



# New Jersey's Alternative Benefit Plan Recommendation

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Assistance and Health Services



# Agenda

- I. Background and Overview
- II. Workgroup Recommendations
- III. Next Steps



# Expected Expansion Population Characteristics

- Characteristics of childless adults enrolled in NJ FamilyCare:
  - Utilized more services
    - Increased access of pharmacy and physician services
  - Suffer from more mental disorders
  - Received less preventive care than Plan D parents
- Newly eligible will likely resemble our current childless adult group and have extensive health care needs.





# Benchmark Coverage Required for Adult Expansion Group

- Alternative Benefit Plan (ABP) must:
  - Cover 10 essential health benefits (EHBs);
  - Meet mental health parity requirements;
  - Provide EPSDT services for those under age 21;
  - Provide non-emergency transportation;
  - Cover prescription drugs.

## 10 EHBs

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care





# Overall Recommendations: Medicaid Expansion

- Managed care delivery system
- Single ABP for newly eligible population
- Secretary Approved option
  - Adopt Plan A Standard Medicaid and add additional benefits for the newly eligible





# Benefit Recommendations: Dental and Autism Services

- Dental
  - Include Medicaid Plan A dental services for ABP
- Autism
  - ABP package will offer PT/OT/ST but will not include ABA therapy
  - If ABA therapy or further autism services required:
    - Beneficiaries under 21 years of age covered by EPSDT
    - Beneficiaries over 21 years of age will be covered through other programs/waivers, if eligible (i.e. DD)





# Benefit Recommendations: Long Term Care and Habilitative Services

- Long term care
  - Include state plan non-institutional services offered in standard Medicaid package (Plan A)
- Habilitative services
  - Adopt proposed definition based on review of New Jersey state regulations and other state models
  - Emphasis on medically necessary component





# ACA Mental Health Parity and Addictions Equity Act (MHPAEA)

- MHPAEA requires group health insurance plans offer coverage for mental illness and substance use disorders in no more restrictive a way than all other medical and surgical procedures covered by the plan.
- ACA requires ten essential health benefit categories be covered in both Medicaid and the individual and small group market, which includes mental health and substance abuse services.
- The ABP must comply with MHPAEA requirements







# Benefit Recommendations: Behavioral Health Services

## Current State Plan Medicaid Services



## Additional Services Included in ABP

- Targeted Case Management (ICMS)
- Community Support Services (1/14)
- Behavioral Health Home (1/14)
- MH Outpatient
- SUD Outpatient (limited)
- Adult Mental Health Rehabilitation (group homes)
- Inpatient psychiatric services
- Methadone maintenance
- Psychiatrist, Psychologist or APN
- Partial Care/Hospitalization
- Medical Detox
- PACT

- Non-medical detox
- SUD partial care
- SUD IOP
- SUD Halfway House
- SUD Outpatient
- SUD short term residential
- Psychiatric Emergency Services/Affiliated Emergency Services



# Next Steps: Fiscal Analysis and Federal Approval

- Preparing fiscal analysis for ABP and additional benefit offerings to currently covered beneficiaries
- Awaiting final ABP guidance from the Centers for Medicare and Medicaid Services (CMS)
- Submit ABP selection to CMS for approval
  - Received positive feedback on recent call with CMS



# Next Steps: Outreach

- Statewide federally subsidized training grant opportunity
  - Educate various entities about:
    - *New* NJ FamilyCare (Medicaid and CHIP)
    - The Affordable Care Act (ACA)
    - The Federally Facilitated Marketplace (FFM)
    - Single Streamlined Application
    - CASS
  - Grant Period: June 2013 through May 2015

# Next Steps: Outreach to Currently Eligible Populations



- Outreach to currently eligible populations:
  - Plan A parents whose children are enrolled but they are not
  - Childless adults under 133% FPL recently denied for single adult coverage
  - Call to action of our advocacy community
  - Application assistant sites including hospitals, FQHC's and MCO's
  - Targeted mailings to existing populations (Medicaid or Marketplace eligible)
  - Departmental in-reach: DFD (EBT system), Dept. of Corrections (upon discharge)





# Next Steps: Outreach to Newly Eligible Populations

- Outreach for newly eligible populations:
  - Treasury (lottery tickets)
  - DMV Commission (license renewals)
  - Dept. of Work Force and Labor Development (messaging to one-stop career centers)
  - Housing Mortgage and Finance Administration (subsidized housing population)
  - Messaging to School Express Lane Applications





# Assessment vs. Determination

## Assessment Model

- The Federally Facilitated Marketplace (FFM) will make an initial assessment of eligibility for Medicaid or CHIP.
- Information gathered from the initial assessment is transmitted to the State Medicaid/CHIP Agency for final determination of eligibility. The State Agency must gather all information needed to determine eligibility.
- The State Agency must make eligibility determinations from applications received by the FFM without delay and must accept any findings to a criterion by the FFM based on the state's verification procedures.





# Assessment vs. Determination

## Determination Model

- The FFM determines Medicaid/CHIP eligibility for those who apply through the Marketplace.
- The FFM will collect documentation to verify eligibility if needed.
- The FFM transmits eligibility determination to the State Agency for enrollment in Medicaid or CHIP program.
- The State Agency must enroll any person determined eligible by the FFM promptly without delay.
- The FFM does not do renewals or change reporting. The FFM will also not make determinations for non-MAGI populations.





# Assessment vs. Determination

## Recommendation: Determination Model

- Streamlined eligibility process. Consumers who apply through the FFM would be determined eligible by the FFM. New Jersey would enroll them in the appropriate Medicaid/CHIP program.
- New Jersey is not considered liable for errors for eligibility determinations made by the FFM.
- Distributing workload until eligibility staff and systems are experienced and working.
- FFM would be responsible for fair hearings and appeals.





# New Jersey Division of Medical Assistance and Health Services

## Quality Strategy



# NJ FamilyCare/Medicaid Quality Strategy

In compliance with federal law, the Quality Strategy incorporates the required activities for a comprehensive written strategy for monitoring, assessing and improving the quality of managed care services, offered in the following programs:

- NJ FamilyCare/Medicaid (NJFC/M);
- Managed Long Term Support and Services(MLTSS); and
- Dual-Eligible Special Needs Plans (D-SNP) (D-SNP is a new Initiative in the Quality Strategy for 2012)



# NJFC/M Quality Strategy

## State Monitoring

New Jersey will conduct periodic reviews to evaluate the effectiveness of the quality strategy and update it as needed or whenever a significant change has been made, as well as provide regular reports on the implementation and effectiveness of the quality strategy.



# NJFC/M Quality Strategy Vision

The right care and supports, for every person, every time, in the appropriate setting, that ensures members have access to quality, equitable, patient-centered, culturally-competent and cost-effective care that results in optimal outcomes, including maximum independence and quality of life.



# NJFC/M Quality Strategy

## Goals

- To improve timely, appropriate access to primary, preventive and long term services and supports for adults and children;
- To improve the quality of care and services;
- To promote person-centered health care and social services and supports; and
- To assure member satisfaction with services and improve quality of life.

# NJFC/M Quality Strategy

## Contract Monitoring

### External Quality Review Activities

- Review Annual Assessment of MCO Operations; NJFC/M
- Validation of MCO Quality Improvement Projects; NJFC/M
- Validation of MCO Performance Measures (HEDIS); NJFC/M
- Optional activities, such as focused studies, care/case management audits, etc.



# NJFC/M Quality Strategy Contract Monitoring Activities Performed by the State

- Monitoring the MCOs' Quality Assessment and Performance Improvement (QAPI) Performance Plans;
- Provider Network Adequacy and Geo-Access reports;
- Physician Access reports;
- Appeals, Grievances and Complaints reports
- Satisfaction Surveys; and
- EPSDT Performance Measurement



# NJFC/M Quality Strategy

## Contract Compliance

- DMAHS utilizes various strategies to assess the level of compliance and to drive improvements in ensuring access and quality of services.
- Adherence to contract requirements is closely monitored and gaps in compliance are addressed promptly.
- A Notice of Deficiency and Request for Corrective Action will be issued when a deficiency in contract compliance is noted.
- If the corrective action proves ineffective, a Notice of Intent to Sanction is issued; and if necessary, a Notice of Sanction will follow.



# NJFC/M Quality Strategy

## Impact of the Comprehensive Medicaid Waiver (CMW)

The Quality Strategy is being updated to support New Jersey's Comprehensive Medicaid Waiver, approved in October 2012. The CMW will ensure better integration of primary, acute medical, long term care services and behavioral health services under a single authority for several existing Medicaid and Children's Health Insurance Program (CHIP) waivers and demonstration programs.



# NJFC/M Quality Strategy

## Aligning Metrics with Healthy NJ 2020

- Access - Children/adults to primary/preventive care
- Birth Outcomes – Reducing pre-term births
- Childhood Immunizations – Combination 3
- Obesity – BMI assessment
- Diabetes – HbA1c testing and control
- Blood Pressure - Control
- CAHPS – Utilization and satisfaction

# NJFC/M Quality Strategy

## HEDIS Measures

- Childhood Immunizations/Immunizations for Adolescents
- Lead Screening for Children
- Well Child Visits in first 15 months of life; in 3, 4 and 5 years of life; adolescent well care visits;
- Appropriate testing for children with pharyngitis
- BMI assessment for children/adolescents
- Breast and cervical cancer screening
- Chlamydia screening
- Use of appropriate medication for people with asthma
- Comprehensive diabetes care
- Prenatal and post partum care
- Follow up for children on ADHD medication
- Follow up care after hospitalization for mental illness (I/DD)



# NJFC/M Quality Strategy

## New Performance Measures

### HEDIS Measures added in 2013

- Adult BMI
- Controlling high blood pressure
- Annual monitoring for patients on persistent medications

### NJ Specific Measures

- Annual preventive dental visit
- Children/adolescents access to primary care
- Adult access to preventive care



# NJFC/M Quality Strategy Performance-Based Contracting Incentive Program

- Beginning on July 1, 2013, New Jersey DMAHS will initiate a performance-based contracting (PBC) incentive program.
- This program is designed to motivate the MCOs' innovation to improve and sustain improvement in clinical areas that are a priority to NJ DMAHS and DOH's Healthy New Jersey 2020 program and their clients.
- These clinical priority areas include: birth outcomes; diabetes; and obesity.



# NJFC/M Quality Strategy D-SNP

In an effort to improve the integration and coordination of health care services, New Jersey has entered into a full benefit Dual Eligible Special Needs Plan (D-SNP), effective January, 2012. This program combines all Medicaid and Medicare benefits to be rendered under one MCO.



# NJFC/M Quality Strategy D-SNP

The updated Quality Strategy also includes provisions for monitoring quality in Dual (Medicaid/Medicare) Special Needs Programs (D-SNP).

- Annual Assessment by the EQRO (currently underway)
- Quality Improvement Project
- Validation of Performance Measures

# Quality Strategy

## Managed Long Term Supports & Services (MLTSS)

- New Jersey convened a Steering Committee, comprised of advocates, MCOs and community service organizations, along with four work groups to plan for the implementation of the MLTSS program.
- The Quality and Monitoring Workgroup met to make recommendations to the Steering Committee.





# MLTSS Quality Strategy

- The State also convened an internal interdivisional Quality Strategy Workgroup to incorporate Steering Committee and Workgroup recommendations into the Quality Strategy.
- CHCS Under an “Innovations in LTSS Grant” from the SCAN Foundation provided technical assistance to the Workgroup and to the State regarding quality in the new MLTSS Article 9 in the Medicaid MCO contract.
- The MLTSS Quality Strategy and a set of performance measures were developed and reviewed by the Workgroup for year 1 of implementation and will be presented to the MLTSS Steering Committee on June 14, 2013.



# MLTSS Quality Strategy

## Guiding Principles

- HCBS is the preferred service delivery method for receiving MLTSS;
- Consumer choice and participation in selecting service providers and living setting, to the maximum extent feasible, should be a priority of New Jersey MLTSS; and
- Participation of all stakeholders is essential in the planning and implementation of MLTSS.

# MLTSS-Specific Quality Monitoring

- At this time there are no nationally recognized measures specific to MLTSS.
- Instead, New Jersey is developing MLTSS-specific measures.
- For the first year there will be about 30 metrics that measure such things as access; member-centered plans of care; provider capacity; member safeguards; member rights and responsibilities; and effectiveness of the MLTSS program.
- In years 2 and 3 New Jersey will add measures specific to Quality of Life.



# MLTSS Quality Strategy

## Year 1 Quality Measure Domains

- Level of Care
- Participant centered service planning and delivery
- Provider capacity and capabilities/provider networks
- Participant safeguards/critical incident management system
- Participant rights and responsibilities/complaints, grievances and appeals
- Measuring effectiveness of MLTSS activities
- **Note:** Additional outcome/quality of life and personal experience measures are being developed for year 2 and 3



# MLTSS Quality Strategy

## Critical Incident Management

All MCOs and providers must comply with State regulation and statute in reporting critical incidents, including:

- o Unexpected death;
- o Suspected or evidenced physical/mental abuse (including seclusion and restraints, both physical and chemical);
- o Abuse/Neglect/Exploitation;
- o Self-neglect;
- o Theft with law enforcement involvement;
- o Missing person/Unable to Contact;
- o Severe injury, including falls, resulting in the need for emergency room utilization or in-patient hospitalization;
- o Medication error;
- o Law enforcement contact;
- o Inappropriate/unprofessional conduct by a provider involving a member; and
- o Suicide attempt.



# MLTSS Quality Strategy

## Critical Incidents

- The critical incidents must be reported verbally to the State by the MCOs within 24 hours and in writing within 48 hours.
- The State will work with the MCOs to develop and implement a critical incident reporting and management system to investigate, track and analyze critical incidents that occur in the HCBS setting.
- The MCOs must educate all staff members and contracted MLTSS providers, who have any type of member contact, about how to identify abuse, neglect and exploitation.
- The MCOs will be required to submit quarterly reports, and on an annual basis, a summary reflecting their analysis of the critical incidents trends including a description of any changes in policies/procedures, trainings and provider corrective actions.
- The MCOs will be required to track critical incidents and develop a system of triggering off-cycle provider credentialing where a pattern has been identified with a particular provider, to take appropriate action, and notify the State.



# MLTSS Quality Strategy

- A Quality of Life Survey will be developed by the State and Implemented by the MCOs on or after January 1, 2015.
- The 2012 survey of waivers (GO,CRPD, TBI and ACCAP) will serve as the baseline prior to the move of waivers to Managed Care.
- Consideration of additional CAHPS questions for MLTSS

# Quality Oversight

## State Agencies involved in the Administration of MLTSS

- DMAHS will maintain the oversight and monitoring authority of all the programs.
- To ensure the successful shift in setting of care, and to ensure timely, appropriate access to care, the State will monitor the MLTSS provider networks and credentialing process.
- The MCO must have back up plans for community services providers.
- MLTSS appeals, grievances and complaints will be monitored separately from the acute population.
- The MCO's yearly quality plans will include MLTSS requirements and must be submitted to the State for approval.





# DMAHS Quality Strategy

- Ongoing review of elements, with a minimum of annual updating
- Routine reporting
- Stakeholder input





**Keeping Families Strong**



**Keeping Children Safe and Well**





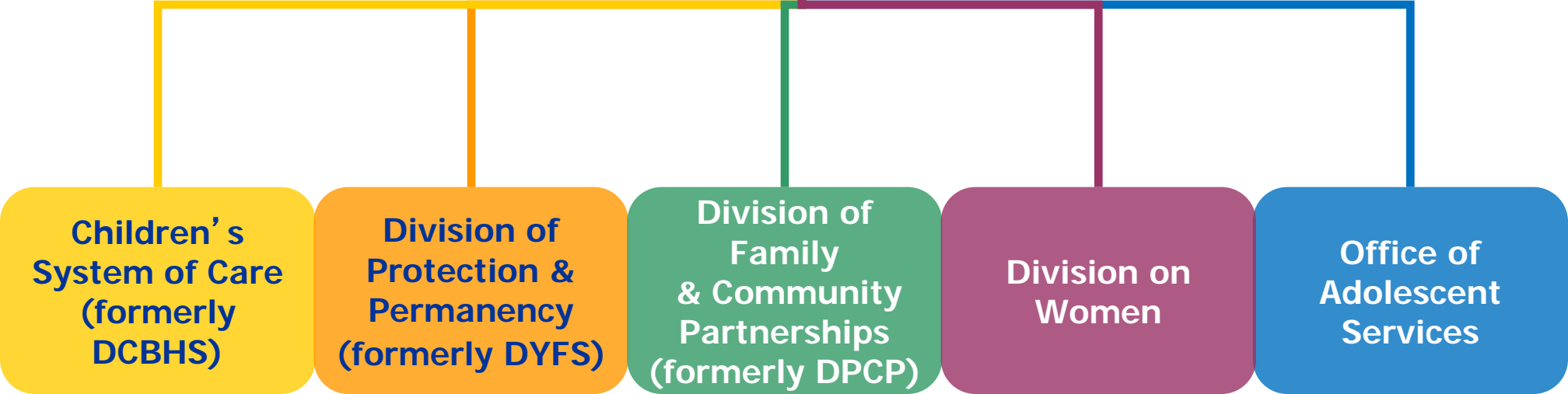
# Dual Diagnosis and Pervasive Developmental Disorder Pilot Update

Presented by

Elizabeth Manley  
CSOC Division Director

# NJ Department of Children and Families

**New Jersey Department  
of Children and Families**  
Commissioner



# ● Children's System of Care Objectives

*We want to keep kids....*



## **At Home**

(with their families and not in out-of-home treatment settings)



## **In School**

(in their regular school in their school district)



## **In the Community**

( and not involved with the Juvenile Justice System or at risk of detention or incarceration)

# Dual Diagnosis IDD/MI

- Medicaid/NJ Family Care Eligible Youth
  - ✓ ages 5 to 21
  - ✓ Co-occurring MH/DD diagnosis
  - ✓ Meets state level of care

# Dual Diagnosis IDD/MI

- New Services
  - Care/case services
  - Individual supports
  - Natural supports training
  - Intensive In Community (IIC) – Habilitation
  - Respite
  - Non Medical Transportation
  - Interpreter Services

# Pervasive Developmental Disorder - PDD

- Medicaid/NJ Family Care Eligibility
- Under 13 years of age
- Meets ICF/MR LOC Criteria
- Diagnosis of PDD



# PDD

- Service Array
  - Physical Therapy
  - Occupational Therapy
  - Speech and Language Therapy
  - Behavioral Consultative Supports (BCS)
  - Individual Behavioral Supports

# PDD

- Service to be tiered by severity and cost limits:
  - \$9,000
  - \$18,000
  - \$27,000

# Children's System of Care

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**For more information and the latest updates on DD services, please visit the PerformCare website:**

**[www.performcarenj.org](http://www.performcarenj.org)**

**1-877-652-7624**

# Additional Information

NJ Department of Children and Families  
website:

- <http://www.nj.gov/dcf>
- CSOC 609-888-7200
- [Elizabeth.Manley@dcf.state.nj.us](mailto:Elizabeth.Manley@dcf.state.nj.us)
- Independent Assessment: (linked on page)  
[www.nj.gov/dcf/behavioral/](http://www.nj.gov/dcf/behavioral/)



**Thank you**

Division of Mental Health & Addiction Services

**wellness**recovery**prevention**

*laying the foundation for healthy communities, together*

# ASO/MBHO and Behavioral Health Home Updates - MAAC Meeting

Lynn A. Kovich

June 10, 2013

# Behavioral Health for Individuals with I/DD and MI/SUD

- As part of the Medicaid Comprehensive Waiver, Individuals with Intellectual/Developmental Disabilities and Mental Illness/Substance Use Disorders will have the management of their Medicaid behavioral health services moved from the MCOs to the ASO/MBHO
- DMHAS, DDD, DMAHS plan to develop a Specialized/Preferred Provider Network to treat individuals with I/DD and MI and/or a substance use disorder

# Developing Services and Capacity for the I/DD and MI Consumers

- The I/DD and MI/SUD treatment work group was developed and included members of the Dual Disorder Task Force, providers, family members, and representatives from NJ Medicaid, DDD, DMHAS and DHS
- The goal for the group was to provide recommendations for the specialized provider network and specialized I/DD-MI/SUD services



# I/DD and MI/SUD Work Group

- A report was developed by the I/DD/MI/SUD work group
- That report is currently under review by the ASO Stakeholder Clinical Work Group with recommendations to be made to DHS June 2013
- The full report will be posted on the DMHAS website when it has final approval by all divisions and DHS

# Behavioral Health Home SPA

- Health Home concept and design were reviewed with SAMHSA on May 30, 2013
  - Currently awaiting their report and approval before submitting the SPA to CMS (as required)
- Expect submission of SPA to CMS in the last quarter of 2013
- Some final decisions made for the SPA that differ somewhat from the concept paper
  - These changes are a result of budget changes, continued data analysis, and recommendations from SAMHSA

# Behavioral Health Home SPA

- BHH SPA will include children/adolescents/youth
  - DMAHS is working with DCF on the development of the children's program design
- Targeted to individuals with Serious Mental Illness/Severe Emotional Disturbances *and* high service utilization
- Plan to roll out the service county by county
  - Bergen – 4th quarter of calendar year 2013
  - Mercer – calendar year 2014
  - DMHAS and DMAHS will measure outcomes and impact on costs
  - Other counties to follow once ASO/MBHO is in place

# MBHO RFP Timeline

- RFP to procure a vendor for the MBHO developed collaboratively by DMHAS and DMAHS
  - Review/finalize design elements by DMHAS/DMAHS executive staff and interdivisional/interdepartmental partners
  - Review/content from Department of Banking and Insurance (DOBI)
  - Review/approval by Commissioner and DHS Central Office Procurement
  - RFP transmitted to Department of Treasury, Division of Purchase and Property (DPP)
  - Completion of rate analysis and publication of FFS rate schedule
- RFP issued by DPP/posted winter 2013
- Responsive bidder identified spring 2014
- 4-6 month readiness review prior to contract start
- MBHO contract start in SFY 2015

# Rate Setting Process

- We have selected Myers & Stauffer, a national CPA firm with broad experience working with State governments on health-care financing issues, to complete a rate analysis for most of our BH/SA service array.
- The rate study and eventually the setting of equitable, market-based rates that fairly compensate provider costs on a fee-for-service basis, are integral pieces of our move to an ASO/MBHO.
- A kick-off stakeholder meeting was held May 20, 2013 to inform the community, gather input, and begin the rate-setting process, throughout which providers will be able to participate.
- The PowerPoint slide deck presented at the meeting can be viewed on the MBHO website at <http://www.state.nj.us/humanservices/dmhs/home/mbho.html>.
- We anticipate that the new rates, once finalized, will be implemented concurrent with the ASO going live in FY2015.

**NJ Department of Human Services  
Managed Long Term Services and Supports (MLTSS)  
Consumer Information and Enrollment Summary: Communications Plan (as of June 2013)**

- **Letters for January 2014 Waiver Participants' Transition**
  - **CMS mandated letter to Medicaid Waiver participants (GO, CRPD, ACCAP, TBI)** that Authority for their MLTSS is moving from a 1915 (c) Waiver to an 1115 Demonstration Waiver. (March 15, 2013)
  - **Letter to Assisted Living and Community Residential Services Administrators** that their Medicaid Waiver residents will receive a letter that, as of January 2014, their MLTSS will be provided by their current managed care plan, with instructions for changing that plan if they wish. Included will be a sample of the consumer letter below. **105 days prior to start date** (mid-Sept. 2013)
  - **Letter to Medicaid Waiver participants (GO, CRPD, ACCAP, TBI)** that, as of January 2014, their MLTSS will be provided by their current managed care plan, with instructions for changing that plan if they wish. **90 days prior to start date** (Oct. 1, 2013)
  
- **Letters for July 2014 Nursing Home Residents' Transition**
  - **Letter to Nursing Facility Administrators** that their Medicaid residents will receive a pre-enrollment letter regarding Medicaid managed care and MLTSS. **105 days prior to start date** (mid-March, 2014)
  - **Letter to Medicaid Nursing Facility residents** that they will soon receive a "Ready to Enroll" packet containing instructions for managed care organization (MCO) enrollment. **90 days prior to start date** (Apr. 1, 2014)
  - **"Ready to Enroll" packet to Medicaid Nursing Facility residents** with Medicaid managed care organization (MCO) enrollment instructions. **60 days prior to start date** (May 1, 2014)
  
- **PowerPoint Presentation – "Medicaid Managed Long Term Services and Supports (MLTSS): The Choice is Yours" – 20 slides** (for training and web posting)
  - Information about:
    - Managed Care
    - MLTSS
    - Eligibility for Medicaid MLTSS
    - Managed Care Plans
      - Medicaid Managed Care Organizations (MCO)
      - Program of All-Inclusive Care for the Elderly (PACE)
  - "Health Insurance Enrollment Options for MLTSS Participants" chart – separate handout

- **MLTSS Frequently Asked Questions (FAQs) for Current Waiver Care Managers – approx. 15 questions** (for use when answering Waiver participants’ questions) To be issued August 2013.
- **MLTSS Frequently Asked Questions (FAQs) – approx. 40 questions** (for training and web posting) To be issued August 2013 and revised as needed.
- **Consumer Communication Plan Roll-Out**
  - **Communication materials** prepared and approved **7 months** prior to start date. (June/Dec.)
  - **Information about Communication Roll-Out sessions** sent to potential participants (approximately 2,000 agencies/units, including state personnel, stakeholder staffs and volunteers) via e-mail in **6<sup>th</sup> month prior to start date.** (July/Jan.)
  - **Participants register** for sessions and **materials sent** via e-mail in **6<sup>th</sup> and 5<sup>th</sup> month prior to start date.** (July-Aug./Jan.-Feb.)
  - **Up to eight face-to-face roll-out sessions** conducted in the **Trenton area**, 40 people per session, in the last two weeks of the **5<sup>th</sup> month prior to start date.** (Aug./Feb.)
  - **Up to four regional “GoToTraining” live sessions** conducted via the web for **administrators/supervisors**, 150 people per session, in the **first week of the 4<sup>th</sup> month prior to start date.** (Sept./March)
  - **Up to eight regional “GoToTraining” live sessions** conducted via the web for **line staff/volunteers**, in the **last three weeks of the 4<sup>th</sup> month prior to start date.** (Sept./March)
  - **Roll-out Sessions upon Request** – Customized trainings will be provided at state and stakeholder convened meetings/conferences, **as resources permit.**
- **Continuing MLTSS Consumer Communications**
  - **“GoToTraining” On-Demand** session posted on MLTSS website for **24/7 access** at the **end of the 4<sup>th</sup> month prior to start date.** (Sept./March)
  - **Letters, PowerPoint Presentation and FAQs** posted on MLTSS website in the **4<sup>th</sup> month prior to start date.** (Sept./March)