morning.
15	at our next meeting.	15	MS. MIELKE: Thank you very much for having
16	I also want to announce that Governor	16	me today, it's really a pleasure. And good morning to
17	Christy has reappointed the following members: Sherl	17	all of you.
18	Brand, Theresa Edelstein, Dot Libman, Mary Coogan,	18	I'm pleased to be here before you and talk
19	Beverly Roberts, and myself.	19	about the reorganization od DMHAS.
20	Next, let's ask the members of the MAAC to	20	As many of you may know, Governor Christy in
21	introduce themselves.	21	the Executive Order reorganized the State departments
22	(Members of the MAAC introduce themselves.)	22	such that the Division of Mental Health and Addiction
23	DR. SPITALNIK: Now let's ask the members	23	Services we had been located at the Department of
24	of the public to introduce themselves.	24	Human Services to migrate and become a part of the
25	(Members of the public introduce themselves.)	25	Department of Health. In addition to that, there are

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1	other functions within the Department of Human	1	in leadership at the Department of Health, as well as
2	Services, such as the Licensing and Investigation Unit	2	leaders in the Division of Mental Health and Addiction
3	for our State psychiatric hospitals that moved over, as	3	Services. We have a myriad of subcommittees together
4	well.	4	working on how to best integrate our functions. So one
5	What really drove this decision is that, as	5	such subcommittee is a legal subcommittee that's
6	we all know, the provision of integrated care, primary	6	looking at our regulations and how to move regulations
7	health and behavioral health services, yield much	7	forward. Another work group is fiscal and looking at
8	stronger outcomes for those that we serve, those who	8	our contracts and how to move that forward. So those
9	have addiction, substance use disorder, and those who	9	committees continue to meet.
10	have a mental illness. We've seen evidence of that in	10	In addition to that, at the Division of
11	some of the initiatives where providers are actually	11	Mental Health and Addiction Services, we are in the
12	providing integrated care. And what they have	12	process of moving out of the building of the Department
13	demonstrated is that there's significant improvements,	13	of Human Services.For our offices that are in
14	both on the primary health side for those individuals	14	Hammonton, our southern region office, and on the
15	as well as their behavioral health issues as well.	15	grounds of Ancora Psychiatric Hospital, they remain in
16	So the move over to the Department of Health	16	place where they are and they will not be moving.
17	really helps to further strengthen our ability to	17	For our northern region office which is
18	provide integrated care through a structure that really	18	located in Patterson, they will continue to remain
19	supports that. And one of those areas has to do with	19	there; they are not moving. Our Intoxicated Driver
20	regulations. And some of the experiences of some of	20	Program which is located on Front Street Trenton, they
21	our provider organizations are some of the challenges	21	are also remaining where they are and are not moving.
22	that existed because they wanted to serve someone who	22	For those of us who are located at 222 South Warren
23	had a substance use disorder, had a coexisting mental	23	Street, we are moving to two different locations.
24	illness, and also had significant primary health needs	24	One location is 127 Stockton Street, which
25	that they actually had to comply with three different	25	is the location prior to the merger of the Division of
	9		11
1	sets of regulations in order to provide that care.	1	Addiction Services and Division of Mental Health
2	sets of regulations in order to provide that care. And so this move, in part, will help to integrate in	2	Addiction Services and Division of Mental Health Services, it's a location where the Division of
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2 3 4	sets of regulations in order to provide that care. And so this move, in part, will help to integrate in terms of our regulations in a way that helps to support integration of care and treatment.	2 3 4	Addiction Services and Division of Mental Health Services, it's a location where the Division of Addiction Services were located. So we moved back into that building already, and those moves took place last
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	12		14
1	individuals and their telephone numbers are changing	1	So that's a general overview of the
2	and moving locations, we still have individuals at a	2	transition where we are right now and really the goal
3	location that are able to answer phones and able to	3	of the transition, which is absolutely to improve,
4	respond to e-mails.	4	continue to enable us to improve the care and services
5	In addition to that, as it pertains to our	5	that are provided to those that we serve.
	-	6	-
6 7	contracts, our contracts are going to continue to remain the same as they are right now.So if you are a	_	Thank you very much for having me and giving me the opportunity to speak.
		7 8	
8	provider who is in Fee-for-Service (FFS) providing	_	DR. SPITALNIK: Well, thank you very much.
9	substance use treatment services, you will continue to	9	And thank you for your leadership in this transition.
10	use NJ SAMS and you'll continue to be paid by CSC, our	10	We know the load on the Division under all
11	fiscal agent. So continue to do what you're doing	11	circumstances and how much extra work, so we really
12	now. As it relates to our contract database, you'll	12	appreciate your leadership.
13	continue to use that for now. If you're in FFS Mental	13	May I open this up to questions? Members of
14	Health and you're using the system, you'll continue to	14	the MAAC.
15	use that now. You'll continue to enter your units of	15	MS. ROBERTS: Thank you, Valerie. But my
16	service that you're providing, your claims and you'll	16	question actually isn't directed to Valerie, it's to
17	continue to get paid through Molina. If you have a	17	point out that there's gap in our knowledge with regard
18	deficit funded contract or if you have a slot-based	18	to the DDD dual diagnosis project because all of the
19	contract, those contracts will continue to operate as	19	information that we've just heard really does not
20	they are right now. Those contract documents also	20	pertain to persons with developmental disabilities who
21	remain the same. So this way we can ensure that	21	are duly diagnosed with behavioral health challenges.I
22	providers continue to be paid in a fashion that you are	22	know there's been change in leadership at the DDD, but
23	right now and that as we'll continue to keep you	23	I'm hoping by next meeting we will be able to get an
24	apprised as our contract processes may change over	24	update on that.
25	time.	25	MS. MIELKE: Absolutely. We'll have some
	13		
			15
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2	One of the things that we've done to not only provide information out there to our stakeholders	2	information to present to you on that.We had actually some concerted work that Commissioner Connolly and Liz,
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	16		18
1	happy to talk about our partnership with them, but I	1	look like. We currently do have our legal staff who
2	think that in terms of presentation that their	2	are part of the Central Office of the Department of
3	presentation might be much more comprehensive.	3	Health, along with the Division of Mental Health and
4	MS. COOGAN: That will be terrific. Thank	4	Addiction Services, sitting down and talking about
5	you.	5	integration and what's currently in all of our
6	DR. SPITALNIK: Thank you.	6	regulations and how we might look to bring that
7	I also know that this is a down-the-line	7	together. There may be some further information,
8	issue, but with the transition, with the administrative	8	though, before the promulgation of regulations of
9	transition, we're also concerned about how Behavioral	9	things that might help to further support integration
10	Health will coordinate with Managed Long Term Supports	10	beforehand. I ask that you stay tuned to that. We're
11	(MLTSS) and other Medicaid services which still remain	11	having those discussions, as well. We're really not
12	in the Department of Human Services (DHS).	12	able to talk specifically more specifically about that
13	Thank you.	13	because we're still in deliberations about how to do
14	Are there questions from Theresa, do you	14	that. It's an important issue and it's a great
15	have any questions?	15	question. So thank you.
16	MS. EDELSTEIN: No, Deb, I don't. Thank	16	DR. SPITALNIK: Anyone else? Anyone on the
17	you.	17	phone?
18	DR. SPITALNIK: Okay. Thank you.	18	Hearing none, I'll say again thank you to
19	I'll take questions from the public. And	19	Valerie for being with us this morning and for your
20	please stand so we can hear you and your name.	20	leadership in this process.
21	MS. JEFFERS: Hi. Raquel Jeffers from the	21	MS. MIELKE: Thank you very much. Thank you
22	Nicholson Foundation.	22	for having me.
23	Good morning, Val.	23	DR. SPITALNIK: As we turn to Julie
24	MS. MIELKE: Good morning.	24	Cannariato's presentation on the NJ FamilyCare
25	MS. JEFFERS: I just had a question given the	25	Comprehensive Demonstration Waiver and The Community
	17		19
1	fact that the reason or the rationale for the	1	Care Program, this will not only be a presentation, but
2	transition is really about developing better	2	this is formally an opportunity for stakeholder input
3	opportunities for integrated care. I was wondering if	3	about the transition of the Community Care Waiver into
4	the department has a timeline for developing a new set	4	the Comprehensive Waiver. This is a role that the MAAC
5	of integrated regulations and/or a process for that	5	has played and a function and so that while the whole
6	component including public input?	6	MAAC process is an opportunity for stakeholder input,
7	MS. MIELKE: Thank you very much for that	7	we are formally recognizing this component of our
8	question.	8	meeting in that vein.
9	Did everyone hear the question.	9	So Julie, welcome. And we'll follow the
10	UNIDENTIFIED SPEAKER: People on the	10	same processes.
11	telephone can't hear the questions.	11	MS. CANNARIATO: Thank you, Deborah.
12	MS. MIELKE: I will repeat it.	12	So I know a couple of you here have been
13	So Raquel Jeffers asked if there was a	13	here for our presentation on the Concept Paper and then
14	timeline for the development of regulations which will	14	also for the unveiling what was in the Comprehensive
15	help to further support the integration of primary	15	Waiver. So you all know it is approved. Our Waiver was
16	health and will behavioral health services as well as	16	approved July 27th of 2017. It was effective as of
17	what the public participation and input will look like.	17	August 1st and it will continue to be effective through
18	So I don't have a definitive date and	18	June 30, 2022.
19	timeline in terms of when regulations will be available	19	(Presentation by Ms. Cannariato.)
20	for public comment. However, as is our process, even	20	(Slide presentations conducted at Medical
21	prior to regulations being posted for formal public	21	Assistance Advisory Council meetings are
22	comment through the Office of Administrative Law, we	22	available for viewing at http://www.state.nj.us
23	will have some stakeholdering to gather some input to	23	/humanservices/dmahs/ boards/maac/.)
24	develop those regulations. So at this point I can't	24	DR. SPITALNIK: Thank you so much, Julie.
25	really speak to specifically what that process will	25	We'll open up to MAAC, and whatever time we

	20		22
1	need for stakeholder input.	1	confusion which we're going through multiple changes
2	Beverly.	2	and to be accurate, and then there's those cynics who
3	MS. ROBERTS: Thank you very much Julie.	3	say that while you say it's not going to go to managed
4	Do you have any further information on the	4	care that this makes it easier now for the State to
5	additional stakeholdering that DDD is planning to do?	5	move the Community Care Program to managed care.So
6	MS. CANNARIATO: I don't, but we could get	6	there's a lot of confusion and additional
7	back to you.	7	stakeholdering, we were not aware that there was of any
8	DR. SPITALNIK: Is that something, Kelly,	8	additional stakeholdering that I do ask that we find
9	that you could speak to at this point?	9	out what's going on.
10	MS. RICE: Kelly Rice, DDD.	10	MS. DAVEY: So I think Kelly might be able
11	Unfortunately, Deborah, I'm not	11	to address the individual supports, but it's two
12	participating in that aspect, but I'm putting it down	12	different things. So similar to what we had in a pilot
13	as a note and I'll follow up.	13	for the IDDMI group for children, we're doing something
14	DR. SPITALNIK: Thank you very much.And we	14	similar on the DD side.So that's the stakeholdering
15	will make sure that that's an agenda item for our next	15	we're talking about, building that pilot on an adult
16	meeting.	16	side.
17	Anything else? Anyone else from the MAAC?	17	When it comes Community Care Waiver moving
18	I wanted to add a clarification that there	18	the CCP, the Waiver Special Terms and Conditions (STCs)
19	were three pilots for children under the first	19	require, and CMS requires, a 30-day transition. So you
20	Comprehensive Waiver and the second you've addressed	20	have 30 days the you must notice the recipients that
21	the two of them serious emotional disturbance and dual	21	are currently in the 1915 authority to move to 1115
22	diagnosis. The autism pilot, because of new guidance	22	authority, as well as we have to send a letter to the
23	from the Centers for Medicare and Medicaid Services	23	region 30 days prior and a public comment period 30
24	(CMS), will become autism services will become part	24	days. So that's that piece.
25	of the State Plan, so it will be handled through a	25	The stakeholdering around the IDDMI pilot is
	21		23
1	State Plan amendment. Meghan has clarified that those	1	what we were talking about with the stakeholder.
2	services will stay in place until the amendment is	2	MR. KEATING: Will there been more
3	made. But that amendment will follow the same kind of	3	information about that?
4	process with rigorous stakeholder input, but there's	4	MS. DAVEY: About the pilot?
5	not yet a timeline established for that.	5	MR. KEATING: Yeah, the pilot.
6	Questions from the public?	6	MS. DAVEY: Yes. I have to talk to
7	Yes, Dan.	7	Jonathan. Liz left, so they were doing some of that.
8	MR. KEATING: Dan Keating, Alliance for	8	So that's why it's not in the current STCs, because in
9	Betterment of Citizens with Disability.	9	concept CMS agrees with it because we already piloted
10	And this may be one man's confusion, but I	10 11	in the children's side.
11 12	wanted to reiterate a couple of things and go with what Bev asked for.	12	What they saying is, we're good with it, but DDD was saying we want to ge more stakeholdering around
13	We were told on September 27th, as is	13	it before we finalize the STC. So that's going on
14	indicated, that the Community Care Waiver was going to	14	now. I can get you more information on it.
15	go into the 1115. We have been told that was submitted	15	MR. KEATING:And when is the stakeholder
16	previously. So I'm surprised to see that the comment	16	period over?
17	period is now opened for a month and we were told about	17	MS. DAVEY: So two different things again.
18	the 27th after the fact. I mean we were told on the	18	So the stakeholdering around DDD is not a public
19	27th. What we were told, my belief again, is that we	19	it's public, but it's not like a CMS requirement; it's
20	were told that the Community Care Waiver (CCW), which	20	just building a program. The public comment period for
21	has been for residential and individual supports. So	21	moving CCW to CCP, which is a requirement of SCCs ends
22	now are individual supports still going to be the	22	October 23rd or 24th. So you have an opportunity to
23	terminology we're using, or it's now Community Care	23	send comments on that. And as of right now there is no
24	Program (CCP)terminology.	24	discussion to moving that to Managed Care.
25	I only raise this because there's a lot of	25	MR. KEATING: Thank you.

	24		26
1	DR. SPITALNIK: My understanding, Meghan,	1	able to sustain themselves with the supports that are
2	was that that was the first Comprehensive Waiver that	2	available in the Supports Program (SP). So as you're
3	was proposed that the DDD Waiver be included, and it	3	going through this, I think you need to look at a
4	was rejected by CMS because it was not an R and D.	4	definitive and solid way that families and
5	MS. DAVEY: Well, originally, we proposed	5	self-advocates are aware of to ask for a move from the
6	all five 'C' waivers move into MLTSS. So only four	6	Supports Program to I'm not even what we're calling
7	moved. DDD did not move. And the reason they didn't	7	the program this the point under the new waivers, but
8	want to move it with 1115 authority at that time was	8	you need to have a definitive process for people to
9	because it wasn't moving to managed care where you need	9	move to more complex services.
10	the authority. What our argument to CMS was that our	10	Second, I'm very appreciative of the
11	supports program wound up having a better package, a	11	Department's desire to look at mental health services
12	more flexible package, because they were under 1115.	12	with people with developmental disabilities (DD) on a
13	So those with a higher acuity level actually had less	13	broader basis. As I have said here before, that's not
14	services. This makes it more flexible for us to make	14	a New Jersey problem only. I think there are only 49
15	changes and give those services timely versus having to	15	other states that have that problem, but our job is to
16	wait. And you know how long 'C' Waivers take to renew.	16	solve it in New Jersey. And I strongly encourage you
17	So that was where we argued and fought to say let us	17	to continue looking at that and to make that an
18	get into 1115, let us get the flexibility we need to	18	important part of what you do. It is still very
19	move the system quicker, faster.	19	difficult with people with developmental disabilities
20	MR. KEATING:That, I remember. The	20	to get mental health services when they need them.
21	confusion, I guess, is between this demonstration	21	Let me talk about stakeholdering for a
22	project that's relatively new and I'd like to learn	22	minute, because I think it's a critical issue. As I
23	more about that. And if we have only until next week	23	wander around and talk to family groups in New Jersey,
24	to get comments in, we need to expedite that. Or am I	24	there's great confusion about a lot of what's going on
25	wrong?	25	in the DDD program. And it's not necessarily a
	25		
1	MS. DAVEY: The CCW moving to the CPP is the	1	criticism of what's going, it's simply a lack of
2	MS. DAVEY: The CCW moving to the CPP is the only thing that's out for public comment right now. So	2	criticism of what's going, it's simply a lack of understanding of what's going on.I think it would be
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2 3 4	MS. DAVEY: The CCW moving to the CPP is the only thing that's out for public comment right now. So if you have any comments around the authority for changing 'C' to 1115, please send those. But there	2 3 4	criticism of what's going, it's simply a lack of understanding of what's going on.I think it would be very wise for the Department not just in DDD, but my interest is in particular in DDD, to develop a dynamic
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	28		30
1	Debra.	1	levels of care in SUD.
2	MS. WENTZ: Hi. For the record, Debra	2	MR. CZVORNYEK: And Julie or Roxanne, could
3	Wentz, New Jersey Association of Mental Health and	3	you explain the difference between the Managed Care
4	Addiction Agencies.	4	contract again, the 15 days?
5	I want to applaud the State in its move to	5	MS. CANNARIATO: Because it's still under
6	the address, the Institutions for Mental Disease (IMD)	6	negotiation, I think we'd like to wait until we do a
7	exclusion. We're very excited that you are jumped on	7	formal presentation and really talk that through with
8	that opportunity that became available from the CMS	8	the group. So I would like to table that question
9	letter.	9	until the next time.
10	And, of course, we're extremely impatient	10	MR. CZVORNYEK: Okay.
11	and anxious for when it would start. So once the	11	MS. CANNARIATO: But we'll definitely make a
12	Waiver is approved, do you have a timeline for when	12	note of it.
13	providers would be able to use that service.	13	MR. CZVORNYEK: Thank you.
14	MS. CANNARIATO: So we're currently working	14	DR. SPITALNIK: And I'll put it on the
15	with CMS on finalizing those STCs in the timeframe, so	15	agenda for next time.
16	we'll have a better idea I hate to say the next MAAC	16	Other questions?
17	meeting, because I know they're quarterly, but probably	17	Any questions from anyone on the phone?
18	in the next couple weeks you'll start seeing	18	MS. EDELSTEIN: This is Theresa. I
19	information coming out from us, but those are still	19	apologize but is there any way that Julie can summarize
20	being negotiated and finalized.	20	what that question was? We couldn't hear any of it.
21	MS. WENTZ: That's exciting. And the up to	21	MS. CANNARIATO: Sure. I'm sorry, Theresa.
22	30 days, it was my understanding, that's across two	22	So Chris Czvornyek had asked for us to
23	months because you're really allowed 15 days in the one	23	summarize the difference between the IMD time frames
24	month; but if you bridge between two months, you're	24	under the Substance Use Disorder (SUD) continuum versus
25	getting the 30 days. Is that correct?	25	the time frames that allowed for Federal Financial
	29		31
1	MS. KENNEDY: That was under the MCO	1	Participation (FFP) in the managed care contract. So
2	contract. We're still negotiating with CMS what that will look like. That was language in the MCO contract.	2	because we're still working through finalizing the STC to CMS, I suggested that we table that conversation
4		4	
4 5	MS. WENTZ: Just building on stakeholdering in general, I think that the Department and Division	4 5	until we can do a thorough presentation at the next MAAC meeting.
6	has been hard at work and I know they study other	6	MS. EDELSTEIN: Okay. Thanks so much.
7	models and there are opportunities for input. I think	7	DR. SPITALNIK: Hearing no other points of
8	I have to echo what Dan and Kevin said, I think on the	8	input, I would thank Julie and the Division for the
9	ground where the rubber hits the road and, you know,	9	presentation.And thank everyone for input and also ask
10	providers are delivering services, individuals and	10	you to fan out the information, particularly on the
11	families are receiving them, that that really does tend	11	last slide about the posting and the time frame
12	to pinpoint areas that could be challenging and need	12	input. Thank you.
13	addressing. So we do appreciate increased and	13	We'll now move to another presentation by
14	consistent opportunities with enough timeframe to have	14	Heidi Smith on NJ FamilyCare, the Aged, Blind and
15	meaningful input.	15	Disabled Program. Heidi is Chief of Operations in the
16	Thank you.	16	Division of Medical Assistance and Health Services.
17	DR. SPITALNIK: Thank you.	17	MS. SMITH: Good morning, everybody.
18	MR. CZVORNYEK: Hi. Chris Czvornyek from	18	So I'm here to talk the streamlining of
19	the Hospital Alliance. I have two additional questions	19	Aged, Blind, Disabled Program for efficiency, some
20	regarding IMD exclusion.	20	things that we were looking at and some things that we
21	So one of them is going to seeking the	21	needed to do from hearing from our constituency, some
22	federal match on this currently excluded population.	22	advocates, some families, and their experience.
23	Is it for all IMDs or just IMDs that are dedicated to	23	(Presentation by Ms. Smith.)
24	inpatient substance patient psychiatric hospitals.	24	(Slide presentations conducted at Medical
25	MS. KENNEDY: It's limited to those three	25	Assistance Advisory Council meetings are

	32		34
1	available for viewing at http://www.state.nj.us	1	is it work income, is it investment income, where did
2	/humanservices/dmahs/boards/maac/.)	2	it come from? So it's just page of that. I do look
3	DR. SPITALNIK: Thank you so.	3	forward to having a meeting with you so that we can
4	Any questions?	4	drill in and look at it more closely. And about Able
5	MS. ROBERTS: Thank you so much. This was	5	accounts, we do have our attorneys with our Department
6	very, very helpful.	6	and our Division are actually starting to look at the
7	I have a couple questions for today for the	7	Able accounts now.We don't have them in New Jersey, but
8	group, but I'm hoping that we can also meet separately	8	you're right, they can exist in other states.
9	because there is some issues pertaining to my	9	MS. ROBERTS: Because when I do trainings, I
10	population for people that are Section 1634 Disabled	10	include that, the fact that they can open an account in
11	Adult Children (DAC). These are people who have had	11	any other state that allows an out-of-state person to
12	SSI and Medicaid and they've met those requirements.	12	open an account there. So you're probably going to
13	Then when mom or dad retired or started to	13	start to see more of that.
14	collect their Social Security or a parent became	14	MS. SMITH: I agree.
15	disabled or died, then the son or daughter who did SSI	15	MS. ROBERTS: Thank you.
16	and Medicaid gets SSDI from the parent's work record.	16	DR. SPITALNIK: Other questions from the
17	Now they're typically getting a whole lot more in their	17	MAAC?
18	monthly benefit from SSDI and they need Medicaid again	18	Joe.
19	from the county. So out of all the tons of people that	19	MR. MANGER: Joe Manger from Verizon Blue
20	you see this is a small percentage. Out of the people	20	Cross/Blue Shield.
21	that I see and I get calls from, I get a lot of these	21	Phenomenal, phenomenal work. I cannot say
22	calls. So I just want to be sure that as this new very	22	enough about how thorough it really is and what an
23	exiting system is set up that it incorporates	23	incredible asset it's going to be. Just a couple of
24	appropriately our folks. And one of the things that I	24	comments or suggestions. Questions are probably in
25	see right off the bat, where it talks on this form how	25	there, but this is first time seeing it, so forgive me.
	33		35
1	much money you're receiving.So if one of our folks	1	The communication stuff I think is fabulous. In
2	who's a DAC needs to get Medicaid again from the county	2	the application process online, is there some one how
3	is getting \$1,300 a month in SSDI from a parent, that's	3	they prefer to be communicated with? Because one of the
4	legitimate, that's what they're getting, they do meet	4	things we see with the changing populations, the face of
5	the requirements. But I have a feeling the way this is	5	Medicaid and AVD is different, family members are doing
6	set up right now, that will be thrown out; oh, you have	6	it. Do we say things like, "Do you prefer e-mail? Do
7 8	too much money coming in, you won't be able to get Medicaid. So that's the kind of stuff I want to just	7 8	you prefer phone?" Because we're finding that to be when we're managing our members a critical thing.
9	make sure we can address.	9	Upfront if you know that, it's kind of helpful. So just
10	A question about ABLE accounts. Are you	10	a suggestion if it's not under consideration.
11	familiar for ABLE?	11	MS. SMITH: We're practicing first with the
12	MS. SMITH: Yes.	12	MAGI population. They get to say whether they want
13	MS. ROBERTS: Is there a way for a person	13	electronic notification or paper notifications. That's
14	who has an ABLE account which of course you can't	14	the easiest letter to send out, so that's on our canary
15	have in New Jersey yet; hopefully one day soon but	15	in the mine. Believe it or not, when the family
16	you can open accounts in other states.Pennsylvania, for	16	chooses the electronic, per the law, you have to send
17	example, has it. Is there a way to include that a	17	them a paper letter anyway just confirming that they
18	person has an able account within this?	18	really want electronic.
19	MS. SMITH: So that was Bev, for people on	19	MR. MANGER: I'm really referring to contact
20	the phone, who had questions about DAC and resources	20	going forward because they're going to Managed Care
21	and income. I should have clarified that this was just	21	MS. DAVEY: Authorized reps and the family
22	a screen shot of one screen. So how we have income, it	22	member.
		23	
23	goes even more. I just didn't want to go and get every	23	MR. MANGER: Exactly. I know you have
23 24	goes even more. I just didn't want to go and get every possible page of every resource. There's more. So	23 24	authorized reps, so maybe it's in there. But what we

	36		38
1	sister, my wife, my husband again, it's probably	1	you, go over because there are association health
2	already in there in some fashion, but we've been	2	plans. We have a lot of experience portals,
3	picking up a lot of that with out cultural linguistic	3	applications, and other stuff. It might be helpful
4	task force meetings that we do is folks being asked	4	information
5	about their communication preferences. That's all.	5	MS. DAVEY: Joe, we meet contract issues
6	And I can follow-up with something with writing.	6	monthly.Maybe we do a demo there so the health plans
7	One other question. The flyer, I love it;	7	can see it.
8	love the flyer. Is there and there probably is	8	MR. MANGER: Thank you.I don't want to be
9	a reason we use Long Term Services Supports and we	9	critical. I think it's incredible.
10	dropped the M? What's the difference?	10	MS. SMITH: The feedback helps us. We love
11	MS. SMITH: I'm going to let Theresa handle	11	to go out, try it, and then we hear from people who ask
12	that one.	12	for these edits and changes, and they make sense, so we
13	It's Long Term Services and Supports, but	13	can put them in. So it's good.
14	all of our care that we deliver Long Term Services and	14	MS. BRAND: What kind of consumer feedback
15	Supports isn't always through Managed Care. We have	15	have you done or have you gotten thus far?
16	PACE agencies also.	16	MS. SMITH: When we did the paper
17	MR. MANGER: So that's managed long-term.	17	application, which is how we came up with the online
18	MS. SMITH: Theresa, are you there?	18	application. We did the paper application. We launched
19	MS. EDELSTEIN: Yeah, I'm here, but I	19	it, and it would be the families calling in going "What
20	couldn't hear Joe's question. So can you quickly	20	do you mean by that question?"
21	repeat it?	21	So when we heard the families and we hard
22	MS. SMITH: So Joe was asking where we call	22	from the agencies on what to do, such as the elder care
23	int Long Term Services and Supports and not Managed	23	attorneys had some suggestions about the brochures and
24	Long-Term Services and Supports in the brochure. And	24	Pace agencies and HCNJ, families also calling into the
25	we have Long-Term Services and Supports because under	25	Division would have questions about "What do you mean
	37		39
1	the option they are talking how you have Managed Care	1	by that?What's a Qualified Income Trust (QIT)?
2	health plans, but you also have Pace and our DDD	2	by that?What's a Qualified Income Trust (QIT)? Because it's an Aged, Blind, Disabled (ABD)
2 3	health plans, but you also have Pace and our DDD population.	2 3	by that?What's a Qualified Income Trust (QIT)? Because it's an Aged, Blind, Disabled (ABD) brochure, it's not an ABD manual, you have to be
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	40	[42
1	on the Division's website. So I think that section may	1	Consumer Assessment of Health Plan Surveys also feeds
2	need some more work in order to make sure that all	2	some of the questions. They are the major feeders.
3	choices are represented, not just health plan choices.	2	What we look at, though, is not necessarily
4	MS. SMITH: Okay. We'll look at that also.	4	every HEDIS measure is also reported because it may be
	I know that they come to when they're in	4 5	one, as I said, where we're excluding a population or
5			it's something we can't capture well. One of them that
6	the Long-Term Services and Supports if it's community	6 7	we are looking to actually, this is kind of like an
7	Medicaid, then PACE isn't an option. So we'll look at that.	8	
		_	announcement for those in the health plans out here.
9	MS. EDELSTEIN: Okay. Thank you.	9	There is a measure that is on concurrent medication,
10	DR. SPITALNIK: No other questions at this	10	children on multiple concurrent antipsychotics. That is
11	time, I want to thank Heidi for this. I know that you	11	a measure in the Healthcare Effectiveness Data and
12	and Bev will follow-up with each other. Thank you so	12	Information Set (HEDIS) world. It's a measure that
13	much.	13	you have been reporting. It's not a measure we had
14	We're now going to turn to a presentation	14	given to HEDIS. Concerned because we wanted to make
15	Child Core Set of Measures, the quality measures for	15	sure with that being it's a carveout from the
16	Medicaid and CHIP. We're appreciative of the Division	16	Behavioral Health, really reporting it barely. But we
17	being so responsive to the request that was made at the	17	did some discussion between our pharmacy director with
18	last meeting and I'm pleased to introduce Cindy Rogers	18	our EQRO and we feel that administratively we will
19	who is the Director of the Office of Quality Assurance,	19	capture.So we are going to look to add that measure
20	Division of Medical Assistance and Health Services	20	actually in this year.
21	(DMAHS).	21	So we look to balance it to know that we're
22	MS. ROGERS: Good morning, everyone. I've	22	giving what's accurate data to reflect New Jersey, and
23	come to you today to talk to you about Child Core Set	23	much of it is HEDIS and CAHPS driven.
24	Measures. I don't know if in our audience we have	24	MS. COOGAN: So my sense from what you're
25	individuals who are familiar with what the Child Core	25	saying, and I commend New Jersey for reporting on as
	41		43
1	Set is, so I want to give you a brief background on it	1	many as you are reporting. The decision is primarily
2	Set is, so I want to give you a brief background on it and let you what New Jersey has been doing over the	2	many as you are reporting. The decision is primarily made because of what you can gather efficiently.
2 3	Set is, so I want to give you a brief background on it and let you what New Jersey has been doing over the last eight years.	2 3	many as you are reporting. The decision is primarily made because of what you can gather efficiently. And I guess my interest is in the developmental screens
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		1	
	44		46
1	quite a bit because of the State's ability to capture	1	MS. JEFFERS: Hi. Raquel Jeffers from the
2	it. Some states are reporting everything and so you	2	Nicholson Foundation. This is really great to see;
3	may have state who has an inflated rate of, say, 45	3	compiling all this data and reporting it to CMS.
4	percent of the children get developmental screening and	4	Has CMS or has New Jersey considered you
5	then you may have a state that says only 7 percent get	5	just shared how you might use the developmental
6	a screen. And some of that is because they're	6	screening data on a quality improvement project with
7	grabbing the autism along with it. So that is one that	7	the plan, has the State or CMS considered or shared
8	has had a lot of discussion within the State, and that	8	with you how they might begin to use this data to drive
9	is the reason why we're not reporting on it.	9	quality improvement projects to change payment
10	DR. SPITALNIK: But that also is reported	10	structures from public reporting. Has any thought been
11	on as one of the measures in the Maternal and Child	11	given to how the data could be used to drive the
12	Health, the Title 5 Block Grant, developmental	12	quality.
13	screening. So maybe this is an opportunity to look at	13	MS. ROGERS: I don't want to totally take
14	that and see if we can come up with a way of assuring	14	how the Division would use that, but certainly when we
15	an accurate reporting.	15	have our information, you know, reporting it through
16	MS. ROGERS: I'm not familiar with that, so	16	Carol, through Meghan so that we can look and see can
17	if you want to talk about that later, that's great.	17	any of this be part of any value base performance
18	DR. SPITALNIK: The follow-up question to	18	payments. And we do have some of our quality measures
19	that is are there any measures that are being used	19	that are a part of current value based payment
20	nationally within this that look at post-developmental	20	considerations. So certain, whether it happens
21	screening, both referral for evaluation and diagnosis.	21	developmental screen or however we look to that.We have
22	MS. ROGERS: There is no measure out there	22	history in the past of doing it. We can certainly use
23	currently on that.	23	it.
24	DR. SPITALNIK: Because I think that's one	24	DR. SPITALNIK: Anyone else?
25	of our next quality challenges both in terms of access	25	Anyone on the phone with any questions for
	45		47
1	and measurement.	1	Cindy?
1	and measurement. MS. ROGERS: Again, just speaking for those	1 2	Cindy? Thank you so much for this presentation and
			•
2	MS. ROGERS: Again, just speaking for those	2	Thank you so much for this presentation and
2 3	MS. ROGERS: Again, just speaking for those in the MCO world out here, we are working on a new	2 3	Thank you so much for this presentation and all the work that goes into it.
2 3 4	MS. ROGERS: Again, just speaking for those in the MCO world out here, we are working on a new quality improvement project, a Quality Improvement	2 3 4	Thank you so much for this presentation and all the work that goes into it. We will now turn to a presentation on
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	48		50
1	verbal complaints taken by staff or written complaints,	1	have gone out of my way for several weeks to contact
2	that's all fine. What about the ability to do a	2	several people from LogistiCare, leaving several voice
3	complaint online.	3	mail messages concerning rides, some that are long
4	MR. TUNNEY: Interesting. That's something	4	distance rides which is outside the 20-mile radius.
5	I can talk about with LogistiCare about for their	5	However, when you have chronic conditions and
6	portal page for the members. I'll see if they don't	6	LogistiCare is calling my health care manager about my
7	have it, and that's actually a pretty good idea to get	7	regular chronic care physician so I can treated within
8	that put on, if it's not already.	8	a 20-mile radius, that kind of behavior is not
9	MS. ROBERTS: Thank you.	9	welcoming. Could you give some emphasis on that,
10	DR. SPITALNIK: Anything else?	10	please?
11	Joe.	11	MR. TUNNEY: I can. They can't tell you
12	MR. MANGER: Joe Manger from Horizon.	12	what you can do. You have the choice.We could, we have
13	Steve, I just wanted to give a shout-out	13	the right to say that we will not transport you 40
14	particularly to your oversight team. I work closely	14	miles if you have a provider that's closer.You have the
15	with your team. I work with them a lot. I don't think	15	right, of course, to come back and question that, and
16	I've seen any complaints about LogistiCare this year.	16	we can we always try to get people to a specialist
17	But most importantly, we've got some really valuable	17	that they need. I'm not going to go into what your
18	referrals coming from your oversight unit were a person	18	issue is because it's not anybody's business, but
19	going on various locations which people have choice;	19	that's something we can work on. I know that is one of
20	we all know that. But we found a couple of folks who	20	the provider types. There are certain provider types
21	we had a care manager reach out just to have a	21	that are exempt from being the 20 miles. And the one
22	discussion and then what we found out was we could	22	issue, I believe, is within that exemption.So that's
23	assist them on much bigger things than just wanting to	23	something that they absolutely should not be doing. We
24	go to a doctor two counters over. So I think that	24	can talk about that offline if you want. We can get
25	oversight process has been a great value add. And the	25	that trip set up.
	49		
	45		51
1	fact that there's clinical involvement has been	1	51 MS. DELVECCHIO: The other concern is when I
1 2		1 2	
	fact that there's clinical involvement has been	_	MS. DELVECCHIO: The other concern is when I
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2 3	fact that there's clinical involvement has been phenomenal because there's direct communication between the oversight unit, our clinical care managers who set up appointments really removed a great barrier. So thank you for all that work.	2 3	MS. DELVECCHIO: The other concern is when I have taken a ride with LogistiCare, on two occasions I've had one of the riders actually smoking: One inside the vehicle with the window down; one has the door ajar with holding themselves with the door
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	52		54
1	please?	1	I thought that they asked, on the calls I've listened
2	MR. TUNNEY: Yes. We've heard that from other people. It's a change that we are going to make.	2	to, they tell you the address and just ask you to
3	They're going to record the time it's going to be	4	confirm that is your address. But if they're doing something differently, that's something, again, we'll
5	from the time the call comes in, not from the time	5	look into. Normally, there's other way that you can
6	whoever answered starts initiating that. I believe	6	have it that when you call, whenever you call in to
7	they extended it. It's supposed to be the call has	7	book a trip, we can have you go to specific person that
8	to be within two business days by noon, it used to be,	8	deals only with you. That way, there's an established
9	and we gave you an additional two hours to kind of	9	relationship, and that's an option. There's things we
10	offset that so if there was any opportunity in other	10	can do. Nothing that can't be fixed.
11	words, you were supposed to call by 12. So hopefully	11	MS. DELVECCHIO: Thank you. I look forward
12	you were not on hold until 2 o'clock. But that's what	12	to that.
13	happens now, people are thinking that they have until 2	13	DR. SPITALNIK: Thank you so much.
14	o'clock. But we're going to work on that. When the	14	MS. SPADOLA: My name is Cynthia Spadola.
15	call comes in, that's part of their new phone system	15	I'm from the Mental Health Association in New Jersey.
16	that they can see what time the call actually came into	16	First of all, I would like to say that there
17	the system and that's the one that they should be using	17	have been a lot of positive changes implemented, and
18	for their time.	18	we're really exciting about that. We, a couple of
19	MS. DELVECCHIO: And lastly, most	19	months ago, met with Chris Echols, the Senior Vice
20	importantly, when a member calls in, you ask the member		President of Operations of LogistiCare. He actually
21	to identify themselves by their name, their date of	21	came up to New Jersey and we went to a wellness center
22	birth, and where they live. Now if they're asking for	22	and he had the opportunity to sit down with some
23	someone to pick them up or if they're in a public	23	individuals living with mental health conditions and
24	place, that's giving the other surrounding people who	24	talk with them directly about their personal
25	are around information, private information about that	25	experiences with LogistiCare. Statistics take you but
	53		55
1		1	
1	individual. How are you going to correct that problem?	1	so far and there's absolute merit in the data, however,
1 2 3			
2	individual. How are you going to correct that problem? MR. TUNNEY: So you're talking about on a will-call?	2	so far and there's absolute merit in the data, however, getting that information from the people is also really insightful. So I just wanted to throw it out there
2 3	individual. How are you going to correct that problem? MR. TUNNEY: So you're talking about on a	2 3	so far and there's absolute merit in the data, however, getting that information from the people is also really
2 3 4	individual. How are you going to correct that problem? MR. TUNNEY: So you're talking about on a will-call? MS. DELVECCHIO: Any call. When you call,	2 3 4	so far and there's absolute merit in the data, however, getting that information from the people is also really insightful. So I just wanted to throw it out there that we have wellness centers that are very interested
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	56	[58
1		4	
1	MS. SPADOLA: It's so appreciated. And I	1	nurse, so when I worked in the hospital, I would write
2	just wanted for you to know on the consumer side,	2	whenever I had somebody who is defend.Do you think you
3	having someone who represents LogistiCare come to them	3	would need beyond having the ability to write a note
4	and explain things and how to ease their minds, let	4	and respond in writing?
5	them know we have heard you and we are making these	5	MS. LAO: I think a little bit more would be
6	changes, is very helpful. So good job, and I hope that	6	appropriate because some deaf people are using American
7	it continues to improve.	7	sign language, which is not an English-based language.
8	MR. TUNNEY: That's actually another very	8	So sometimes writing isn't an appropriate form of
9	good idea. I know they right now they only go to	9	communication for them because it can cause
10	providers. Again, I won't speak with them, but I will	10	miscommunication. The driver doesn't have to be
11	bring it up to them. I don't see why they could not do	11	proficient in American Sign Language, but if they knew
12	that with individuals that are having because it	12	some basic conversational skills, just going, like, for
13	does seem like when something goes wrong, boy, does it	13	example, the doctor, so that the person then would feel
14	go wrong. It's like holy cow, how did this happen.	14	a little bit more comfortable. Because sometimes what
15	How can I get 99.9 percent when nothing went wrong, and	15	happens when a deaf person uses this type of service is
16	this other person everything goes wrong. So that's a	16	the person just opens the door and just kind like, "Get
17	good idea. We will take that into consideration as	17	in. Get in." And its very disconcerting for the deaf
18	well. Thank you.	18	person, so just some basic communication. Writing,
19	DR. SPITALNIK: Thank you so much for that	19	yes, would be good. But some basic maybe teaching them
20	point.	20	visual communication maybe, maybe not eve American Sine
21	Steve, thank you so much.	21	Language, but visual communication so they can help
22	MS. ROBERTS: Just one very quick thought	22	make the consumer feel a little bit comfortable. And
23	that I had with regard to the comment earlier about	23	this would also be really beneficial if they could just
24	smoking. Are there signs in the vehicles that say	24	learn some techniques to work with somebody who is
25	smoke is not permitted in this vehicle?	25	defend and blind because there are a lot of deaf people
	57		59
1	MR. TUNNEY: Yes, there's no smoking.	1	or deaf-blind people who would use the service.
2	MS. ROBERTS: I didn't know. But it would	2	And just another thought came to my mind.
3	just seem that would be a simple way that the driver	3	If we have a deaf who has CP, their writing skills are
4	could say, "This isn't my rule. This the rule from New	4	going to be very limited, so just some basic ways to
5	Jersey Medicaid."	5	make them feel a little bit more comfortable utilizing
6	DR. SPITALNIK: We have a question in front.	6	and the second sec
7			this service will be great.
	MS. LAO: Yes, I do have question. Thank	7	this service will be great. MR. TUNNEY: Understood. My writing skills
8	MS. LAO: Yes, I do have question. Thank you. My name is Khanh Lao, and I am the President of	7 8	-
8 9			MR. TUNNEY: Understood. My writing skills
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25 /humanservices/dmahs/boards/maac/.) 25 quality improvement project the MCOs are going to be		available for viewing at http://www.state.ni.us	24	MS, ROBERTS: There was mention of a new

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1	starting, so if there's more information that we can
2	have on that, that would be great.
3	DR. SPITALNIK: Anything else?
4	Again, thank you to Meghan and to all the
5	staff of the Division of Medical Assistance and Health
6	Services, both those who presented today. And I thank
7	people who are on the phone for muting as well as
8	participating. Always our thanks to Lisa Bradley and
9	to Phyllis Melendez for organizing the meeting.
10	Do I have a motion to adjourn?
11	MS. COOGAN: Motion to adjourn.
12	MS. ROBERTS: Second.
13	DR. SPITALNIK: Motion by Coogan and
14	seconded by Roberts. We are adjourned.
15	(Meeting concluded at 12:56 p.m.)
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