MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
New Jersey State Police Headquarters Complex
Public Health, Environmental and Agricultural Laboratory Building
3 Schwarzkopf Drive
Ewing Township, New Jersey 08628

October 19, 2017
10:09 A.M.

FINAL MEETING SUMMARY

Members Present:
Deborah Spitalnik, PhD, Chair
Sherl Brand
Mary Coogan
Theresa Edelstein
Dorothea Libman
Beverly Roberts

Members Excused:
The Honorable Mary Pat Angelini
Christine Buteas
Wayne Vivian

Members Unexcused:
Mary Lund

State Representative:
Meghan Davey, Director
Division of Medical Assistance and Health Services

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Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac.

Attendees in Person

Mark Warthur	AbbVie
Cheryl Reid	Aetna Better Health New Jersey
Daniel Keating	Alliance for the Betterment of Citizens with Disabilities
Cathy Chin	Allman Group
Brian Atkisson	Association of New Jersey Chiropractors
Matthew Minnella	Association of New Jersey Chiropractors
Shabnam Salih	Camden Coalition of Healthcare Providers
Tara Porcher	Centers for Medicare & Medicaid Services
Cheryl Golden	Cumberland County Board of Social Services
Lisa Upshaw	Essex County Welfare Agency
Liza Grundell	Family Resource Network
Karen Brodsky	Health Management Associates
Chris Czvornyek	Hospital Alliance of New Jersey
Carol Katz	Katz Government Affairs
Tammy Dellavecchio	Member of the Public
Cynthia Spadola	Mental Health Association of New Jersey
Lori Price Abrams	MWW
Khanah Lao	NJ Association of the Deaf
Wardell Sanders	NJ Association of Health Plans
Debra Wentz	NJ Association of Mental Health and Addiction Agencies
Mary Abrams	NJ Association of Mental Health and Addiction Agencies
Kevin Casey	NJ Council on Developmental Disabilities
Dennie Todd	NJ Council on Developmental Disabilities
Grace Egan	NJ Foundation for Aging
Crystal McDonald	NJ Health Care Quality Institute
Selina Haq	NJ Primary Care Association
Kim Higgs	NJ Psychiatric Rehabilitation Association
David Drescher	Office of Legislative Services
Robin Ford	Office of Legislative Services
Karen Shablin	Optum, Inc.
Sonia Delgado	Princeton Public Affairs Group
Catherine Mabee	Riker, Danzig, Scherer, Hyland & Perretti, LLP
Jennifer Farnham	Rutgers Center for State Health Policy
Kathleen Lockbaum	Salem County Board of Social Services
Arturo Brito	The Nicholson Foundation
Raquel Jeffers	The Nicholson Foundation
Shirley Samuels	Unknown
Zinke McGeady	Values Into Action NJ
Deborah Brown, DMD	WellCare
John Kirchner	WellCare
Lisa Knowles	WellCare
Nancy Tham	Wellcare

Hannah Good	NJ Treasury, Office of Management and Budget
Graham Ruff	NJ Treasury, Office of Management and Budget
Kelli Rice	NJ Division of Developmental Disabilities
Freida Phillips	NJ Division of Family Development
Marie Snyder	NJ Division of Family Development
Chris Cheethom	NJ Medicaid Fraud Division
Joshua Liichtblau	NJ Medicaid Fraud Division
Kay Ehrenksantz	NJ Medicaid Fraud Division
Stefanie Muzgai	NJ Department of Health
Laura Otterbourg	NJ Division of Aging Services
Julie Cannariato	NJ Division of Medical Assistance and Health Services
Linda Edwards	NJ Division of Medical Assistance and Health Services
Meghan Davey	NJ Division of Medical Assistance and Health Services
Carol Grant	NJ Division of Medical Assistance and Health Services
Marc Gonzer	NJ Division of Medical Assistance and Health Services
Roxanne Kennedy	NJ Division of Medical Assistance and Health Services
Phyllis Melendez	NJ Division of Medical Assistance and Health Services
Maribeth Robenolt	NJ Division of Medical Assistance and Health Services
Cynthia Rogers	NJ Division of Medical Assistance and Health Services
Heidi Smith	NJ Division of Medical Assistance and Health Services
Steven Tunney	NJ Division of Medical Assistance and Health Services

Attendees by Phone:

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

Area Code	# of Callers
215	2
518	1
609	8
732	1
973	1

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, and it's my pleasure to welcome you to the October 19th meeting of the Medical Assistance Advisory Council (MAAC). We have sign language interpretation available today in the auditorium. If that's something that you need to utilize, please join the interpreters in front of the podium.

I also want to mention that if people do need accommodations, please let Phyllis Melendez know prior to a meeting so we can make sure that everyone can fully participate.

I want to welcome everybody to this meeting. We will do introductions. I will explain some things about how we function. We'll look at minutes. We have an informational update, a series of presentations, and more additional updates.

It's my responsibility to let you know that the procedures in the unlikely event of an emergency that if the fire alarm sounded or an evacuation announcement was made, you need to quickly leave the building via the nearest exit, go to Lamp Post No. 9 in the parking lot, and then we'll check off your names on the attendance list.

I have to let you know that pursuant to New Jersey's Open Public Meeting Act, adequate notice of

the schedule of this meeting was posted according to State requirements.

Our custom is that the members of the MAAC introduce themselves, then I ask the members of the public who are in the auditorium to introduce themselves. We also have people participating by phone, so at the end of that, I will ask them to identify themselves, and that does include one MAAC member today.

Prior to introductions, I am pleased to announce two new appointments to the MAAC: Christine Buteas and The Honorable Mary Pat Angelini have been appointed to the MAAC. Unfortunately, they are not able to be with us today, but they plan to be with us at our next meeting.

I also want to announce that Governor Christy has reappointed the following members: Sherl Brand, Theresa Edelstein, Dot Libman, Mary Coogan, Beverly Roberts, and myself.

Next, let's ask the members of the MAAC to introduce themselves.

(Members of the MAAC introduce themselves.)

DR. SPITALNIK: Now let's ask the members of the public to introduce themselves.

(Members of the public introduce themselves.)

DR. SPITALNIK: And now I'd like to ask the people on the phone to identify themselves.

(Participants via phone introduce themselves.)

DR. SPITALNIK: So the way that the MAAC functions, and we have been proud to be able to do this, is that we don't just reserve an isolated period for public comment. We discuss each issue. We ask that the members of the MAAC ask questions first, and that would also include Theresa on the phone. Then we'll open that to the members of the public. We ask that people make questions, not statements, and that people are as succinct as possible. When you do make a statement, please identify yourself by name for the benefit of our record reporter so we have an accurate record. We've never had to limit that kind of dialog, and we hope to continue to live up to that.

So our first piece of business is to turn to the minutes of our last meeting, which was July 20th, and I will ask for any additions or corrections from members of the MAAC or a motion for approval.

MS. BRAND: Motion to approve.

DR. SPITALNIK: Thank you.

Second?

MS. ROBERTS: Second.

DR. SPITALNIK: In favor?

(MAAC members vote by a show of hands.)

DR. SPITALNIK: The minutes of July 20th are approved.

Our first business is a presentation from Valerie Mielke from the Division of Mental Health and Addiction Services (DMHAS).

Welcome, Valerie. We're delighted to see you.

And as Valerie is making her way to the podium, let me remind people that the slide that are being shown today are posted on the Division's web site to ensure access at: Http://www.state.nj.us /humanservices/dmahs/boards/maac/.

Valerie, welcome and good morning.

MS. MIELKE: Thank you very much for having me today, it's really a pleasure. And good morning to all of you.

I'm pleased to be here before you and talk about the reorganization od DMHAS.

As many of you may know, Governor Christy in the Executive Order reorganized the State departments such that the Division of Mental Health and Addiction Services -- we had been located at the Department of Human Services -- to migrate and become a part of the Department of Health. In addition to that, there are

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other functions within the Department of Human Services, such as the Licensing and Investigation Unit for our State psychiatric hospitals that moved over, as well.

What really drove this decision is that, as we all know, the provision of integrated care, primary health and behavioral health services, yield much stronger outcomes for those that we serve, those who have addiction, substance use disorder, and those who have a mental illness. We've seen evidence of that in some of the initiatives where providers are actually providing integrated care. And what they have demonstrated is that there's significant improvements, both on the primary health side for those individuals as well as their behavioral health issues as well.

So the move over to the Department of Health really helps to further strengthen our ability to provide integrated care through a structure that really supports that. And one of those areas has to do with regulations. And some of the experiences of some of our provider organizations are some of the challenges that existed because they wanted to serve someone who had a substance use disorder, had a coexisting mental illness, and also had significant primary health needs that they actually had to comply with three different

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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.

So as of September 30th, all Division of Mental Health and Addiction Services staff became Department of Health staff. I've heard questions as to whether or not this move was one to save money; and what I will tell you is that it is not a hundred percent of my staff, so myself and my staff throughout the Division who were a part of the Department of Human Services, have moved over to the Department of Health. In addition to that, in Central Office, Department of Human Services, there were a number of staff that were there who also help support the functions of our Division. Those staff, as well, moved over to the Department of Health to continue to -- and to work in their Central Office and to continue to support our Division and our activities.

Right now we're in the midst of the first hundred days in terms of transition over to Health. Some of the things that are happening right now are that there are subcommittees that have been devised that are comprised of representatives in leadership at the Department of Human Services, individuals who are

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in leadership at the Department of Health, as well as leaders in the Division of Mental Health and Addiction Services. We have a myriad of subcommittees together working on how to best integrate our functions. So one such subcommittee is a legal subcommittee that's looking at our regulations and how to move regulations forward. Another work group is fiscal and looking at our contracts and how to move that forward. So those committees continue to meet.

In addition to that, at the Division of Mental Health and Addiction Services, we are in the process of moving out of the building of the Department of Human Services.For our offices that are in Hammonton, our southern region office, and on the grounds of Ancora Psychiatric Hospital, they remain in place where they are and they will not be moving.

For our northern region office which is located in Patterson, they will continue to remain there; they are not moving. Our Intoxicated Driver Program which is located on Front Street Trenton, they are also remaining where they are and are not moving. For those of us who are located at 222 South Warren Street, we are moving to two different locations.

One location is 127 Stockton Street, which is the location prior to the merger of the Division of

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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 week - so staff are currently in place there. And then the bulk of the Division are moving over to the building where the Division of Developmental Disabilities (DDD) is currently housed.

And so those moves have begun, and they'll be continuing to occur in three waves.For those staff who have moved to 120 South Stockton, their telephone numbers will be remaining the same as those numbers have transitioned over.For those of us who are moving to the previous DDD site, our telephone numbers are changing. So we will notify stakeholders as our telephone numbers change.

With this transition the issue that is front and foremost for both Commissioner of Human Services Connolly, and Department of Health Commissioner Bennett, as well as myself, is to ensure that there's a continuity of care to ensure that consumers, family members, and providers, that you're still able to get in touch with us. And so through this transition, whole units aren't moving over together. We're really phasing it in over the three phases so that as

individuals and their telephone numbers are changing and moving locations, we still have individuals at a location that are able to answer phones and able to respond to e-mails.

In addition to that, as it pertains to our contracts, our contracts are going to continue to remain the same as they are right now.So if you are a provider who is in Fee-for-Service (FFS) providing substance use treatment services, you will continue to use NJ SAMS and you'll continue to be paid by CSC, our fiscal agent. So continue to do what you're doing now. As it relates to our contract database, you'll continue to use that for now. If you're in FFS Mental Health and you're using the system, you'll continue to use that now. You'll continue to enter your units of service that you're providing, your claims and you'll continue to get paid through Molina. If you have a deficit funded contract or if you have a slot-based contract, those contracts will continue to operate as they are right now. Those contract documents also remain the same. So this way we can ensure that providers continue to be paid in a fashion that you are right now and that as we'll continue to keep you apprised as our contract processes may change over time.

One of the things that we've done to not only provide information out there to our stakeholders but also to receive feedback is that we've had meetings in each of the 21 counties. And each of those meetings, there's a representative from the Department of Health leadership staff, as well as a representative from the Division of Mental Health and Addiction Services that are there to present and talk about the transition and to answer questions. And so those meetings have been completed.

What I'll share with you, because I had the opportunity to attend about eight of those meetings, is that the feedback and information that we received is all very helpful. It's been compiled and consolidated, and we're using that information to help inform our planning processes going forward.

What's upcoming now are meetings at our state psychiatric hospitals. And so the presentations there are the same exact presentations that we've done in the 21 counties, but the audience will be primarily consumers and family members, and then there will be state staff who work at our state hospitals. So those meetings are coming in a couple of weeks and notices have gone out to stakeholders informing them of those meetings.

So that's a general overview of the transition where we are right now and really the goal of the transition, which is absolutely to improve, continue to enable us to improve the care and services that are provided to those that we serve.

Thank you very much for having me and giving me the opportunity to speak.

DR. SPITALNIK: Well, thank you very much. And thank you for your leadership in this transition. We know the load on the Division under all circumstances and how much extra work, so we really appreciate your leadership.

May I open this up to questions? Members of the MAAC.

MS. ROBERTS: Thank you, Valerie. But my question actually isn't directed to Valerie, it's to point out that there's gap in our knowledge with regard to the DDD dual diagnosis project because all of the information that we've just heard really does not pertain to persons with developmental disabilities who are duly diagnosed with behavioral health challenges.I know there's been change in leadership at the DDD, but I'm hoping by next meeting we will be able to get an update on that.

MS. MIELKE: Absolutely. We'll have some

information to present to you on that.We had actually some concerted work that Commissioner Connolly and Liz, as well as myself, were working on with its consultants. So we'll be able to share that.

MS. ROBERTS: Thank you.

DR. SPITALNIK: And I should follow that up with announcing that Jonathan Seifried is now acting Assistant Commissioner for the Division of Developmental Disabilities. Elizabeth Shea has exited her post. We have a representative from DDD here today. Thank you.

Other questions?

MS. COOGAN: I guess it's similar in terms of the interaction now with the Department of Children and Families. Maybe we can get an update the next meeting in terms of providing services to the family and children served under that department who need addiction services. You want to speak to that when you give the update for DDD?

MS. MIELKE: One of the things I might respectfully recommend is that maybe someone from the Department of Children and Families be here to present because they really have a breadth and a depth of services that they are providing to individuals who have an addiction or under the age of 21. And so I'm

happy to talk about our partnership with them, but I think that in terms of presentation that their presentation might be much more comprehensive.

MS. COOGAN: That will be terrific. Thank you.

DR. SPITALNIK: Thank you.

I also know that this is a down-the-line issue, but with the transition, with the administrative transition, we're also concerned about how Behavioral Health will coordinate with Managed Long Term Supports (MLTSS) and other Medicaid services which still remain in the Department of Human Services (DHS).

Thank you.

Are there questions from -- Theresa, do you have any questions?

MS. EDELSTEIN: No, Deb, I don't. Thank you.

DR. SPITALNIK: Okay. Thank you.

I'll take questions from the public. And please stand so we can hear you and your name.

MS. JEFFERS: Hi. Raquel Jeffers from the Nicholson Foundation.

Good morning, Val.

MS. MIELKE: Good morning.

MS. JEFFERS: I just had a question given the

fact that the reason or the rationale for the transition is really about developing better opportunities for integrated care. I was wondering if the department has a timeline for developing a new set of integrated regulations and/or a process for that component including public input?

MS. MIELKE: Thank you very much for that question.

Did everyone hear the question.

UNIDENTIFIED SPEAKER: People on the telephone can't hear the questions.

MS. MIELKE: I will repeat it.

So Raquel Jeffers asked if there was a timeline for the development of regulations which will help to further support the integration of primary health and will behavioral health services as well as what the public participation and input will look like.

So I don't have a definitive date and timeline in terms of when regulations will be available for public comment. However, as is our process, even prior to regulations being posted for formal public comment through the Office of Administrative Law, we will have some stakeholdering to gather some input to develop those regulations. So at this point I can't really speak to specifically what that process will

look like. We currently do have our legal staff who are part of the Central Office of the Department of Health, along with the Division of Mental Health and Addiction Services, sitting down and talking about integration and what's currently in all of our regulations and how we might look to bring that together. There may be some further information, though, before the promulgation of regulations of things that might help to further support integration beforehand. I ask that you stay tuned to that. We're having those discussions, as well. We're really not able to talk specifically more specifically about that because we're still in deliberations about how to do that. It's an important issue and it's a great question. So thank you.

DR. SPITALNIK: Anyone else? Anyone on the phone?

Hearing none, I'll say again thank you to Valerie for being with us this morning and for your leadership in this process.

MS. MIELKE: Thank you very much. Thank you for having me.

DR. SPITALNIK: As we turn to Julie Cannariato's presentation on the NJ FamilyCare Comprehensive Demonstration Waiver and The Community

Care Program, this will not only be a presentation, but this is formally an opportunity for stakeholder input about the transition of the Community Care Waiver into the Comprehensive Waiver. This is a role that the MAAC has played and a function and so that while the whole MAAC process is an opportunity for stakeholder input, we are formally recognizing this component of our meeting in that vein.

So Julie, welcome. And we'll follow the same processes.

MS. CANNARIATO: Thank you, Deborah.

So I know a couple of you here have been here for our presentation on the Concept Paper and then also for the unveiling what was in the Comprehensive Waiver. So you all know it is approved. Our Waiver was approved July 27th of 2017. It was effective as of August 1st and it will continue to be effective through June 30, 2022.

(Presentation by Ms. Cannariato.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/ boards/maac/.)

DR. SPITALNIK: Thank you so much, Julie.

We'll open up to MAAC, and whatever time we

need for stakeholder input.
Beverly.
MS. ROBERTS: Thank you very much Julie.
Do you have any further information on the additional stakeholdering that DDD is planning to do?
MS. CANNARIATO: I don't, but we could get back to you.
DR. SPITALNIK: Is that something, Kelly, that you could speak to at this point?
MS. RICE: Kelly Rice, DDD.
Unfortunately, Deborah, I'm not participating in that aspect, but I'm putting it down as a note and I'll follow up.
DR. SPITALNIK: Thank you very much.And we will make sure that that's an agenda item for our next meeting.
Anything else? Anyone else from the MAAC?
I wanted to add a clarification that there were three pilots for children under the first Comprehensive Waiver and the second you've addressed the two of them serious emotional disturbance and dual diagnosis. The autism pilot, because of new guidance from the Centers for Medicare and Medicaid Services (CMS), will become -- autism services will become part of the State Plan, so it will be handled through a

State Plan amendment. Meghan has clarified that those services will stay in place until the amendment is made. But that amendment will follow the same kind of process with rigorous stakeholder input, but there's not yet a timeline established for that.
Questions from the public?
Yes, Dan.
MR. KEATING: Dan Keating, Alliance for Betterment of Citizens with Disability.
And this may be one man's confusion, but I wanted to reiterate a couple of things and go with what Bev asked for.
We were told on September 27th, as is indicated, that the Community Care Waiver was going to go into the 1115. We have been told that was submitted previously. So I'm surprised to see that the comment period is now opened for a month and we were told about the 27th after the fact. I mean we were told on the 27th. What we were told, my belief again, is that we were told that the Community Care Waiver (CCW), which has been for residential and individual supports. So now are individual supports still going to be the terminology we're using, or it's now Community Care Program (CCP)terminology.
I only raise this because there's a lot of

confusion which we're going through multiple changes and to be accurate, and then there's those cynics who say that while you say it's not going to go to managed care that this makes it easier now for the State to move the Community Care Program to managed care.So there's a lot of confusion and additional stakeholdering, we were not aware that there was of any additional stakeholdering that I do ask that we find out what's going on.
MS. DAVEY: So I think Kelly might be able to address the individual supports, but it's two different things. So similar to what we had in a pilot for the IDDMI group for children, we're doing something similar on the DD side.So that's the stakeholdering we're talking about, building that pilot on an adult side.
When it comes Community Care Waiver moving the CCP, the Waiver Special Terms and Conditions (STCs) require, and CMS requires, a 30-day transition. So you have 30 days the you must notice the recipients that are currently in the 1915 authority to move to 1115 authority, as well as we have to send a letter to the region 30 days prior and a public comment period 30 days. So that's that piece.
The stakeholdering around the IDDMI pilot is

what we were talking about with the stakeholder.
MR. KEATING: Will there been more information about that?
MS. DAVEY: About the pilot?
MR. KEATING: Yeah, the pilot.
MS. DAVEY: Yes. I have to talk to Jonathan. Liz left, so they were doing some of that. So that's why it's not in the current STCs, because in concept CMS agrees with it because we already piloted in the children's side.
What they saying is, we're good with it, but DDD was saying we want to ge more stakeholdering around it before we finalize the STC. So that's going on now. I can get you more information on it.
MR. KEATING:And when is the stakeholder period over?
MS. DAVEY: So two different things again. So the stakeholdering around DDD is not a public -- it's public, but it's not like a CMS requirement; it's just building a program. The public comment period for moving CCW to CCP, which is a requirement of SCCs ends October 23rd or 24th. So you have an opportunity to send comments on that. And as of right now there is no discussion to moving that to Managed Care.
MR. KEATING: Thank you.

DR. SPITALNIK: My understanding, Meghan, was that that was the first Comprehensive Waiver that was proposed that the DDD Waiver be included, and it was rejected by CMS because it was not an R and D.

MS. DAVEY: Well, originally, we proposed all five 'C' waivers move into MLTSS. So only four moved. DDD did not move. And the reason they didn't want to move it with 1115 authority at that time was because it wasn't moving to managed care where you need the authority. What our argument to CMS was that our supports program wound up having a better package, a more flexible package, because they were under 1115. So those with a higher acuity level actually had less services. This makes it more flexible for us to make changes and give those services timely versus having to wait. And you know how long 'C' Waivers take to renew. So that was where we argued and fought to say let us get into 1115, let us get the flexibility we need to move the system quicker, faster.

MR. KEATING:That, I remember. The confusion, I guess, is between this demonstration project that's relatively new and I'd like to learn more about that. And if we have only until next week to get comments in, we need to expedite that. Or am I wrong?

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 really is no change to anyone's benefits or services. There's really no change to the client. It's really an authority change to make it simpler for New Jersey to manage it.

MR. KEATING: Thank you.

DR. SPITALNIK: Thank you.And thank you for raising that.

Kevin Casey.

MR. CASEY: Kevin Casey, New Jersey Council on Developmental Disabilities.

I was going to Google the word "stakeholdering" to the see if in fact that's a word, but I actually kind of like it. So if you don't mind, I'm going to adopt.

A couple of things. One, the move that the Department made to say essentially that everybody gets a shot at the Supports Program was as good a move I've seen in State Government, frankly, across the country.Liz deserves great credit for that. I think one of the things we need to look at, though, is that not everybody who applies for supports is going to be

able to sustain themselves with the supports that are available in the Supports Program (SP). So as you're going through this, I think you need to look at a definitive and solid way that families and self-advocates are aware of to ask for a move from the Supports Program to -- I'm not even what we're calling the program this the point under the new waivers, but you need to have a definitive process for people to move to more complex services.

Second, I'm very appreciative of the Department's desire to look at mental health services with people with developmental disabilities (DD) on a broader basis. As I have said here before, that's not a New Jersey problem only. I think there are only 49 other states that have that problem, but our job is to solve it in New Jersey. And I strongly encourage you to continue looking at that and to make that an important part of what you do. It is still very difficult with people with developmental disabilities to get mental health services when they need them.

Let me talk about stakeholdering for a minute, because I think it's a critical issue. As I wander around and talk to family groups in New Jersey, there's great confusion about a lot of what's going on in the DDD program. And it's not necessarily a

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 stakeholder process that allows self-advocates and families to get a say anytime you're about to make a policy change and before you make a policy change in terms of what you're doing. It's just crucial. And unfortunately, as valuable as computerized information is -- and we're obviously in an era where that's valuable. There's also to get out around the state, talk to family groups, get questions back, be able to answer those questions, and that kind of thing, because many families will have a question that may not come up in a formalized process.

But there are a number of models in other states about how to set up a stakeholder system that involves self-advocates and families and that can be useful to those self-advocates and families and, by the way, useful to the Department. One of the things I have found is that it's very possible for the Department to avoid mistakes by listening to what self-advocates and families are saying.

Thank you.

DR. SPITALNIK: Thank you.

Debra.

MS. WENTZ: Hi. For the record, Debra Wentz, New Jersey Association of Mental Health and Addiction Agencies.

I want to applaud the State in its move to the address, the Institutions for Mental Disease (IMD) exclusion. We're very excited that you are jumped on that opportunity that became available from the CMS letter.

And, of course, we're extremely impatient and anxious for when it would start. So once the Waiver is approved, do you have a timeline for when providers would be able to use that service.

MS. CANNARIATO: So we're currently working with CMS on finalizing those STCs in the timeframe, so we'll have a better idea -- I hate to say the next MAAC meeting, because I know they're quarterly, but probably in the next couple weeks you'll start seeing information coming out from us, but those are still being negotiated and finalized.

MS. WENTZ: That's exciting. And the up to 30 days, it was my understanding, that's across two months because you're really allowed 15 days in the one month; but if you bridge between two months, you're getting the 30 days. Is that correct?

MS. KENNEDY: That was under the MCO contract. We're still negotiating with CMS what that will look like. That was language in the MCO contract.

MS. WENTZ: Just building on stakeholdering in general, I think that the Department and Division has been hard at work and I know they study other models and there are opportunities for input. I think I have to echo what Dan and Kevin said, I think on the ground where the rubber hits the road and, you know, providers are delivering services, individuals and families are receiving them, that that really does tend to pinpoint areas that could be challenging and need addressing. So we do appreciate increased and consistent opportunities with enough timeframe to have meaningful input.

Thank you.

DR. SPITALNIK: Thank you.

MR. CZVORNYEK: Hi. Chris Czvornyek from the Hospital Alliance. I have two additional questions regarding IMD exclusion.

So one of them is going to -- seeking the federal match on this currently excluded population. Is it for all IMDs or just IMDs that are dedicated to inpatient substance patient psychiatric hospitals.

MS. KENNEDY: It's limited to those three

levels of care in SUD.

MR. CZVORNYEK: And Julie or Roxanne, could you explain the difference between the Managed Care contract again, the 15 days?

MS. CANNARIATO: Because it's still under negotiation, I think we'd like to wait until we do a formal presentation and really talk that through with the group. So I would like to table that question until the next time.

MR. CZVORNYEK: Okay.

MS. CANNARIATO: But we'll definitely make a note of it.

MR. CZVORNYEK: Thank you.

DR. SPITALNIK: And I'll put it on the agenda for next time.

Other questions?

Any questions from anyone on the phone?

MS. EDELSTEIN: This is Theresa. I apologize but is there any way that Julie can summarize what that question was? We couldn't hear any of it.

MS. CANNARIATO: Sure. I'm sorry, Theresa.

So Chris Czvornyek had asked for us to summarize the difference between the IMD time frames under the Substance Use Disorder (SUD) continuum versus the time frames that allowed for Federal Financial

Participation (FFP) in the managed care contract. So because we're still working through finalizing the STC to CMS, I suggested that we table that conversation until we can do a thorough presentation at the next MAAC meeting.

MS. EDELSTEIN: Okay. Thanks so much.

DR. SPITALNIK: Hearing no other points of input, I would thank Julie and the Division for the presentation.And thank everyone for input and also ask you to fan out the information, particularly on the last slide about the posting and the time frame input. Thank you.

We'll now move to another presentation by Heidi Smith on NJ FamilyCare, the Aged, Blind and Disabled Program. Heidi is Chief of Operations in the Division of Medical Assistance and Health Services.

MS. SMITH: Good morning, everybody.

So I'm here to talk the streamlining of Aged, Blind, Disabled Program for efficiency, some things that we were looking at and some things that we needed to do from hearing from our constituency, some advocates, some families, and their experience.

(Presentation by Ms. Smith.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are

available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

DR. SPITALNIK: Thank you so.

Any questions?

MS. ROBERTS: Thank you so much. This was very, very helpful.

I have a couple questions for today for the group, but I'm hoping that we can also meet separately because there is some issues pertaining to my population for people that are Section 1634 Disabled Adult Children (DAC). These are people who have had SSI and Medicaid and they've met those requirements.

Then when mom or dad retired or started to collect their Social Security or a parent became disabled or died, then the son or daughter who did SSI and Medicaid gets SSDI from the parent's work record. Now they're typically getting a whole lot more in their monthly benefit from SSDI and they need Medicaid again from the county. So out of all the tons of people that you see this is a small percentage. Out of the people that I see and I get calls from, I get a lot of these calls. So I just want to be sure that as this new very exiting system is set up that it incorporates appropriately our folks. And one of the things that I see right off the bat, where it talks on this form how

much money you're receiving.So if one of our folks who's a DAC needs to get Medicaid again from the county is getting $1,300 a month in SSDI from a parent, that's legitimate, that's what they're getting, they do meet the requirements. But I have a feeling the way this is set up right now, that will be thrown out; oh, you have too much money coming in, you won't be able to get Medicaid. So that's the kind of stuff I want to just make sure we can address.

A question about ABLE accounts. Are you familiar for ABLE?

MS. SMITH: Yes.

MS. ROBERTS: Is there a way for a person who has an ABLE account -- which of course you can't have in New Jersey yet; hopefully one day soon -- but you can open accounts in other states.Pennsylvania, for example, has it. Is there a way to include that a person has an able account within this?

MS. SMITH: So that was Bev, for people on the phone, who had questions about DAC and resources and income. I should have clarified that this was just a screen shot of one screen. So how we have income, it goes even more. I just didn't want to go and get every possible page of every resource. There's more. So they can split out and tell us when they have income,

is it work income, is it investment income, where did it come from? So it's just page of that. I do look forward to having a meeting with you so that we can drill in and look at it more closely. And about Able accounts, we do have our attorneys with our Department and our Division are actually starting to look at the Able accounts now.We don't have them in New Jersey, but you're right, they can exist in other states.

MS. ROBERTS: Because when I do trainings, I include that, the fact that they can open an account in any other state that allows an out-of-state person to open an account there. So you're probably going to start to see more of that.

MS. SMITH: I agree.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Other questions from the MAAC?

Joe.

MR. MANGER: Joe Manger from Verizon Blue Cross/Blue Shield.

Phenomenal, phenomenal work. I cannot say enough about how thorough it really is and what an incredible asset it's going to be. Just a couple of comments or suggestions. Questions are probably in there, but this is first time seeing it, so forgive me.

The communication stuff I think is fabulous. In the application process online, is there some one how they prefer to be communicated with? Because one of the things we see with the changing populations, the face of Medicaid and AVD is different, family members are doing it. Do we say things like, "Do you prefer e-mail? Do you prefer phone?" Because we're finding that to be when we're managing our members a critical thing. Upfront if you know that, it's kind of helpful. So just a suggestion if it's not under consideration.

MS. SMITH: We're practicing first with the MAGI population. They get to say whether they want electronic notification or paper notifications. That's the easiest letter to send out, so that's on our canary in the mine. Believe it or not, when the family chooses the electronic, per the law, you have to send them a paper letter anyway just confirming that they really want electronic.

MR. MANGER: I'm really referring to contact going forward because they're going to Managed Care --

MS. DAVEY: Authorized reps and the family member.

MR. MANGER: Exactly. I know you have authorized reps, so maybe it's in there. But what we find is if you say, "I really which you'd call my

sister, my wife, my husband -- again, it's probably already in there in some fashion, but we've been picking up a lot of that with out cultural linguistic task force meetings that we do is folks being asked about their communication preferences. That's all. And I can follow-up with something with writing.

One other question. The flyer, I love it; love the flyer. Is there -- and there probably is -- a reason we use Long Term Services Supports and we dropped the M? What's the difference?

MS. SMITH: I'm going to let Theresa handle that one.

It's Long Term Services and Supports, but all of our care that we deliver Long Term Services and Supports isn't always through Managed Care. We have PACE agencies also.

MR. MANGER: So that's managed long-term.

MS. SMITH: Theresa, are you there?

MS. EDELSTEIN: Yeah, I'm here, but I couldn't hear Joe's question. So can you quickly repeat it?

MS. SMITH: So Joe was asking where we call int Long Term Services and Supports and not Managed Long-Term Services and Supports in the brochure. And we have Long-Term Services and Supports because under

the option they are talking how you have Managed Care health plans, but you also have Pace and our DDD population.

MR. MANGER: Makes sense. Again, just a question.

One other thing. Probably already in other coverage, but I know my brethren from MFD are here as well. Are there questions about other insurances? I think one of the challenges we all see is -- Bev talks about it too -- they might have had piece of Medicare but not all of Medicare.

Someone might have had a piece of policy or not a policy. And it's probably in there. You do now how critical that is for all of us to know?

MS. SMITH: Maybe I made it more confusing by just showing you one page. But when you do the insurance side of it, they get to talk about their Medicare or their second policy or their policy.

MR. MANGER: And I'll contact you after because other managed care plans, as well -- I believe, again, I don't want to speak out of turn, but I believe managed care plans are allowed to market to the individuals who are applying for AVD. Am I correct? I'm just wondering if we should be stakeholder in the process.In other words, have a separate meeting with

you, go over -- because there are association health plans. We have a lot of experience portals, applications, and other stuff. It might be helpful information --

MS. DAVEY: Joe, we meet contract issues monthly.Maybe we do a demo there so the health plans can see it.

MR. MANGER: Thank you.I don't want to be critical. I think it's incredible.

MS. SMITH: The feedback helps us. We love to go out, try it, and then we hear from people who ask for these edits and changes, and they make sense, so we can put them in. So it's good.

MS. BRAND: What kind of consumer feedback have you done or have you gotten thus far?

MS. SMITH: When we did the paper application, which is how we came up with the online application. We did the paper application. We launched it, and it would be the families calling in going "What do you mean by that question?"

So when we heard the families and we hard from the agencies on what to do, such as the elder care attorneys had some suggestions about the brochures and Pace agencies and HCNJ, families also calling into the Division would have questions about "What do you mean

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 careful with the language, and it's short, small, so it was a challenge to try to keep a high level and just explanatory. But that let us know. The first rendition of this brochure didn't have anything about the authorized rep in it, and the whole Long-Term Services and Supports section changed because they weren't getting that it's a concurrent review process. It's two different agencies. It's help you to meet eligibility. So after we had a couple renditions of the paper, that helped us to build the online.

MS. EDELSTEIN: Heidi, can I ask a question? This is Theresa.

We had talked briefly about how to better represent Pace as an option on the health plan page. The introductory paragraph of that page concerns me a little bit because it really is almost directing the applicant to choose right now. Even though it says, "If you don't choose, you can choose later," it doesn't make reference to the fact that if they want more information about Pace where they get it. And may be a sentence or two about where Pace is even available and how to find out more or a link to the Pace page maybe

on the Division's website. So I think that section may need some more work in order to make sure that all choices are represented, not just health plan choices.

MS. SMITH: Okay. We'll look at that also.

I know that they come to -- when they're in the Long-Term Services and Supports if it's community Medicaid, then PACE isn't an option. So we'll look at that.

MS. EDELSTEIN: Okay. Thank you.

DR. SPITALNIK: No other questions at this time, I want to thank Heidi for this. I know that you and Bev will follow-up with each other. Thank you so much.

We're now going to turn to a presentation Child Core Set of Measures, the quality measures for Medicaid and CHIP. We're appreciative of the Division being so responsive to the request that was made at the last meeting and I'm pleased to introduce Cindy Rogers who is the Director of the Office of Quality Assurance, Division of Medical Assistance and Health Services (DMAHS).

MS. ROGERS: Good morning, everyone. I've come to you today to talk to you about Child Core Set Measures. I don't know if in our audience we have individuals who are familiar with what the Child Core

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.

(Presentation by Ms. Rogers.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

DR. SPITALNIK: Thank you so much, Cindy. Mary.

MS. COOGAN: Thank you, Cindy. This was really helpful.

Can you talk a little bit about how New Jersey decides which measures they're going to report?

MS. ROGERS: Sure. The question was which measures does New Jersey decide that we report on. So from the 27 measures that we're anticipating this year, we're saying we're reporting on 18 of them. The majority of those 18 will be The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data measures, because the information has been gathered from the health plan. We then have to work the HEDIS information that comes in to put it into MACPro reporting. And then we also have measures that we report on that come from your CAHPS survey, so your

Consumer Assessment of Health Plan Surveys also feeds some of the questions. They are the major feeders.

What we look at, though, is not necessarily every HEDIS measure is also reported because it may be one, as I said, where we're excluding a population or it's something we can't capture well. One of them that we are looking to -- actually, this is kind of like an announcement for those in the health plans out here. There is a measure that is on concurrent medication, children on multiple concurrent antipsychotics. That is a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) world. It's a measure that you have been reporting. It's not a measure we had given to HEDIS. Concerned because we wanted to make sure with that being it's a carveout from the Behavioral Health, really reporting it barely. But we did some discussion between our pharmacy director with our EQRO and we feel that administratively we will capture.So we are going to look to add that measure actually in this year.

So we look to balance it to know that we're giving what's accurate data to reflect New Jersey, and much of it is HEDIS and CAHPS driven.

MS. COOGAN: So my sense from what you're saying, and I commend New Jersey for reporting on as

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 in terms of trying to see if we can't get a report on that. And to be fair, I appreciate the concern that you don't want to be reporting on the dataset that may not come out fairly to the plans; I understand that.

MS. ROGERS: You bring up a great question. And actually, in my note I wrote developmental screening.

Developmental screening, again, has been topic of discussion. There is a developmental screening measure. There is concern with it, so that is why we are not reporting. We actually have calls with CMS with our EQRO with regard to that one.

The developmental screening measure, the way that is written by the steward allows you to take a tool that is also including autism screens and considering that a developmental screen, so that it's arbitrarily the inflating the percentage that looks as if they've got a true development screening completed. So New Jersey is intentionally not reporting on that one because you're not able to differentiate developmental screens from autism. And that is one of the measures that comes up in discussion

quite a bit because of the State's ability to capture it. Some states are reporting everything and so you may have state who has an inflated rate of, say, 45 percent of the children get developmental screening and then you may have a state that says only 7 percent get a screen. And some of that is because they're grabbing the autism along with it. So that is one that has had a lot of discussion within the State, and that is the reason why we're not reporting on it.

DR. SPITALNIK: But that also is reported on as one of the measures in the Maternal and Child Health, the Title 5 Block Grant, developmental screening. So maybe this is an opportunity to look at that and see if we can come up with a way of assuring an accurate reporting.

MS. ROGERS: I'm not familiar with that, so if you want to talk about that later, that's great.

DR. SPITALNIK: The follow-up question to that is are there any measures that are being used nationally within this that look at post-developmental screening, both referral for evaluation and diagnosis.

MS. ROGERS: There is no measure out there currently on that.

DR. SPITALNIK: Because I think that's one of our next quality challenges both in terms of access

and measurement.

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 Project that's coming up this year. They were just admitted and they should be getting kicked off next year. And it is with regard to early intervention and developmental screening. So health plans, this is certainly, again, the topic that we're working with them. We did a focus study on developmental screenings, so we gathered some information and could see how many were getting done, what happened at the provider's office, how did referrals happen, how did health plans follow up after the referral. And from that information that we learned, health plans are now -- they've just submitted them in so that starting off in the new year we can actually do a quality improvement project. Again, when we did the improvement project as I mentioned earlier on BMI, we saw the rates go up, so we're hoping that getting this focus effort in terms of developmental screening we'll see the same.

DR. SPITALNIK: Thank you.

Anything else from MAAC?

Raquel.

MS. JEFFERS: Hi. Raquel Jeffers from the Nicholson Foundation. This is really great to see; compiling all this data and reporting it to CMS.

Has CMS or has New Jersey considered -- you just shared how you might use the developmental screening data on a quality improvement project with the plan, has the State or CMS considered or shared with you how they might begin to use this data to drive quality improvement projects to change payment structures from public reporting. Has any thought been given to how the data could be used to drive the quality.

MS. ROGERS: I don't want to totally take how the Division would use that, but certainly when we have our information, you know, reporting it through Carol, through Meghan so that we can look and see can any of this be part of any value base performance payments. And we do have some of our quality measures that are a part of current value based payment considerations. So certain, whether it happens developmental screen or however we look to that.We have history in the past of doing it. We can certainly use it.

DR. SPITALNIK: Anyone else?

Anyone on the phone with any questions for

Cindy?

Thank you so much for this presentation and all the work that goes into it.

We will now turn to a presentation on Non-Emergency Medical Transportation Contract Provisions. And welcome Steve Tunney who is the Chief of Behavioral Health and Customer Service.

MR. TUNNEY: Good afternoon.

Non-emergency contract New Jersey, for those of you who don't know, we have a single broker model where all non-emergency medical transportation is provided by one broker.In this case it's LogistiCare.

(Presentation by Mr. Tunney.)

(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

DR. SPITALNIK: Thank you so much.

Any questions?

Beverly.

MS. ROBERTS: Thank you, Steve. This was a really, really helpful presentation. And I'm thrilled about the GPS. I think that will be helpful.

One question that I have has to do has to do with complaints. So in the slide that you talked about

verbal complaints taken by staff or written complaints, that's all fine. What about the ability to do a complaint online.

MR. TUNNEY: Interesting. That's something I can talk about with LogistiCare about for their portal page for the members. I'll see if they don't have it, and that's actually a pretty good idea to get that put on, if it's not already.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Anything else?

Joe.

MR. MANGER: Joe Manger from Horizon.

Steve, I just wanted to give a shout-out particularly to your oversight team. I work closely with your team. I work with them a lot. I don't think I've seen any complaints about LogistiCare this year. But most importantly, we've got some really valuable referrals coming from your oversight unit were a person going on various locations -- which people have choice; we all know that. But we found a couple of folks who -- we had a care manager reach out just to have a discussion and then what we found out was we could assist them on much bigger things than just wanting to go to a doctor two counters over. So I think that oversight process has been a great value add. And the

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.

MR. TUNNEY: Thank you.

MR. MANGER: It is a testament. We work well with LogistiCare. And they came to us and said, "Can you help us? We see these things. We're coming across problems people are having, they had drivers that go into the home and they observe things and they don't know what to do." So we said tell us and then we'll work with people. Sometimes there is no answer. Other times we're able to make a difference. So let us know. If we can help people, if we can get them at least connected with a service that's appropriate, then that's a good thing to do.

DR. SPITALNIK: Yes.

MS. DELVECCHIO: My name is Tammy DelVecchio.

Mr. Tunney, I think you know me by name. I've called your office many times.

Unfortunately, I do have some concerns about LogistiCare as well as your office. A lot of messages have gone out to yourself as well as LogistiCare. I

have gone out of my way for several weeks to contact several people from LogistiCare, leaving several voice mail messages concerning rides, some that are long distance rides which is outside the 20-mile radius. However, when you have chronic conditions and LogistiCare is calling my health care manager about my regular chronic care physician so I can treated within a 20-mile radius, that kind of behavior is not welcoming. Could you give some emphasis on that, please?

MR. TUNNEY: I can. They can't tell you what you can do. You have the choice.We could, we have the right to say that we will not transport you 40 miles if you have a provider that's closer.You have the right, of course, to come back and question that, and we can -- we always try to get people to a specialist that they need. I'm not going to go into what your issue is because it's not anybody's business, but that's something we can work on. I know that is one of the provider types. There are certain provider types that are exempt from being the 20 miles. And the one issue, I believe, is within that exemption.So that's something that they absolutely should not be doing. We can talk about that offline if you want. We can get that trip set up.

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 smoking.That has not been addressed, otherwise, it wouldn't have happened recently. Could you help me on that as well, please?

MR. TUNNEY: That's, obviously, not allowed. It's a tough situation on the driver, but the driver should be the person who has to take charge of that. Let me who -- that's something we have to work through the transportation provider to make sure their drivers are not allowing people to smoke on the vehicle.That's the first one I heard. I know you told me about the other issue. That's the first time I heard about that. That's something that you're probably best going through my office with.

MS. DELVECCHIO: And a few other concerns.

When you do call, when the participants call to make the appointment, the cutoff time is usually 2 o'clock. However, if you're on hold for a long period of time, it doesn't collect the call until after the 2 o'clock point and it makes it like the participant has called over that time. Can you assist me with that,

please?

MR. TUNNEY: Yes. We've heard that from other people.It's a change that we are going to make. They're going to record the time -- it's going to be from the time the call comes in, not from the time whoever answered starts initiating that. I believe they extended it. It's supposed to be -- the call has to be within two business days by noon, it used to be, and we gave you an additional two hours to kind of offset that so if there was any opportunity -- in other words, you were supposed to call by 12. So hopefully you were not on hold until 2 o'clock. But that's what happens now, people are thinking that they have until 2 o'clock. But we're going to work on that. When the call comes in, that's part of their new phone system that they can see what time the call actually came into the system and that's the one that they should be using for their time.

MS. DELVECCHIO: And lastly, most importantly, when a member calls in, you ask the member to identify themselves by their name, their date of birth, and where they live. Now if they're asking for someone to pick them up or if they're in a public place, that's giving the other surrounding people who are around information, private information about that

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, you have to identify yourself by your full name, your date of birth, where you live. So let's say sometimes the constituent is outside of a private area, maybe they're in a doctor's office or somewhere where they can't be private. If you have a doctor's office in the city, there's no where for any privacy. How are you able to identify yourself without giving all that information? I have suggested in the past giving members an ID number or some kind of personal PIN so that they can easily identify themselves so that information is not compromised in any kind of way.

MR. TUNNEY: That's an operational concern for LogistiCare. I'll bring it up, but I know they have to have some way to verify who you are to make sure that you are the Medicaid client that's calling. That's part of a way to avoid fraud. I'm not saying you have a sister or that you would do this, and that she would be calling claiming to be you to get a trip someplace. So they ask certain information just to verify it's you. They get away from using the Medicaid ID number and they went with the name and birth date.

I thought that they asked, on the calls I've listened to, they tell you the address and just ask you to confirm that is your address. But if they're doing something differently, that's something, again, we'll look into. Normally, there's other way that you can have it that when you call, whenever you call in to book a trip, we can have you go to specific person that deals only with you. That way, there's an established relationship, and that's an option. There's things we can do. Nothing that can't be fixed.

MS. DELVECCHIO: Thank you. I look forward to that.

DR. SPITALNIK: Thank you so much.

MS. SPADOLA: My name is Cynthia Spadola. I'm from the Mental Health Association in New Jersey.

First of all, I would like to say that there have been a lot of positive changes implemented, and we're really exciting about that. We, a couple of months ago, met with Chris Echols, the Senior Vice President of Operations of LogistiCare. He actually came up to New Jersey and we went to a wellness center and he had the opportunity to sit down with some individuals living with mental health conditions and talk with them directly about their personal experiences with LogistiCare. Statistics take you but

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 in sharing their experiences and stories. And if you would be interested in setting up a meeting or attending a meeting, we would honor and welcome that opportunity for you to get that type of insight.

MR. TUNNEY: That's an easy one, because I know that LogistiCare also increased the number of their field representatives, and their sole job is to go out and meet with providers and to address whatever your concerns are. And the people that they have worked with, they've had a lot of great successful. I'm not going to lie to you and say every problem is always solved. Like I said, there's some problems that are just difficult. But that is something that we've reached out to them. We said that we would really focus on that. And if you'll notice, the other part is I don't want it to just be that we looked at 99.9 percent of the vehicles. I want to know on that .1 what did we find, that kind of stuff that we are trying to get more into looking into the actual record. Beyond just quantitative, we want to get more into the qualitative.

MS. SPADOLA: It's so appreciated. And I just wanted for you to know on the consumer side, having someone who represents LogistiCare come to them and explain things and how to ease their minds, let them know we have heard you and we are making these changes, is very helpful. So good job, and I hope that it continues to improve.

MR. TUNNEY: That's actually another very good idea. I know they right now they only go to providers. Again, I won't speak with them, but I will bring it up to them. I don't see why they could not do that with individuals that are having -- because it does seem like when something goes wrong, boy, does it go wrong. It's like holy cow, how did this happen. How can I get 99.9 percent when nothing went wrong, and this other person everything goes wrong. So that's a good idea. We will take that into consideration as well. Thank you.

DR. SPITALNIK: Thank you so much for that point.

Steve, thank you so much.

MS. ROBERTS: Just one very quick thought that I had with regard to the comment earlier about smoking. Are there signs in the vehicles that say smoke is not permitted in this vehicle?

MR. TUNNEY: Yes, there's no smoking.

MS. ROBERTS: I didn't know. But it would just seem that would be a simple way that the driver could say, "This isn't my rule. This the rule from New Jersey Medicaid."

DR. SPITALNIK: We have a question in front.

MS. LAO: Yes, I do have question. Thank you. My name is Khanh Lao, and I am the President of the New Jersey Association of the Deaf. And I wanted to make a comment not necessarily related to smoking, but regarding two complaints.

If you have a deaf consumer who's using LogistiCare, how can the client and the driver communicate? I'm wondering if you have drivers who could go through some training that maybe just would have some brief classes ASL. We wouldn't expect fluency, but we would expect maybe that would be able to have just some brief communication tools to work with somebody who is deaf. Because there are a lot of deaf people in New Jersey who are deaf and defend blind or defend and in a wheelchair, so it would be nice if there was some way to establish some type of communication between deaf consumers and people who are driving for LogistiCare.

MR. TUNNEY: What I did -- I'm a registered

nurse, so when I worked in the hospital, I would write whenever I had somebody who is defend.Do you think you would need beyond having the ability to write a note and respond in writing?

MS. LAO: I think a little bit more would be appropriate because some deaf people are using American sign language, which is not an English-based language. So sometimes writing isn't an appropriate form of communication for them because it can cause miscommunication. The driver doesn't have to be proficient in American Sign Language, but if they knew some basic conversational skills, just going, like, for example, the doctor, so that the person then would feel a little bit more comfortable. Because sometimes what happens when a deaf person uses this type of service is the person just opens the door and just kind like, "Get in. Get in." And its very disconcerting for the deaf person, so just some basic communication. Writing, yes, would be good. But some basic maybe teaching them visual communication maybe, maybe not eve American Sine Language, but visual communication so they can help make the consumer feel a little bit comfortable. And this would also be really beneficial if they could just learn some techniques to work with somebody who is defend and blind because there are a lot of deaf people

or deaf-blind people who would use the service.

And just another thought came to my mind. If we have a deaf who has CP, their writing skills are going to be very limited, so just some basic ways to make them feel a little bit more comfortable utilizing this service will be great.

MR. TUNNEY: Understood. My writing skills are a little but limited sometimes, too. I can't even read my own. That's an area where we're going to have to reach out. That's kind out of my field. I'll look into it to see what we can.

DR. SPITALNIK: Thank you for the question.

And thank you, Steve, for the presentation.

We'll now turn to Meghan Davey, the Director of the Division of Medical Assistance and Health Services for an update or NJ FamilyCare.

MS. DAVEY: I just have a few quick slides on an update.But I do want to take an opportunity to just thank my Medicaid team. I think today has been a lot of very informative, comprehensive presentations. And I don't think they get the credit for the amount of time and effort that goes into these things together when they have a day job to do. So I just want to thank them for all their great work and for all those great presentations.

(Applause.)
MS. DAVEY: So just kind of a quick level set of where we are with FamilyCare.
(Presentation by Ms. Davey.)
(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)
DR. SPITALNIK: Any questions?
Raquel.
MS. JEFFERS: I just had a question about CHIP. Is there any conversation about the State stepping up to the plate in the event the Feds drop --
MS. DAVEY: So we have a lot of options circulating, and I can't speak for the Administration right now, but we have a lot ideas. You know, we used to have a buy-in program. Is it something that we would maintain? Do they move to the marketplace? Lots of options, papers going around and planning for all the different scenarios, but I can't speak that a decision's been made. We just don't know what the future is going to bring, so...
DR. SPITALNIK: Yes?
MS. DELVECCHIO: Could you give the definition of other?

MS. DAVEY: Sure. It's actually in the slide. So you'll be able to get it. Includes dental, transportation, home health, long term care, vision and crossover claims for duals. So that's kind of a lot. But the slides will be available online and it has that breakout in the bottom.
MS. DELVECCHIO: Thank you.
DR. SPITALNIK: Any other questions?
Any questions from the phone?
Meghan, thank you so much. And I know you're keeping the pulse of what's going on.
Laura, in the interest of time, I'm going to ask you to see if there's any information that you can refer to quickly or summarize. I know have a lot MLTSS activity and accomplishments.
MS. OTTERBOURG: I can make it very quick. A lot of these slide, we do on a regular base for the MAAC meeting, so it just gives you an update on where we are in MLTSS in terms of the numbers. I'm just going to quickly go through them.
(Presentation by Ms. Otterbourg.)
(Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)

DR. SPITALNIK: Anyone?
Joe.
MR. MANGER: It's a quick one. I apologize, I should have asked Mehgan.
Any insight into the enrollment fluctuations that are going on?
MS. DAVEY: Yeah. I had mentioned that. I don't if you I heard me.
MR. MANGER: I apologize.
MS. DAVEY: We think it's because of the redeterminations are back. The last six months we have redets happening in the last six months of each year because of the way the expansion came in and FFM cases getting batched to us. But we're watching it closely.
DR. SPITALNIK: Any additional questions for Laura?
Any questions for those on the phone?
Laura, thank you so much. It's great to see the progress. Also, friends should be aware there's a very active MLTSS Steering Committee that meets very regularly and takes a much deeper dive into this excellent data.
There are a couple of things that we need to do. Before I go through the suggested agenda items EMT for our next meeting, this will be on the website, but

let me give you advanced notice of the meetings for 2018. Wednesday, January 24th is our next meeting, followed by April 11th, July 18th, and October 17th. From the information that we've discussed today, there was an interest in a agenda item around the dual diagnosis pilot between DDD and Mental Health;
Interest in stakeholder input around the changes with the Community Services Support Program, and well bring to DDD the request for more stakeholder clarity and information;
The issue of ABLE Accounts was raised with Heidi Smith around the application process;
Also a commitment between Heidi to convene around the disabled adult child;
There was interest in meeting with -- and I this would be offline for the meeting right now -- around developmental screening in terms of trying to understand our metrics and how else we might use the data;
In the moving target category is the CHIP reauthorization as well as the Medicaid program.
So those are continued update items.
Anything else for our agenda next time?
MS. ROBERTS: There was mention of a new quality improvement project the MCOs are going to be

starting, so if there's more information that we can have on that, that would be great.

DR. SPITALNIK: Anything else?

Again, thank you to Meghan and to all the staff of the Division of Medical Assistance and Health Services, both those who presented today. And I thank people who are on the phone for muting as well as participating. Always our thanks to Lisa Bradley and to Phyllis Melendez for organizing the meeting.

Do I have a motion to adjourn?

MS. COOGAN: Motion to adjourn.

MS. ROBERTS: Second.

DR. SPITALNIK: Motion by Coogan and seconded by Roberts. We are adjourned.

(Meeting concluded at 12:56 p.m.)