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

January 1, 2019
10:08 A.M.

FINAL
MEETING SUMMARY

DR. DEBORAH SPITALNIK: Good morning and Happy New Year. Welcome, everyone, to the first Medical Assistance Advisory Council (MAAC) meeting of 2019. I'm Deborah Spitalnik, the Chair of the MAAC. And I need to begin by letting you know that pursuant to New Jersey Open Public Meetings Act, adequate notice of the scheduled quarterly meetings of the MAAC, as well as public notices and invitation to attend, have been published in all the requisite forms of media.

I also have to tell you that in case of the emergency, which I don't believe that we will have, but in the event, I'm obligated to tell you, as we are guests in this building, that if there was some sort of an emergency, we would ask you to exit from the back through the entrance to the building and gather as Lamppost No. 9.

Having done that, let me more warmly welcome

you and go through our procedure and our agenda for today.

One of the things that we pride ourselves on at the Medical Assistance Advisory Council Meeting is that not do only have an open public meeting, but that we are able to engage in dialog. Many councils and committees restrict public input to a very isolated portion of the agenda. We have never had to do that. We hope to never resort to that. But what we do is after a presentation, we permit the members of the MAAC to make their comments and questions. And then we open that up to the public, and we rely on you to be succinct, and we're appreciative of your attendance and input.

Before I have people introduce themselves, we have a wonderful change in our agenda, and we'll be welcoming Commissioner Carole Johnson to make remarks.

So let me ask the members of the MAAC to introduce themselves. Then let me ask the public to introduce yourselves. In the interest of public health, we're not passing a microphone around, so I'll ask people to speak loudly and clearly.

(Members of the MAAC introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Welcome, everyone. We're

always gratified by the interest and participation.

Let me review our agenda. We're going to invite Commissioner Johnson's remarks first, then turn to the approval of the minutes, and then we have a series of presentations on the Autism Services State Plan proposed amendment, Customer Satisfaction Survey for Behavioral Health Transportation, Emergency Department triage fee. Then we have a series of informational updates: New Jersey Family Care, Managed Long Term Services and Supports (MLTSS), Office Based Addiction Treatment (OBAT), and the NJ FamilyCare Managed Care contract. So we have a full and robust agenda.

I'm delighted to welcome you back, Commissioner Johnson, and we look forward to your presentation and remarks. Thank you.

COMMISSIONER JOHNSON: Thank you. Thank you, everyone. Thank you to Deb and members of the MAAC and to those of you in attendance for the opportunity to be here.

Today is the one-year anniversary of the Murphy Administration, and so I thought that was a great opportunity for me to just come back. I came to a MAAC early on, and I said a little bit about what we hope to do going forward. And so today seemed like a good day to talk about what has happened in the year that we've been

here and to hear from you about ideas going forward.

As you know, our mantra in the Murphy Administration is about building a stronger and fairer New Jersey, and a number of things have happened over the last year in the Department of Human Services to help us along the path to that goal.

We have done a series of things in Medicaid. I think probably those of you in this room know this better than most, but it's worth sort of the racking up in one place.

We've added new diabetes prevention benefits which include self-management, education, and training, medical nutrition therapy, and the National Diabetes Prevention Program which, as you know, is a national model program. This is the kind of thing that people from other states have reached out to me to say, "How are you doing this? What are the opportunities here? This really feels like a place where we could make a difference in really helping to curb the increasing number of people with diabetes." So it's a very exciting place for us in the prevention space.

We also expanded hepatitis C treatment. It's been a longstanding challenge across the country to ensure that people with hepatitis C get access to curative therapy as quickly as possible. New Jersey has still had policy

in place that sort of limited this access to the place where you had to actually demonstrate you had liver damage before you could get access to curative therapy. Early on in my tenure here, Meghan came to me and said this is a place where we could modernize our benefits. And we've been able to modernize our benefits and say as soon as you have a diagnosis, you get access to curative therapy.

Just last week in this room, we had a conversation with stakeholders about our new autism spectrum disorder benefits. This is a really exciting space for us where we are able to build in Medicaid in the base program benefits for autism spectrum disorder, with input of the broader community. We have had in New Jersey a small pilot program that was really capped out at about 200 young people. And we're now going to be able to open that up to the base Medicaid benefit and ensure that young people get access to the benefits that they need.

We've lifted the prior authorization requirements on tobacco cessation services, particularly on pharmaceuticals and other services to ensure that -- as we all know, those of you who work in public health know this better than anyone, when someone's ready to quit, they're ready to quit. And you have to be there and ready to meet them where they are when they're ready. And so barriers to that service are not going to be a useful way

to ensure people quit. So there are places where prior authorization makes sense and where they need to be part of the benefit package. This is a place where we thought that removing all barriers was essential.

We are also really excited to be expanding access to family planning benefits. As you may know, one of the first things the Governor did was sign legislation restoring funding to Planned Parenthood. In conjunction with that, he also signed legislation that expands access to family planning up to 205 percent of poverty. And so we've taken that opportunity to really try to build on a benefit that best serves women and men with the series of services that are really the full suite of family planning benefits. And so we're working aggressively on that.

And then high on our list, as has been for some time, is really treating opioid use disorder. So we are implementing the federal waiver and have now gone online with ensuring that long-term residential treatment services can be paid by Medicaid. As those of you who know the Medicaid restrictions on there, that is not something Medicaid has previously paid for. Under our waiver, we're able to pay for those services. And so we are moving forward on that, which actually just gives us more opportunity to have more resources in our substance use disorder prevention and treatment bucket because we're

able to bring federal matching money in for those services. We're also implementing the hundred million dollar initiative that the Governor outlined in his budget last year and which we secured through the Legislature. So more to come on that front, but we are continuing to do what we need to do make sure that we have a full complement of opioid treatment disorder services.

In addition, outside of just the Medicaid specific bucket, I wanted to share with you some of the other things that we're doing across the department. We were really delighted to be able to welcome the Division of Mental Health and Addiction Services back to the Department of Human Services this year. That is something that -- that Division was transferred over to Health at the end of prior administration. Since day one, stakeholders have been asking the Governor to move it back to DHS so that it was under the same roof as Medicaid, and we were able coordinate those services as well as possible. So we were able to used state dollars to draw down federal dollars where it made sense and ensure that we were coordinating our services well across the full continuum. And so we were able to bring the Division back, and we're really excited about that. And that is how we're coordinating on implementing the Governor's opioid money. We also received a significant chunk of money as part of

the larger federal opioid response. So we're coordinating those across the Division and Medicaid.

We've implemented the Stephen Komnino's Law which took effect on May 1st. This is legislation that was passed at the end of 2017, and its goal was really to strengthen the protections for people with intellectual and developmental disabilities who reside in the community and really build stronger connections between those providers and families and guardians and provide more opportunities for families and guardians to be engaged in those services.

In practice, what it means is that we as a department have to make two unannounced visits to every group home a year and then ensure that we are on site within -- I believe it's 48 hours of reported incidents in those homes.

So that has been a significant staffing and resource issue for us over the last year is to make sure we have the capacity to comply with the law and ensure that the expectations that families have for what this law will accomplish are in place. And we were happy that we were able to do that and get that staffing up and running and training and have the resources and tools to be able to implement the law.

We also launched NJ ABLE this year. NJ ABLE

is the program that allows individuals with disabilities to better save for their needs throughout their lifetime by creating tax advantage savings accounts. And so this is a place where I would really ask those of you in the audience here to think through with us ways to continue to get the message out about the fact that this exists, because this is really an opportunity. The advocacy community came together and went to Feds and asked for a way to create tax advantage savings accounts, and then every state had to adopt it. So we've adopted it in New Jersey. We really now have a way that people can prepare better for their education and health and housing and transportation needs over their lifetime by putting money in these tax preferred savings accounts. And there's a lot of excitement in the community about it. But I think we are standing up, sort of a Speakers Bureau, to make sure we have some capacity if you have venues where it would be good for us to do some presentations or outreach that we can do that. But we think it's just a wonderful thing, a wonderful complement to all the many things we do in the State, and we want to make sure we get the word out.

We also were able to increase wages this year for direct support professionals who care for those with a special development disability in the community. This was -- what we were excited to be able to do in particular

here was the Legislature added $20 million in the budget. That $20 million gets split between us and the Department of Children and Families and the Department of Labor. The bulk of the money comes to us, but we were able to quickly -- this took a lot of technology work over several weekends. We were quickly able to build it into our Medicaid rates so that we were able to draw down federal match on that money and expand the resources available. So we were able in our Department to essentially double our pot and get $32 million built into the rates to increase wages, which worked out to about a 4 percent increase.

In no way was anyone taking a big victory lap here saying that this work is done. There is much more work to be done across the state and nationally on the need to address wages because this is vital and important work and we need to make sure people are paid well for the services that they deliver. But we were excited to be able to do this piece of it and be able to draw down additional federal match to increase the dollars on the table.

We also put new investments in child care this year. I'm particularly excited about this because the Governor's larger agenda is creating a stronger and fairer New Jersey and putting everyone on the best possible financial footing. And families can't get there if they

don't know that their children are in safe and affordable childcare. And for probably the better part of the decade, center-based childcare subsidy rates have not increased. So we were able to put $38 million as part of a federal initiative on the table to help us increase childcare subsidy rates for families that are lower income. And our childcare subsidies work on a sliding scale, so they actually help families further up the income scale who really struggle to pay for childcare subsidies. And then we were able to complement this with the fact that the Governor's budget included a tax credit for child care services as well. So for lower income families and those sort of trying to -- those who are on the threshold between lower income and middle income, we have our subsidy program. And then the tax credit is able to help families who are middle income and above.

We also undertook an initiative this year to expand food assistance for community colleges. One of the things that we had heard a great deal about was about the growing issue of food insecurity on college campuses. And as you know, one of the Governor's priorities is free community college and making sure that we create an opportunity to bring more people into higher education. And as we expand the base of who comes into higher education and we try to get sort of nontraditional students and older

students and people who have families into educational base so that they can strengthen their economic opportunities, we need to make sure that those families have the supports they need. For a lot of families, college affordability is not just about tuition; it's about tuition and childcare and food assistance and the kinds of things that would make that equation work for them. So there was a way that we figured out that we were able to ensure that community college students who are in career and technical assistance programs met the threshold for what would count as training programs for SNAP, which is the food assistance program. And when we were able to do that and write our rules to be able to change that regulation, we were now able to make that easier for them to get Supplemental Nutrition Assistance Program (SNAP). So that's an initiate that we worked on this year. We're continuing to look for ways to ensure that those set of services that make it easier for families that want to go to college and want to make sure that they have those educational opportunities get the supports and services they need to be able to do that.

We also, as you know, are the home of our Division of Aging Services. And one of our initiatives in the Division of Aging this year has really been to say we have a lot of terrific opportunities for people to come

in the door and benefit from our aging programs. But they were dispirit and there were different applications for each program, and it was time consuming to be able to figure out what you might be eligible for. So our Aging team really took on the challenge of building a single, one-stop portal, one application, to be able to come in and put your information in one place and for us to determine, with the help of the counties, whether you were eligible for pharmaceutical assistance, the Medicare savings programs that help pay Medicare premiums and deductibles and co-pays, the utility assistance programs. Like, let's put that all in one place, have people come in one place, give us their information, and then we'll figure out which of those things we can help them with. And so this is really part of our larger goal of trying to make sure that we capture people where they are, we meet people where they are, and we try to make it as easy as possible for them to access the resources and services that are available to them. This has been a great partnership with counties, with the faith community, with pharmacies on just getting the word out that that exists and that there's a way to just go to NJ Save, which is what we call the program and what we've branded the website, go to NJ Save do the one app for this assistance.

And I'll just as a side note say to those of

you in this room, you all know how important Medicare savings programs by getting people who are eligible for Medicare savings program who can then get help with their Medicare premiums and help with their Medicare co-pays and deductibles. That's a huge win if we can make sure we can identify those folks and get them signed up.

We've also tried to expand our community footprint in our outreach efforts. So over the summer, we worked hard on an initiative to do -- our Commission on the Blind and Visually Impaired has the capacity to do eye screenings in the community. And what we did was partner with members of the Legislature to host events in their districts over the summer to draw more people into our eye screenings. And then we were able to also have this assistive technology that we have for individuals who are deaf or hard of hearing at those events, too, so that people could see the full complement and range of tools that are available to them. So we actually got a lot of great feedback from those events, and we're able to encourage more legislators to host them throughout the summer.

Along those same lines, the Commission on the Blind and Visually Impaired has been working on a library access program that allows for the libraries to have the tools to make it easier for people who are blind and

visually impaired to use their computers, to use their iPads to do training on how to use those facilities and make it easier for people. It's a big issue for people who are blind. But people who are becoming visually impaired, that's more of a progression that sometimes happens to people and they don't always know what resources are available to them. And the library can be a go-to place for that. We expanded at the Newark Public Library this year. The Lieutenant Governor joined us for that rollout, and it was really fun day.

We also have the New Jersey Hearing Aid Project at our Division of the Deaf and Hard of Hearing Run. This is where we collect hearing aids that are -- when someone gets new hearing aids, we'll collect their old hearing aids or we ask people to donate their old hearing aids. And then we get them refurbished, and then we're able to give them to lower income individuals, older individuals in the State who need access to hearing aids. When we started, when we came in earlier this year, this program had a decent-size footprint, but our challenge was we need an audiologist to be part of that equation. We can't just take a refurbished hearing aid and hand it to you. We need an audiologist to be part of that. We were paying a fee to the audiologist for that service, but that fee wasn't really enough to recruit enough audiologists to be part

of the program. So we actually increased that fee from 150 to $300, and we've actually seen some additional uptake in audiologists being willing to participate in the program.

We have opened an assistive device demonstration center, which is really a place that someone can go and see the various technologies that may be available to them as someone who is deaf or hard of hearing. This includes seeing up close and tactile what it looks like to have phones that have closed captioning, phones that have voice, fire alarms that have voice. There's just a whole host of technology there, a room that's looped. All the things are in one place so people can see and try them out and utilize them before they make any purchases on their own.

And then I'm particularly excited and proud that we did this this year. Our team at Medicaid found the resource and capacities for us to be able to contribute to the larger statewide efforts to get people enrolled in the Affordable Care Act coverage. So we actually backfilled a little bit. We could fill the whole hole by any means, but we backfilled those federal navigators that had existed in New Jersey who were the community-based organizations in our State who had been federal navigators when the current administration in Washington cut those

grants. We actually gave grants to those organizations to do outreach and enrollment assistance this year during open enrollment. And so we were excited to be able to do that. They were at Christmas parades and turkey giveaways, and you name it, they were there, trying to get people enrolled.

We did a number of sessions early on in the year for Hurricane Maria evacuees who were here in New Jersey. There was a lot of uncertainty about how long FEMA would let those folks stay in hotels. There was just a lot of uncertainty. And we were able to connect them with our county partners and the resources that we had available to help people with emergency assistance and food assistance and the like.

I will note before I wrap up that the other things that we've been a doing in addition to all of our sort of programmatic and policy changes is trying to be as actively engaged as we possibly can be with our Attorney General, with our voice and our pen at pushing back at some of the policies that are coming out of Washington that are detrimental to the people we serve. So we've been able to file declarations in the AG's lawsuits to protect the Affordable Care Act, to document what Medicaid expansion has meant in this State in the lawsuit in Texas that's trying to undercut and dismantle the Affordable Care Act.

We've been able to file declarations in the contraception lawsuit to document what limiting access to and undoing the preventative benefits for contraception in the ACA would mean to people in the State. And we filed comments pushing back strong and hard against the administration in Washington's push to try to expand the public charge definition and threaten services that immigrants in our state receive. And so we'll continue to use our voice on those issues as we continue to build out our policy opportunities and our strategies for ensuring that we in the Department of Human Services are helping to make a stronger and fairer New Jersey.

So thank you, everyone. Thank you for all of your work. It would not be possible for us to have done this if it weren't for the ideas that you bring to us every day. We try to follow up on what we can. And we really are thinking through strategically where the opportunities are.

I'll take a question or two if folks have some.

THE COURT: Thank you so much, Commissioner.

Any questions from the MAAC?

MS. ROBERTS: Thank you so much. This was very wonderful to hear, all of these really great accomplishments.

With regard to NJ ABLE -- and I agree with you

that it's very, very helpful and we want the word to get out. I'm wondering if it would be possible as one of the presentations that gets done if there could be something for the MAAC so that everybody here -- I mean, I know quite a bit about it, not that I can make a presentation. But I've heard presentations, and I think it would be a good way for everybody to understand. And one of the things that I'm particularly interested in everybody recognizing is putting -- it's up to $15,000 a year is my understanding is what can be deposited into an ABLE account. And that could be used as a legitimate spend-down for somebody who needs Medicaid that they have to have below $2,000 to be able to apply for Medicaid or below 4,000, depending on which category you're applying for, that that's a legitimate way if a person has $10,000 in the bank and they're otherwise Medicaid eligible. So that's just the kind of information that would be really good for everybody to know.

COMMISSIONER JOHNSON: Terrific. We will make that happen. Thank you for suggesting it.

CHAIRWOMAN SPITALNIK: Anyone else?

Anyone from the public for the Commissioner?

Would you please state your name for the record?

MS. VERNA: Sure. Marie Verna, Dominion

Behavior Health Policy. To follow-up on that question, you mentioned a Speakers Bureau. Is there a member of your staff that we should contact? Because I did do some of that education for people who receive services at one of our largest behavioral health provider agencies, and we did have a little bit of trouble helping them understand that it is not actually immediate help with some of the things they can save for, but we do want to make sure they understand this is your future.

COMMISSIONER JOHNSON: Anthony, can you raise your hand?

Anthony will follow-up with you and make sure he has your contact, and we'll get you connected to the right folks.

We are doing the internal training now to make sure our staff has the capacity and the right information to go out and do these trainings. But that's our goal, is to have people who can do that kind of community-based outreach and answer those kinds of questions.

MS. TODD: Dennie Todd with the New Jersey Council on Developmental Disabilities.

Carole, that was wonderful. It was very nice to hear that news.

What can we do to help you?

COMMISSIONER JOHNSON: Thank you so much for

that.

So I'm going to say what is most -- what is most helpful to us, I think, in the short term is -- you all know this better than I do because you have been working in this base for a long time. The budget environment is tight and our opportunities are therefore -- I'm looking at my colleagues from [ONB] in the middle of the room. The budget environment is tight, therefore, our opportunities to make good policy changes are somewhat structured by that. We're continuing to push ahead, but they are somewhat structured by that. So to the extent that folks can prioritize, the kinds of things that would be most helpful, the kinds of things that on your list of here's the five things that would really matter to our community, if you could tell us here is the one that has the biggest impact, here's the one that -- lowest cost, highest impact is always the best. But if it cost a little bit, and still this is the one that has the highest impact, that's the most helpful to us because in a tough budget environment, you always have to make tough choices.

Thank you for the question.

And, again, I just can't thank you all enough. As I may have mentioned in the past, I came home to New Jersey to take on this role. And it has been one of the great joys of this role, not only to work for Governor

Murphy, but to have such a strong and vibrant advocacy community in New Jersey that is willing to stand up and really ask for and fight for what the people in our State need. And after eight long years of some real difficulty in doing that, our administration wants to be as helpful as possible, and we want to do it in strategic and smart ways.

Thank you all. Thanks so much.

(Applause.)

CHAIRWOMAN SPITALNIK: We will now turn to the review of the minutes of October 17, 2018.

Do I have any comments, corrections, and/or a motion for approval?

MS. ROBERTS: Motion to approve.

CHAIRWOMAN SPITALNIK: Thank you.

Second?

MS. LIBMAN: Second.

CHAIRWOMAN SPITALNIK: Thank you. The minutes of October 17th are approved.

We now move to the presentations phase of our meeting. You will hear in Michele Schwartz' presentation that we are presently in the midst of a 30-day comment period about estate plan amendment for autism services for children. There was a stakeholder forum last week at this time for significant input. As you're listening, we also

want to encourage people to submit written comments. Given that we are in this comment period, the structure of federal Medicaid regulation requires that Children and Families and Medicaid are not able to answer substantive questions. We might entertain clarifying questions. But I really encourage people both to go to the website and you'll see the link, and the 30-day comment period will end on February 2nd.

So I'm delighted to welcome Michele Schwartz from the Children System of Care in the Department of Children and Families.

MS. SCHWARTZ: Thank you so much.

We were out here in October. We presented at the October MAAC some basic information. So we just want to thank you all for attending today, as well as to the Council for the opportunity to provide some additional information moving forward towards the State Plan. I'm pleased to be able to present this, the Children System of Care, in collaboration with the Division of Medical Assistance and Health Services.

For some of you who may not be aware, I just want to provide again some basic background information on where we were and how we got here.

(Slide presentation by Ms. Schwartz.)

(Slide presentations conducted at Medical

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

CHAIRWOMAN SPITALNIK: Thank you. As we said in the beginning, the Plan is for any clarifying questions that the MAAC has.

Clarifying questions?

If not, thank you so much. And I really encourage people to comment. When you go to the DMHS website, the notice about the State Plan Amendment is maybe six or eight boxes down on the listing of notices, but it very clearly says EPSDT and State Plan.

Thank you so much, Michele.

We'll now turn to Steve Tunney who is Chief of Behavioral Health and Customer Service at the Division to speak about a customer satisfaction survey for behavioral health transportation services.

Steve, welcome.

MR. TUNNEY: Thank you. My name is Steve Tunney. I oversee the contract for the transportation that we have currently with LogistiCare. I did a presentation before where we presented a customer service satisfaction that my staff had done. Some people had some question about it being done by our staff. So we had IPRO, who does our outside auditing for the Division, complete

a totally neutral assessment. Everybody that was included in this survey is somebody who was transported to a Behavioral Health service, totally random, just picked on a date and the trips provided the day before that trip.

(Slide 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/)

CHAIRWOMAN SPITALNIK: Thank you, Steve.

I'll turn to the MAAC for any questions.

MS. EDELSTEIN: Steve, thank you, first of all.

Just a quick question. You have 288 responses you could use. Do you know what proportion of the total number of behavioral health trips that represents? Is it 5 percent? Is it 2 percent? Do you know?

MR. TUNNEY: For the survey, the number that we had completed, yeah. It's going to be a low percentage because Behavioral Health is our largest population with transporting and they're doing, I think, approximately 300,000 trips a month, or something along those lines. So if you calculate that out, it's a thousand trips a day. So out of the thousand to get a hundred, you're looking

around 15, 20 percent maybe.

MS. EDELSTEIN: Okay.

CHAIRWOMAN SPITALNIK: Anything else from the MAAC?

From the public, any comments or questions?

Yes, please state your name.

MS. ABRAMS: Mary Abrams, New Jersey Association of Health and Addiction Agencies.

So I'm wondering how the various percentage, particularly that no show, I think it's 3.8 percent, how do they compare to the contract standards? Because when you take 300,000 trips a month, this is a small percentage of quite a lot of trips.

MR. TUNNEY: So the 3.8 percent that says that there's a no-show does not necessarily mean that vehicle did not show up. The person may not have been there within the 15 minutes. The vehicle might come, the person isn't really out there at that exact time, the vehicle could have left. You can't get into that kind of level of detail when we're doing a phone call. This is self-reported by the person, and they're saying that there was no vehicle that was there. So that's something that we deal with that's been actually going pretty good now because we have the GPS. So anytime we have any kind of complaint about a vehicle did not show, we can actually go back, they can

track it, and it says that vehicle was there from 10:42 to -- it might say 10:45. If that's the case, they only stayed three minutes. Then we have a problem with that provider.

LogistiCare is working with those providers to try and get those numbers improved. They know we're looking, so now they should be staying for that entire 15 minutes before they move on to the next trip.

We get people who tell us, "I was ready and I was sitting there and no one showed up," but we have electronically that they were right at your address right at the front door, those kind of disputes are, again, very, very difficult. All I can say is that the vehicle was there whether or not the person was able to find them.

If we have areas that are big housing complexes, we've worked with those complexes to have a designated pickup spot so that people aren't wandering around the building or wondering where the person is going to pick them up.

So, again, another thing that we're just constantly working on trying to improve. And now LogistiCare has a new company that they brought in with better technology that they're going to be able to work out things that will automatically run and try and improve on the numbers that they're getting.

CHAIRWOMAN SPITALNIK: Yes?

MS. SPADOLA: Hi. Cynthia Spadola, Mental Health Association. I have a few questions.

One of them was just simply how did you choose the population sample? Was it at random from their users? How did you choose who you called?

MR. TUNNEY: Well, the mental health portion was not at random. What we did was we took the entire file. And out of that file, they randomly selected until they got a population that was within the hundred that we needed for each one.

MS. SPADOLA: So it was representative of people with mental health conditions, people with physical health conditions, all of that?

MR. TUNNEY: This was anybody who was going to a mental health or behavioral health provider, be it substance use -- we don't ask specifics. Again, we ask. And people are not obligated to tell us where they're doing. We try to record it just so that we have a better idea of who we're dealing with so that we can do these kinds of studies. But these are people that reported they were going to a behavioral health provider.

MS. SPADOLA: And I also wanted to know if you asked about complaints, if anyone who you surveyed had filed a complaint or what happened, what their experience

was.

MR. TUNNEY: No, we did not. In this survey, we did not ask that.

MS. SPADOLA: And can you just repeat for me the name of the company that conducted the survey?

MR. TUNNEY: IPRO, I-P-R-O.

CHAIRWOMAN SPITALNIK: Meghan, would you explain that?

MS. DAVEY: They are our external quality review organization contracted with the Department.

CHAIRWOMAN SPITALNIK: Marie.

MS. VERNA: My question was simply a question about the recruitment process.

CHAIRWOMAN SPITALNIK: Thank you.

And in the back. Please state your name.

MS. HIGGS: Kim Higgs, New Jersey Psychiatric Rehabilitation Association.

Related to the line of questioning that Cindy started, is there any consideration of looking at the experience of behavioral health consumers in getting to their physical health care appointments? That's the area that we get reports of issues all the time. Someone needs specialty care. I think this came up last time and we talked about this. Someone needing to get to a provider who is outside the transportation's preferred range and

how long are people waiting. And may I also suggest to you that a reasonable question for a lot of folks in this population is what do you consider a reasonable time to wait? Sadly, a lot of our consumers are waiting hours.

MR. TUNNEY: Well, we did have the time, if you look that was 15 minutes before, the 15 minutes they waited, and 15 minutes after. We had the measurements of those trips that they're able to get from the GPS.

MS. HIGGS: This will be on the website?

MR. TUNNEY: It will be on the slide. We have those results. It's difficult to -- LogistiCare's data does not identify a person as having mental health disorder. It's much easier to pick the provider where they're going because that is a question that they ask. It's just the nature of the trip. But I don't know -- I'd have to look into if there's a way that we can figure something like that out and maintain confidentiality, whatever needs to be done.

CHAIRWOMAN SPITALNIK: Anything else?

Steve, thank you so much.

I'm happy to introduce Gregory Lovell who is the Fiscal Administrator of the Division of Medical Assistance and Health Services who is going to present us on the emergency department triage.

(Slide presentation by Mr. Lovell.)

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

CHAIRWOMAN SPITALNIK: Thank you so much.

Are there questions from the MAAC?

Beverly.

MS. ROBERTS: Have you ever heard of Danielle's Law.

MR. LOVELL: No.

MS. DAVEY: Yes.

MS. ROBERTS: Meghan has. And there may be people here who can talk more intelligently than I can. But the summary of it is that within the Developmental Disability System, a law was passed a number of years ago and signed by the Governor which arose from somebody with a developmental disability who was living in a group home and, very sadly, died. And so what this law says is it describes situations that they describe as life-threatening emergencies, but everybody might not consider them such. Nonetheless, a low-paid direct-care provider in a group home is required under certain circumstances to be calling 911 for an individual under Danielle's Law that they think may be having a life-threatening emergency, have them go to the emergency

room and be checked out. And if the low-paid direct-service provider or professional doesn't call 911, they can be held liable for a very large fine for not following the law.

So my question is whether under the exceptions something could be added that would include individuals who, because of Danielle's law, there's a requirement that they have to go to the emergency room and be checked out.

MR. LOVELL: And also to go along with that, I need to emphasize that no one will be turned away if they walk in the emergency room, whether the determination later is low acuity or not, they will be treated in the emergency room. So we're not turning anybody away.

MS. DAVEY: Right. This doesn't change the treatment at a hospital, it's just a payment, and how the hospital gets paid for that.

MS. ROBERTS: I can see where the hospital in terms of what they might have to do, the appeals and it could be unyielding.

MS. DAVEY: We'll definitely take that under consideration.

MS. ROBERTS: Thank you.

CHAIRWOMAN SPITALNIK: Thank you.

Other comments or questions from the MAAC?

Other comments or questions from the public?

Yes?

MS. ABRAMS: Mary Abrams.

I'm just curious. You said you were working on the system. So are those rates being paid now or it's not implemented or --

MR. LOVELL: As of right now, we're working with Molina. Right now, they're currently processing the claims as they normally have been prior to the law. Because of the programming that's involved, it's taking a bit longer than what we anticipated. We will be sending out a new letter and alert to the providers telling them when it has been in effect and we'll retro it back to November 1st. But as of right now, it's paying as it normally has.

MS. DAVEY: We'll recycle the claims back.

MS. ABRAMS: It will be retroactive?

MS. DAVEY: It has to be, per the law.

CHAIRWOMAN SPITALNIK: Marie.

MS. VERNA: My question has to do with, so the Attorney General is trying to collect new information about overdoses. So how do these codes interact with the codes that the treating provider in the emergency room is indicating it's an overdose and obviously high acuity. Do you know that connection?

MS. DAVEY: They wouldn't hit this as a low

acuity claim. They would be considered a high acuity claim and they would be paid as an emergent visit.

MS. EDELSTEIN: Just a comment. When the Division was working on the code list, we, the NJ Hospital Association (NJHA) -- not speaking in my MAAC capacity, speaking in my NJHA capacity -- worked with them to look at the codes. We have coders on staff who are very familiar. And we eliminated virtually all behavioral health related codes, including SUD. So they are not on the low acuity list.

MS. VERNA: Okay.

CHAIRWOMAN SPITALNIK: Yes?

UNIDENTIFIED SPEAKER: Do you know approximately what personal of fee-for-service (FFS) hospital visits not emergent?

MR. LOVELL: Number of claims?

UNIDENTIFIED SPEAKER: What percentage of actual visits are we talking about here?

MS. DAVEY: We can get back to you on that. I think we have it, I just don't have it now.

CHAIRWOMAN SPITALNIK: Yes? Name, please.

MR. GILLESPIE: I'm Pat Gillespie with Amerigroup.

Give us a little more information on how the exclusion categories grew and maybe what the State intends

to save under the State Plan Amendment with the exclusion category.

MR. LOVELL: So the exclusions that we determined were for pregnant women. All of our population is the most vulnerable population for New Jersey Medicaid, but elderly is 65 and above, children ages six and below, and pregnant women are the most vulnerable. We felt that by all services will be rendered in the emergency room regardless, but if they're going to go to the emergency room, we wanted to make sure that any issues that they could easily get a lot worse or change radically, let them be treated in the emergency room regardless of payment. And then we don't want them to fear they have to go to another place. So that was the determining factor behind that. Pregnant women, as we indicated with the diagnosis codes, almost all except for one diagnosis code for pregnancy was eliminated as a low acuity. So pregnancies, we won't have any hit the low acuity regardless of what exclusion or not. So then we were looking at the above 65 and below 6, and we're looking at that now at the same time. They could be changed and modified as we go on, but we determined that was the most vulnerable population.

CHAIRWOMAN SPITALNIK: Yes?

MS. EHRENKRANTZ: Kay Ehrenkrantz.

What is the overall goal of doing this? Are

you trying to have hospitals not admit people to emergency rooms and socialize people to go to urgent care instead? What is the goal?

MR. LOVELL: Well, this became law and so we have to abide by that regardless. But I think the overall goal is to pay and reimburse facilities providing the services that they're rendering at the appropriate rate that should be set. If these services were rendered at another facility, the $140 would have an average rate that would have been paid. So we don't want to necessary say that we want to take people out emergency room, but we want to put them in the most appropriate setting and reimburse them at that rate.

CHAIRWOMAN SPITALNIK: I think this does rise for us that this is a fiscal lever to address that. But it does raise for our broader consideration and long-term consideration, which is do people have access to care in more appropriate settings, are people aware of that, and are those settings responsive to their needs. And this is some of fiscal drop, but I think that's a long-term agenda for the MAAC and certainly the Division and the Department.

MR. GILLESPIE: I think the overall goal of this is to provide the right care and the right time in the most appropriate setting. And on behalf of

Amerigroup, we talk to our primary care partners all the time and we talk to them about trying to keep their members out of the emergency room and try to treat them at the primary care level where, again, we believe that the highest quality of care is going to be rendered at the primary care level with either FQAC partners or other primary care doctors and pay at appropriate rate. Our provider incentive programs are also geared toward the primary care level. And when one of our members goes to the ER for a low acuity condition, not only does the State ding the MCOs for it, but we in turn ding our provider partners as part of the quality programs, they miss a revenue opportunity.

So I think the overall goal, if you were to talk to the legislative sponsors, is that continually hospitals in this State, not just one or two, but it's a pervasive practice, advertise the convenience and immediacy of the emergency room, either online, on billboards, in flyers, or other display advertising. And we hear routinely from our primary care partners and our FQAC partners that when they try to counsel their members not to go to the emergency room for low acuity conditions -- and that's what we're targeting here, low acuity conditions -- that they just can't keep up with and they can't compete against advertisements they see from these others.

CHAIRWOMAN SPITALNIK: Thank you.

Theresa.

MS. EDELSTEIN: I have a question for you. And this is not meant as a comment on Patrick's comment. I was going to ask it anyway.

What direction, guidance, and instructions are you prepared to provide to the managed care organizations, since this is a FFS policy, to ensure that beneficiary access to the emergency department is preserved? Within the contract, within guidance, within instructions, what's the Division's thinking?

MS. DAVEY: So our guidance was we're asking the MCOs to follow the same criteria or methodology that we have for the low acuity claims process. But, again, this is a FFS rate. So that's what was legislated. The MCOs can negotiate whatever rate they want with hospitals, but we're asking that they follow, even if they're paying more -- they can't pay less. They can pay more, but that they follow the code and process. So that's guidance to the plans.

MS. EDELSTEIN: Thank you.

CHAIRWOMAN SPITALNIK: Anyone else?

Greg, thank you so much.

Now we move to informational updates. And the first is on NJ FamilyCare. Meghan Davey, the Director of

the Division of Medical Assistance and health Services (DMAHS).

MS. DAVEY: Just to kick off the informational part just with where we're at with our enrollment stats.

(Slide 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/)

CHAIRWOMAN SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: Thank you very much, Meghan. Two quick questions.

On the duals, I just wanted to confirm that the enrollment of duals into a FIDE SNP is going to continue to be voluntary.

MS. DAVEY: Of course, yes.

MS. ROBERTS: And then the other question, following up your presentation at the last MAAC, and I was reminded of this when I read through the minutes from the last meeting, you had talked about a streamlined process that was going to be starting soon for people that had had SSI and then they went onto SSDI because the parent retiring, becoming disabled, passing away, and that you could provide an update.

MS. DAVEY: Heidi, you want to do that?

MS. SMITH: So it's a matter of what we're doing -- and I think we talked about before -- is providing four months of temporary coverage while we evaluate them for full Medicaid eligibility. So this is a process that we alerted to the counties. We let them know that this is out there and this is available. So they get the information of who is terming because of SSI. They know, they're aware that that person has four months, so they're pulling that case to look at it. And if they need other information, what they're sending out is a request for information form to get anything additional that they may need, because we don't know the data or the demographics too much on the SSI person. So that's it.

MS. DAVEY: So we started that streamlined process. So it doesn't put the onus on the person anymore, that we can data mine it and just ask specifically what we need, not a full application.

MS. ROBERTS: Which is great. So this request for information, this will be an automatic? Like, once you find out this is happening, that request for information goes out automatically?

MS. SMITH: So the person who is affected by the SSI term -- I think this is what you're asking -- they will get a letter from DMAS that will go to them saying

you've been termed by SSI, you're going to be evaluated for continued Medicaid eligibility while you maintain temporary insurance. In the letter, we gave them a picture of what to look for and to respond to. If we need something, look for this in the mail. This is going to come to you, you need to respond to it because the coverage that you have now is temporary. We call it the heads-up letter.

MS. ROBERTS: Okay. I'll contact you. I'd love to see it so I can let people know that it's going to be coming.

And is this going statewide? Or is it starting only in certain counties?

HEIDI: No, it's statewide.

MS. ROBERTS: And will an Aged, Blind and Disabled, (ABD) application be needed? Or it really won't be needed?

MS. SMITH: No. What we're seeking for these families is just the additional pieces of information. Maybe we need their MAGI tax information, maybe we need more; I don't know. So it's a request for information form that we're using, and that's what will go out to them.

MS. ROBERTS: Thank you.

MS. LIBMAN: Just to piggyback on that, so all counties have been given the same training and the same

information and no matter what county you're in, you should have the same response?

HEIDI: Yes.

CHAIRWOMAN SPITALNIK: Other questions from for the MAAC for Meghan?

Gwen. And congratulations on your new job.

MS. ORLOWSKI: Thank you very much. So I am now here today on behalf of Disability Rights New Jersey, but I'm also going to just touch for a second in my capacity at Central Jersey Legal Services where I'm technically for the month of January a volunteer attorney. And one of the reasons that I have that additional responsibility is because at Central Jersey Legal Services we are litigating over the SSI case. It actually settled yesterday. I don't know if you know that. And part of it was that you did this.

(Applause.)

MS. ORLOWSKI: So I just have to say this has been three years of work, and I'm just thrilled that we're at that point.

MS. DAVEY: All the credit to Heidi and her eligibility team.

MS. ORLOWSKI: Thank you. Thank you. Thank you. An issue that was near and dear to my heart, obviously there. And I will follow-up also because I,

just like Deb, would like to see those, and I think the folks at Central Jersey Legal Services as well.

MS. DAVEY: And we need to know if it's working, right? So we started this new process, how is it working and where we can improve it.

MS. ORLOWSKI: Exactly.

So now I'm going to put back on DDD Disability Rights hat and say that huge accomplishment, so appreciative, but that this same issue exists for other people losing Medicare eligibility, so certainly for the ACA Medicaid folks, turning 65 or getting Medicare. I also want to say we've appreciative of the New Jersey Save. It's fabulous, but it doesn't relieve the Division of its responsibility when people are coming off other Medicaid programs to screen them for MSPs. And I was really happy to hear the Commissioner talk about the importance of those programs. So I just want to say a little reminder. We'll follow-up on that as well. But mostly I just want to say thank you and how appreciative we are and how glad I am that the lawsuits have settled.

CHAIRWOMAN SPITALNIK: Thank you.

Yes?

MR. MINNELLA: Matt Minnella, Association of New Jersey Chiropractors.

I was just wondering what the status was on the

implementation of 21st Century Cures Act and the moratorium on chiropractors and other professionals joining the State Medicaid panel.

MS. DAVEY: The moratorium was lifted in July of 2018. And we're still working with -- DSC is working with our providers to get them to be Fee For Service eligible. But now all chiropractors can go through that process. The moratorium has been lifted as of 7/1/18.

MR. MINNELLA: Thank you.

CHAIRWOMAN SPITALNIK: Thank you.

Other questions or comments for Meghan Davey?

Yes?

MS. ABRAMS: Mary Abrams.

Is there any status update on the processing of long-term Substance Use Disorder (SUD) claims for the base rate and for both short-term and long-term --

MS. DAVEY: Yes. So there were some system edits that were happening. I think as of January 21st edits will be in, and we'll be able to retro those claims back and pay them correctly. I know there were some glitches, but that was just some programming that was going on.

MS. ABRAMS: We were looking at late February into March.

MS. DAVEY: No. Now it's they'll pay

March 1st. The edits will be in and we'll recycle everything. But I think Mental Health and Addictions has been working provider-by-provider if there's any cash flow issues.

MS. ABRAMS: Thank you.

CHAIRWOMAN SPITALNIK: Other comments or questions?

Meghan, thank you so much.

And we'll now turn to an update on Managed Long Term Services and Supports and welcome back Liz Brennan who is the Assistant Director of Division of Aging Services.

MS. BRENNAN: Thank you.

Good morning. So last time I was here, we presented on the June statistics. Just a reminder, we have a three-month lag so that we can capture claim information. So now we're focusing on the October 2018 statistics.

(Slide presentation by Ms. Brennan.)

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

CHAIRWOMAN SPITALNIK: Elizabeth, we're always in admiration of your ability to take so much

complex data and make it so clear. And I think it's worth congratulating the State, the plans for the home and community-based services percentage crossing the line from facility-based services and that rebalancing. We want to recognize that.

Questions or comments from the MAAC?

Theresa.

MS. EDELSTEIN: Elizabeth, thanks, as always. A quick question for you.

Back in November, the State Auditor issued a report on MLTSS. And one of the conclusions reached in the report was that some who qualify for MLTSS don't actually opt to receive those services. And the auditor stated that the MCOs are getting additional capitation dollars because they're MLTSS eligible even if they don't access MLTSS services to the tune of about $76 million. So what steps is the Division taking to address those findings?

MS. BRENNAN: So I can let Meghan expand on that. But the Division was very appreciative of the auditor's audit and findings. It's always an opportunity for the State to look at how we're doing and ways that we can improve. In the State response, we were pretty clear that individuals who are being served on MLTSS are required to meet a very specific criteria in that they meet nursing

facility level of care. These individuals, if it weren't for the services that they were receiving, whether it's the formal services, informal services, State Plan services, would be in a nursing facility. And so the State -- we feel that that was one area that the auditors are not quite in tune with us, is the best way to say it, because these individuals -- New Jersey has one of the strongest nursing facility level of care requirements. We require three activities of daily living, whereas other states only require one. And when we personally delved into and looked at that analysis of the individuals who weren't receiving services, we, in fact, did find that those individuals were receiving services. So some of them were receiving services, such as Personal Preference Program (PPP), which wasn't showing up in the claims. They were receiving State Plan services. And certainly, there are some learning opportunities to identify individuals who are not accessing services, who state, "I don't need these services. I can be served on different programs or just through the State Plan."

So I think it's something that we're continually looking at. The audit has raised several issues for us to reconsider. We are in our fifth year of MLTSS, which is always a great opportunity to say where we are, where we have been, and what are some opportunities

for improvement? So I know that we specifically offered a response to the auditors simply in that analysis of back capitation payment.

MS. DAVEY: There's just a little bit of educating around risk based capitation for the auditors. It's not easy thing to explain to somebody in the aggregate how costs go up and down depending on the acuity level of somebody. So I think there was a little bit of that as well.

MS. EDELSTEIN: Thank you.

CHAIRWOMAN SPITALNIK: Anyone in the public? Dennie.

MS. TODD: Dennie Todd, the New Jersey Council of Developmental Disabilities. I don't know if this is the appropriate time to ask this. I believe it is.

In October, we asked the question would DDD divert placements out of the DCs. We were concerned as to how many individuals in IDD and DD were being placed in the nursing home facilities. You guys said you would get back to us with the stats today.

MS. DAVEY: Thanks for the reminder.

MS. BRENNAN: Thank you. I mean, we do traditionally have a slide that talks about how many are in the MLTSS waiver, but I don't know that we have that for the nursing home. But we'll take it back. My

apologies.

CHAIRWOMAN SPITALNIK: I'll add it to the agenda for the next meeting. Thank you for raising that.

Gwen.

MS ORLOWSKI: Gwen Orlowski, Disability Rights New Jersey.

First of all, just following up on what Theresa said, I wasn't actually aware of that audit report. Is that something that's publicly available? Is it your website?

MS. DAVEY: OLS. It's an OLS audit.

MS. ORLOWSKI: Okay, great. Thanks. I will definitely take a look at it. But what I'm hearing is that some people are not necessarily accessing waiver services because the New Jersey PCA and adult medical day, by way of example, are State Plan services so that might not show up. And that's misleading and that's part of the problem, because in other states PCA would be a waiver service.

Thanks. I'll take a look at that.

First of all, thank you. Very appreciative. I'm interested at a future presentation we could get a breakdown in the MLTSS of the TBI participants because that waiver was rolled into MLTSS, and that really is a distinct population that presents differently in these numbers. So in addition to statistics on them, I'd also like to hear

a little bit about how people are accessing those services, you know, what information is being given to the individuals and their families, how do you know how they're being assessed, how the system works.

CHAIRWOMAN SPITALNIK: Thank you.

Other comments or questions?

Liz, thank you so, as always.

We'll next turn to an informational update on office based addiction treatment and turn back to Steve Tunney.

MR. TUNNEY: Hello again.

Office based addiction treatment is something new that we're offering in New Jersey. It is an attempt to engage our primary care providers which gave us the opportunity to bring Managed Care into the fold and into the fight against opioid addiction. This is a group of providers that have been kind of absent in the treatment of addiction. They would make referrals out, and we want to try get them more involved in it. To do that, we had to make some offers to reduced barriers, increase some rates, and just give them the support and help that they needed to try and get this program going. It officially starts January 1st. The managed care plans are starting to roll it now. I'll get to some of the other parts in a second.

(Slide 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/)

CHAIRWOMAN SPITALNIK: Thank you so much.

Any questions from the MAAC?

Any questions from the public?

Yes?

MS. ABRAMS: Mary Abrams. So I'll probably have a lot more questions once I go home or go back to the office --

CHAIRWOMAN SPITALNIK: I'm sorry. We can't hear you.

MS. ABRAMS: I just said probably many questions, but one I just want to clarify. The navigator rate, did it say that when you have the intake, the physician intake, the three and a quarter, that the navigator rate can be billed along with that?

THE WITNESS: The navigator is for the navigator services, right? So they will establish that treatment plan and they will do their own assessment and planning, and that's separate from the history and physical and intake that the physician has to do. There may be a lot of same questions that are asked when a

physician does an intake, but the actual planning should take place with the client. It's supposed to be individualized. That's where you find out their employment status, their housing status, do they already have a counselor in the program, what program did you try, did they fail? That sort of history, that's separate. So they can bill once during that week and then the physician can bill, obviously, for an intake and assessment only one time. After that point, the physician can bill every day if he can medically justify a reason to see the client. Doctors bill however doctors bill. But for the navigator, it will be restricted to just once per week, the first week for the intake and then you get the bill basically two units, then it goes weekly for the four to six, and then it's monthly.

MS. ABRAMS: I don't know if it comes to mind, but the big thing with the Fee For Service rates when we went to the three and a quarter and then it increased is if it's a licensed clinician other than APN or an MD, that we can't do both of those intakes. Where definitely you have one is the psychiatrist and then we usually have the other stuff, which is a lot of same stuff, you know, social, psychosocial stuff.

MR. TUNNEY: That's for the clinics. In reality, in a clinic, the bulk of that obtaining the

psychosocial history, the biosocial, is done by staff and the physician reviews it quickly and signs off on a treatment that they wrote. So in this situation, you're seeing your doctor. This will be done by the doctor. These doctors that are providing the service now are very vested in making sure that their involved in this treatment. So they will be in there asking their own questions and developing their own plan. It's a very separate treatment plan as opposed to the psychosocial part.

CHAIRWOMAN SPITALNIK: Marie Verna.

MS. VERNA: Marie Verna.

So for years, the Mental Health Association of New Jersey has run consumer connections and been required by DMHAS -- one of the required standard training programs for somebody to be a peer specialist. You didn't mention anything about the training that a navigator needs.

MR. TUNNEY: They're not technically a peer. They're going to be separate. They're more a case manager. The peer training that you're talking about currently, that will be -- we're going to develop peers in the State Plan. We want to do it in different levels because of programs that are going on. Children's program utilize peers. We want to utilize peers in this situation. So it's a little more complex so that kind of

got separated out from this, and we didn't want to hold this one up.

MS. VERNA: I understand you've got an advisory committee formed to figure out those Medicaid guidelines, because we only got Medicaid reimbursement for peer specialists in supported housing maybe seven years ago. So the years of lived experience I understand, but we are going to have a standard training program besides the bachelor's, right?

CHAIRWOMAN SPITALNIK: You are asking about training for navigators, the training requirement for navigators is the question.

MS. ABRAMS: Yeah, because there wasn't anything in your list.

MR. TUNNEY: There's nothing that's currently required. Let me find out if they have something. I'll talk with the Division of Mental Health and Addition Services and see if they want to establish a formal training that we can offer to those people.

MS. ABRAMS: It's a pretty rigorous curriculum.

MR. TUNNEY: So you're thinking along the same lines of what did they for the peer?

MS. ABRAMS: Yes.

MR. TUNNEY: They are very similar in the

functions they're doing. Okay.

CHAIRWOMAN SPITALNIK: Thank you.

Other questions or comments?

Thank you so much.

We turn to our last update, last but not least, it's central to what we all do. The update on the NJ FamilyCare Managed Care contract. Carol Grant who is the Deputy Director.

MS. GRANT: Good afternoon.

Finally, an update on the July 18th contract. I'll tell you where we are. We've gotten an approvable contract from CMS, which has currently been signed off five health plans, undergoing internal review and signature. It gets approved at the Division level, at the Department level, and at the Attorney General level. It's sent back to CMS and then they actually issue us an actual official approval in which case we will then post the contract to the website as we normally do.

When I go through these changes -- we've done it by article for ease of reference as you look at our 900-page contract so that you can, in fact, find the changes. So I'm just going to go through these.

(Slide presentation by Ms. Grant.)

Slide presentations conducted at Medical Assistance Advisory Council meetings are

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

CHAIRWOMAN SPITALNIK: Carol, thank you.

Questions from the MAAC?

Beverly.

MS. ROBERTS: Thank you very much, Carol.

So I wanted to raise a concern about 4.1.2A.27 with regard to DDD enrollees who can have all mental health services except for targeted case management. So my concern broadly is that people who are DDD enrollees, I think, have been given short shrift in terms of recognition broadly of dual diagnosis and services to meet their needs, and I know that's been discussed before numerous times. I'm delighted with the expansion of autism services for up to 21. That is absolutely terrific. But I'm talking about 21 and over and also people who have an intellectual or developmental disability without an autism diagnosis also. I just wanted to be very much on the record that this is a concern that has been expressed repeatedly, and the concerns are growing. The needs are very, very much there. So it's targeted case management but also broadly there are problems in getting services for this population.

MS. GRANT: We definitely are looking at that and trying to understand the capacity in the system to

currently provide services and where we do need to go in the future. I think more to come on this for everyone, but duly noted.

MS. ROBERTS: Thank you.

CHAIRWOMAN SPITALNIK: Other concerns?

MS. CHEN: Hi, Carol. Thank you so much for everything that you do.

CHAIRWOMAN SPITALNIK: Name, please.

MS. CHEN: Cathy Chen.

4.45E.11, MCL responsible for all inpatient medically necessary services at a general acute care hospital, specialty hospital, and psychiatric facility.

Specialty hospital, could you define that? Or is it in the definitions in the current contract and I can look it up?

MS. GRANT: It should be.

CHAIRWOMAN SPITALNIK: Side 112.

MS. CHEN: I mean, if you don't know the definition of specialty hospital, if it's same as it was --

MS. GRANT: Tell me what your concern is.

MS. CHEN: I want to make sure that rehabilitation hospitals are included, et cetera.

MS. GRANT: Well, any kind of an acute setting.

Correct?

MR. TUNNEY: Acute hospital care. It kind of

goes back and forth. It does include rehab hospitals, it includes psychiatric hospitals -- some psychiatric hospitals are listed as a specialty care hospital, other ones are listed --

MS. CHEN: But you have a definition of it?

MR. TUNNEY: It would be anything that's an acute medical admission. It would be covered under those three categories, because that's the three provider types that we have for hospitals.

MS. CHEN: Thank you.

CHAIRWOMAN SPITALNIK: Other contract issues?

Carol, thank you for your fortitude in getting through those slides.

So what we traditionally do at this point is to recap the items that were raised as agenda items for our next meeting, which is Thursday, April 25th. So what I have so far is a presentation on the New Jersey ABLE Program, an inquiry about Danielle's law and the new triage funding requirement, an update on the population of people with serious mental illness, and also an update on duals in terms of CMS's letter. There was the inquiry again about individuals who are eligible for the Division of Developmental Disability Services being placed in nursing homes, and inquiry about the population of people with traumatic brain injury under MLTSS, the request for data.

And, again, the issue of individuals with intellectual and developmental disabilities who also bear mental health or behavioral health diagnoses.

Did I miss anything? Is there anything else to add?

Having said that, let me announce that I just mentioned our next meeting, and our meeting dates are now posted on the Division's website. All the presentations will be posted on the website by this afternoon. Our next meeting is April 25th. The meeting after that is July 25th and then October 24th at this same location from 10 to 1.

I want to thank all the presenters and the excellent work of the Division of Mental Health Services. Everyone in the Division, particularly Director Davey. And, again, Phyllis Melendez makes it possible for us to all meet. Thank you, Lisa Bradley for recording.

Do I have a motion to adjourn?

MS. LIBMAN: Motion to adjourn.

MS. EDELSTEIN: Second.

CHAIRWOMAN SPITALNIK: Thank you all. Happy and healthy New Year, safe traveling, no snow, and we look forward to seeing you in April.

(Meeting adjourned at 12:34 p.m.)

Transcriber, Lisa C. Bradley
THE SCRIBE
6 David Drive
Ewing, New Jersey 08638
(609) 203-1871
The1scribe@gmail.com

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