New Jersey Behavioral Health Planning Council
Meeting Minutes,
April 13, 2016 10:00 A.M.

Attendees:

Winifred Chain	Harry Coe (p)	Phillip Lubitz
Lisa Negron (p)	John Calabria	David Moore
Connie Greene	Damian Petino	Renee Ingram (p)
Christopher Lucca	Michele Madiou	Patricia Matthews
Dan Meara	Pam Nickisher	John Pellicane
Bianca Ramos	Thomas Pyle	Rocky Schwartz
Brenda Sorrentino	Irina Stuchinsky	Pamela Taylor
LeeAnn Wagner (p)	Robin Weiss	Bruce Blumenthal (p)

DMHAS, CSOC & DDD Staff:

Geri Dietrich	Donna Migliorino	Mark Kruszczynski

Guests:

Louan Lukens	Scott Campbell	David Drescher
Judy Banes	Asst. Comm. Mielke	Matt Shaw
Maria Kirchner	Al Glebocki	

I. **Welcome/Administrative Issues/Announcements**
   A. Overview from Donna on SAMHSA site review
   B. Minutes from last meeting (2/10/16) approved with corrections.

II. **Adult Suicide Prevention** – Al Glebocki & Dr. Maria Kirchner
   A. Handouts highlighting goals and prevention plan
   B. Every 13.2 minutes, someone commits suicide.
   C. An advisory council that meets once a week by conference call.
   D. 13 goals in our plan that we have prioritized.
   E. Atlantic Care BH and Rutgers BH have adopted our concept and is moving forward with it.
   F. State Psychiatric Hospitals are just about ready to implement.
   G. We will present all deliverables to executive staff in May.
   H. Hotline calls keep going up, and half of the calls come from youth & young adults.
   I. Suicide rates are going up.
   J. Comment – Patricia Matthews – In the Division of Aging, we identified a possible need for training
      Comment – Al – We can help with that.
   K. Comment – Rocky – (regarding her experience as a family member) Hospitals are not looking for suicide warning signs. My young adult son was in a partial hospitalization program, recommended to go inpatient because his suicide and/or

homicide risk was so high. But they were a voluntary only facility, so he refused to go and they discharged him and said to wait for something further to happen. He disappeared, turned up at the local ER. He has been there 8 times in the last 6 months. They have on record that there have been suicide attempts. They claim he did not want to kill himself. This is a real urgent issue. It doesn't appear we have behavioral health people that are being called in, in an acute setting. Even though these basic are warning signs. People who've been in the system long enough, and don't want to be admitted, they know as long as they don't say "I want to kill myself" they (facility staff) won't blink.

L. Question – Maria Kirchner – Was the official assessment done?
Answer – Rocky – They wouldn't let us come in the room but we told them he'd been discharged and was recommended for inpatient.

M. Comment – Al – One of the reasons some of those goals are a little bit later in time is because we don't have authority over the Emergency System in NJ but we work with people from the DOH on the Adult Suicide Prevention Advisory Council that do. So as we roll this whole program out, I think we'll get there.

N. Comment – Rocky – It's very difficult, and even in this instance, a restraining order has been filed.

O. Q – Joe Gutstein – I have no idea where to reach out to. I can call the help line or the drop in center. I can spend up to 5 days in the ER, I can move to a day program. What is changing for the population most likely to take its own life?
A – Phil – In my work group, we had 2 individuals that represented a consumer organization of people who've attempted suicide. It was a real wake up call to our committee about what works and what doesn't work. It was an educational experience and dispelled some of the generally held beliefs that we may have had as a result of training.

C – Joe Gutstein – I know more people with means and methods than have a strategy what to do when they're hurting. They've reached out before and it can be terrible and they don't reach out again.

C – Phil – One of the things that should be recommended is a greater awareness of this particular self-help group organization that's made up of people who've attempted suicide and are much more welcoming and have a different approach to people who may be considering suicide.

C – Maria Kirchner – All these areas we've just addressed are included in the plan.

P. Q - Lisa Negron – Regarding suicide, can the council be made aware of a suicide prevention presentation?

C – Connie (to Rocky) – The goal is that these stories aren't told anymore.
C – Maria – You need to be heard, that helps us take the next step.

III. **Community Support Services (CSS)** – Harry Reyes

A. We're hoping the CSS regulations will be promulgated soon and then it will begin the process of having new Supportive Housing (SH) providers who will become CSS providers, and have to get new licenses and Medicaid numbers to access the CSS services. We've had over the last 2 years, trainings on psych rehab services which is being done by the School of Health Related Professions from Rutgers. We have over a thousand trained direct care staff and their supervisors. A good portion of them have moved on for the certification as a psych rehab professional, which is one of the billable services that once CSS is initiated, there is a rate associated to a peer with certification that can also be billed. CSS is driven by plans that are then supported by credential staff. There's an individual plan that is submitted that will identify the credential staff that will be working with a consumer based on the goals that the consumer and the staff have identified. So that will be driven by services, medical… there are 5 bands, medical, APN, masters level, individual psychologists, RN, BA level individuals, LPN, then there's a high school and peer band. So services that the consumer receives based on the approved plan, will be submitted through IME. We will have a webinar for this & also for fraud division. Rates were unveiled and corrections are being made. Once they're done we will post those on website.

B. Q – Phil – What are the advantages of this?
A – Harry – There's no cap, you are driving that plan based on the need of the consumer. Not driven by a contract.
C – Phil – So, more individualized services, service now can be delivered by peers, and that service can reimbursed by Medicaid, and then we bring more federal dollars into the system.
A – Harry – Absolutely.
C- Irina – Not just peers, bachelors level as well.
A – Harry – Absolutely.

C. Q - Geri – Can you explain IME to the non-state employees.
A – Harry – Interim Management Entity (IME), acting managed care entity for right now that will be approving the plans as they are submitted and then allowing services to be rendered and then they will notify Molina on a daily basis of what has been approved, issuing prior authorizations.

D. Q – Robin – What about all the clients that have been out there? Are they going to have to have new plans?
A – Harry – Yes. They will have to have individual rehab plans submitted instead of treatment plans. And there will be a transition for that.

E. Q – Tom – Will the provider get with him to create a plan, and how long for it to be made and approved.
A –Harry - in the Regulations, you have 60 days in which to create your comprehensive needs assessment that has to be completed within 14 days of your approval in the community. Then you have your 46 days to complete your individual rehab plan (IRP) for submission to the IME.

F. Q – Tom – How long does it take the IME to approve?
A – Harry – Their commitment has been 24-48 hour turnaround time.

G. Q – Pam – Can you give an example?
A – Harry – You have an individual in one of our psychiatric hospitals, they're ready for discharge and have been assigned a provider. The provider goes in and engages with the individual and creates a preliminary assessment. Say you anticipate the discharge date will be May 1st, send the plan, and then you have 60 days. 55 days later I'm submitting the individual rehab plan to the IME, the first 60 days are over, the prior authorization for IRP begins, and that's a much more intensive, goal driven plan. The approval is for 6 months.

H. C – David Moore – I welcome the overall plan, the hope is that there will be an increased motivation but my fear is that FFS have a tendency to serve folks that can be handled within the rates required. We still have a problem with significant chronic homelessness that results in "super users" of very high end services like incarceration, hospitals, emergency departments, emergency management systems. The big proponent is the housing first initiative that I'm involved in. My fear is that the FFS system may have rules that eliminate portions of the population from participation. That may exclude all alcoholics, because they are going to relapse, and then they're out. MH, addiction, homelessness, they continually get left out. Those people need housing. I applaud what you're doing but I want to assure there's a safety net. Nothing works without housing.

I. C – John - Going back to Tom's thought, if someone was in rehab or STCF, the turn-around is roughly 7 days and you said the care plan could be anywhere from 14 – 60 days. One of the problems is, for rehab. Let's say its 28 days and with detox it's 33 days, but when you have that kind of a circumstance and that slower turn around time, which may be systematically a great improvement, and real well received, those clients are going back out. They don't only become superusers because they failed and they don't get it and they're difficult. They become super-users because the system doesn't really prepare them to be able to step right into a place. Turn-around time for someone leaving STCF means that person has gone to the board of social services as a discharge plan because there is nowhere to send them for housing, and no place to go. My question would be, how do you address that issue, where someone is leaving a rehab or STCF or even a long term care facility, and there's not enough time to set this up.

A – Harry – the first phase of the CSS process is for targeted for individuals coming out of state institutions or for those who are RIST providers or At Risk Providers who may have openings in the community which would prevent an individual from going into an institution. The planning starts the moment you're in the community and your plan has been approved. If I'm in the community and I'm going into a provider who has At-Risk openings, then that's an immediate opening and that starts right then and there. The other individuals are coming in from the state institutions. So that's in the first phase, that's a limited focus at this point as CSS begins. In phase 2 it will broaden but Phase 1 it's dedicated to those coming out of state hospitals and those in the community who are At-Risk providers who have openings.
C - John – So then it's really tailored for mental health, not tailored for SA.
A – Harry – Right, SMI.
C – Tom – (inaudible) Regarding Rocky's story, these 3 things need to be worked on. You have to be in a state hospital to get this service. So many others are already screaming for service. We need to look at how do they transition into what they need so their families can also continue their support and be relieved of these.

J. Q – Geri – Regulations aren't promulgated yet, at what stage are you?
A – Harry – waiting on clearance to move ahead

K. Q – Geri – Where is the code?
A- Harry – NJ 1037A, CSS is 1037B.
C – Rocky – My son has 11 ER visits since 2014 at the same facility. That goes back to the assessment issue.
C- Robin – In my experience, for a number of years I worked in screening, as a peer. What I saw was, when a person was a super user, they're not paid attention to anymore, just sent home. That's a problem.
C – Phil – CSS isn't going to solve all our problems, but this is a helpful conversation in getting some of those issues out on the table.

IV. **Governor's Budget** – Valerie Mielke & Matt Shaw

A. In the Budget this year, proposed $127 million increase in Adult Behavioral Health System. That's for Substance use treatment and mental health treatment and services. The breakdown of that, $20 million of that is new state appropriations. The balance of that is our resources we're leveraging through what we call federal financial participation (FFP), $20M new state dollars we're able to increase $127.5 new dollars. How we're going to realize that is through Fee-for-Service (FFS). In addition to that, inmate drug treatment program, $2 million. There are currently 2 facilities that are vacant, operated through DOC. What we're looking to do is to have substance use treatment provided in these facilities. They'd exclusively have inmates who have a substance use disorder, receive treatment. It's in preparation for re-entry back into community. We've worked closely with DOC to develop a service that could be regulated.

B. $1.7 million in new dollars to further expand opioid overdose recovery programs. Since January, we've already shown a strong impact on individual's lives as it relates to opioid treatment. We're working with Connie & her staff . We currently have Opioid Overdose recovery in 5 counties. This will enable us to expand to 67 additional counties, we have not identified those counties yet. Analysis to determine.

C. Some resources to Accountable Care Organizations. It's not something we're directly involved in but it's something that will give great benefit to the individuals that we serve.

D. The big announcement had to do with Fee For Service. We are looking to transition our SU & MH treatment services to FFS. With our SU treatment services, many of them are already Fee-for-Service (FFS) There's a uniform rate that our providers will bill either one of our initiatives under state dollars or through Medicaid. Currently in our state contracts are rate based, they receive a 12th of the annualized award to provide those services. For MH contracts, currently cost based, not uniform rate for the same service. It's a deficit funded contract so our dollars are the last dollars in.

E. We had 10 sessions with MH & SA providers to set up rates & get questions. 18-20 hours total. May see changes on website based on feedback.

F. Some of our services reimbursed under medicare, some capped at medicare rate.

G. Presentations on Youtube. Also PowerPoint presentation up on website. Rates included there as well. One of the things that changed, a couple of the rates were increased.

H. Q – David – MH side, is that indefinite?
A – Val – No, currently deficit funded contracts that are transitioning to FFS. Transition for MH will be January 2017. Transition for SA will be July 2016. Changes in Medicaid rates for both change July 2016. All of this is contingent upon this being approved in the budget.

I. Q- Judy – How much of that $127 million is going to housing assistance?
A – Val – Not housing subsidies. We have, separate from this, Olmstead. We're looking at creating 220 additional SH slots. The $127 million is for services.
C – Phil – The division's budget projections really call for serving the same amount of consumers, the same number of units of service as the previous year.
A – Val- we didn't project growth but it is our hope that we do see growth. With Medicaid, we hope to attract others to begin to accept Medicaid. We've had a lot of feedback regarding the rates that we've struck. Med clinics, psych evalutions, that's something that we're actively looking at.

J. Q – Tom – Cost burdens to the providers, capital gains, what are the reactions of the agencies?
   A – Val – We built that into the rates as well. They'll have greater flexibility. Right now, they have contract restrictions. Once they are FFS, that all goes away. So if they want to purchase a new vehicle, they don't need approval.
   C- Tom – My worry is with FFS, that buffer will disappear. There still needs to be a capital allocation somewhere.
   A – Val – Part of the challenge is that most don't have capital reserves. If they have unspent dollars at the end of the year, they have to negotiate with us how they will use them that fiscal year or they come back to us. We're talking about now, through this transition, can we develop some capacity to be able to support this transition. Ultimately, it's on the agency.

K. Q – Phil – What's the safety net? At the end of the year, the math doesn't work out, the agency hasn't met its bottom line, what happens?
   A – Val – That's the question that's been coming up. One of the things we proposed in our PP presentation, providing agencies 2 months advance payment at the start of FFS. Since these hesitations, we've had some additional discussions with providers. Can't really speak to it now but we've heard the concerns and we're actively having discussions.

L. Q – Joe – (inaudible) loss of programs, decrease of access?
   A – Val – some of the feedback that we're hearing consistently, rates won't support the services. We capped at medicare rate. That's something that we're taking a look at.

M. Q – Phil – Are you able to go above the Medicare rate?
   A – Val – That's one of the things we're examining.

N. Q – Joe – Whole list of services that are paid for, there would be no loss of programs or decrease of access, is that correct?
   A – Val – We're going to take a look at it. Looking at some of the rates now based on the feedback. Our goal is not to decrease access but to have rates to encourage additional providers to come into our system so that we're increasing access.

O. Q – John – Some of the rates result in a pretty healthy increase in what they're getting. How can that be earmarked is it increases capacity? Is there anything that says that money doesn't automatically mean everybody gets a raise? A new Annex A maybe?
   A – Val – True up, with SA treatment services, when we had Medicaid expansion here in the state, there are Medicaid service that became available to individuals from SU disorder who are part of that expansion that are not available in Medicaid to individuals who are currently in Plan A. Come July, individuals in Plan A, will now be Medicaid reimbursed. New $'s coming in, now Medicaid. We can't limit salaries, how they spend their costs.

Q – John – If it doesn't increase capacity but the cost to state increases?
A – Val – Except for the fact that we do have a finite resource for state dollars but Medicaid isn't a time limited service. There's an opportunity where more individuals are Medicaid eligible and our providers are billing Medicaid so you're going to see more people being served.

Q – Phil – Alternate benefit package, now to be extended to Plan A? Does that include psychiatric emergency?
A – Val – They're already billing that.

Q – Phil – What about someone that showed up at a regular ER in a hospital that provides psychiatric services.
A – Val – I believe the rate is only available to our screening services and our affiliated emergency screening services.
C – David – Screening services is a new outreach there's no rate that's available for the screening. Screening is covered anywhere in the state.
C – Val - You will get a sense of billing, providers get up to a year to bill Medicaid. The only data that exists is through Medicaid.
C- Matt – We will be monitoring Medicaid, utilization should improve.
C – Challenge is, we do want to transition smoothly, we do want to support that transition, continue to be a dialogue. Providers are understandably anxious.

V. **Closing** – Phil

A. Next month – Membership meeting
B. A – Phil – Maybe Advocacy can help you with this.
C. C – Chris – MH meeting next month. Regarding the housing issue, we've started a housing data and outcomes working group. If you're interested in this please get in touch with me.
D. C – Louan – We're also working on housing.
E. C – Chris – We don't want to re-create the wheel, if those working group people can plug into what you're doing, I'm all for that.
F. Q – Scott Campbell – HIPPA allows exchange of medical records including therapy notes. Distributes handout on recommendations. I was denied access to care as a result of coming here to address this. Can council adopt this? We need separate conversations from medical records. Mr. Campbell proposes:

    "1. To amend the state requirement of progress notes defined in NJAC 10:37 which is in confliction and in contrary with the federal requirement of psychotherapy notes defined in 45 CFD 164.501. Require that all mental health care providers separate all conversational content (therapy notes) from the rest of the medical records used for "purposes of treatment, payment and healthcare operations" (TPO).
    2. To create an auxiliary form that can be approved by the DMHAS for the purposes of TPO. Require that all mental healthcare providers use the auxiliary form in replace of any photocopy of reproduction of the

consumer's chart when acting on a 3rd party request for the purposes of TPO. The auxiliary form can assist in meeting the demands of the insurer and their subcontractors by providing only the minimum necessary information to satisfy the request without including the consumer's conversational content (therapy notes). "

NEXT GENERAL MEETING TO BE HELD
Wednesday May 11, 2016, 10:00 am
First Floor Conference Room (CR 1-100A)