MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Videoconference

February 1, 2023

10:00 a.m.

FINAL MEETING SUMMARY

MEMBERS PRESENT:
Deborah Spitalnik, Ph.D., Chair
Sherl Brand
Mary Coogan
Theresa Edelstein
Beverly Roberts
Wayne Vivian

MEMBERS NOT PRESENT:
Chrissy Buteas
Dorothea Libman

ALSO PRESENT:
Lisa Asare, Deputy Commissioner,
NJ Department of Human Services
Jennifer Langer Jacobs, Assistant Commissioner,
NJ Division of Medical Assistance & Health Services
Greg Woods, Chief, Innovation Officer,
NJ Division of Medical Assistance & Health Services
Carol Grant, Deputy Director,
NJ Division of Medical Assistance & Health Services
Reut Ghodsi, Pharmacy Consultant

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

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, the Chair of the New Jersey Medical Assistance Advisory Council (MAAC), and it's my pleasure to welcome you to this February 1, 2023 meeting, the first meeting of the MAAC for this calendar year. The notice of the MAAC meeting, both this meeting and the year's meetings, have been duly filed under the New Jersey Public Meetings Act, and we are in compliance with that. I will also use this moment to announce our calendar for the year of April 26th, July 19th, and October 25th. That will be the meetings for this year.

Before I introduce the MAAC, let me just mention a few things about how we proceed. We're delighted to see so many of our Medicaid and NJ FamilyCare community participating. If you are participating as a stakeholder, you can submit questions through the question-and-answer box. There's no chat enabled for this meeting.

I also want to let People know that the PowerPoint slides that will be used during the meeting will be posted on the Division of Medical Assistance & Health Services (DMAHS) web page, the Department of Human Services, under the MAAC tab.

So let's start with introductions of the

members. Mary, Theresa, and Sherl, would you unmute and introduce yourselves?

MS. COOGAN: Sure. Thank you. Mary Coogan, President and CEO of Advocates for Children of New Jersey.

DR. SPITALNIK: Thank you.

MS. BRAND: Good morning, everyone. This is Sherl Brand. I'm Senior Vice President with CareCentrix.

DR. SPITALNIK: Thank you.

Theresa.

MS. EDELSTEIN: Good morning. I'm Theresa Edelstein. I'm one of the Senior Vice Presidents at the New Jersey Hospital Association.

DR. SPITALNIK: Thank you.

Bev and Wayne.

MS. ROBERTS: Good morning, everyone. I'm Beverly Roberts with the Arc of New Jersey.

DR. SPITALNIK: Thank you.

MR. VIVIAN: Wayne Vivian, President of the Coalition of Mental Health Consumer Organizations of New Jersey.

DR. SPITALNIK: Welcome, everyone. I will now review the agenda, which is on the screen in front of you. We've dealt with welcome and call to order. We'll approve the minutes. We'll review NJ FamilyCare

membership, policy implementation, Naloxone 365, Behavioral Health utilization for Developmental Disability (DD)-eligible adults, Cover All Kids, the Medicaid eligibility checks, the 2022 NJ FamilyCare year in review. So we have a mighty agenda in front of us.

Let me also welcome Assistant Deputy Commissioner Lisa Asare and, of course, our DMAHS colleagues Jennifer Langer Jacobs, Greg Woods, and others who you'll meet in due course.

We'll now turn to approval of the minutes. And so I would ask the MAAC members if there are any additions or corrections.

Beverly?

MS. ROBERTS: No.

DR. SPITALNIK: Anyone?

If not, may I have a motion for approval and a second?

MS. ROBERTS: Motion to approve.

MS. EDELSTEIN: Second.

DR. SPITALNIK: All those in favor.

MAAC MEMBERS: Aye.

DR. SPITALNIK: Any abstentions?

Any no votes?

By my crack calculus, I think the minutes

are approved.

We will now move into the presentation by Greg Woods on NJ FamilyCare membership.

Again, a reminder to put questions in the Q&A. We try to respond to those live; but if not, I want to assure everyone that all these questions are taken very seriously and brought back for further threshing by the staff.

So good morning, Greg, and thank you for this presentation.

MR. WOODS: Thank you, Dr. Spitalnik.

I'm just going to start by giving the normal update that we've given the last several MAACs on overall NJ FamilyCare enrollment. I think this is a continuation of the trends that we've seen previously. As of the end of last year, we had approximately 2.2 million enrollees. That's an increase of about 500,000 or 30 percent over our pre-pandemic levels, so quite a large increase. And as we've discussed before, we primarily attribute this growth to the federal continuous coverage requirement that has been in place since March of 2020, which in most cases has meant that members have remained enrolled regardless of whether their income or their circumstances have changed during that time period.

I will note we now know that that requirement will begin sunsetting in a couple months, and we're going to talk in a lot more detail later in today's presentation. All I will say now is as that occurs, we would gradually expect the enrollment trends to shift, and we would expect at least some decrease in total enrollment. Although, since we really are in uncharted territory here, I don't think we have a precise estimate on what that's going to look like. So in future MAACs, we will continue to keep you posted and see what overall enrollment looks like as we move into this new phase.

I'll pause there to see if there are any questions on this.

Dr. Spitalnik, would you like me to keep going? I think the next part of the agenda is also mine.

I'm going to take silence as a yes, I think, and go ahead. Please jump in, though, if you'd like me to pause.

DR. SPITALNIK: Yes, please.

MR. WOODS: Thanks, Dr. Spitalnik.

So I think the next section of our agenda, we're going to give a few brief policy updates, mindful of the fact that we do have quite a robust agenda

today. I'm going to go through each of these relatively quickly. But please do let me know if you have any questions.

The first one I wanted to talk about is just a quick update on the status of our Section 1115 Demonstration Renewal. As we've discussed with the MAAC before, the 1115 Demonstration, the NJ FamilyCare Comprehensive 1115 Demonstration, is the mechanism through which we receive federal authority to run major elements of our Medicaid program, and it needs to be renewed and renegotiated with our federal partners roughly every five years.

For the past two years, we've been going through our renewal cycle, and we had hoped that we might have an approval to report at this MAAC meeting. Unfortunately, we're not quite across the finish line. Our partners at the federal Centers for Medicare and Medicaid Services, or CMS, have instead extended our existing Demonstration for what we hope and expect will be the last time to the end of this quarter, so until March 31st. And they requested that extension in order to allow them to complete the review and work through some of the last issues with some of the federal agencies they need to sign off from before the final approval. All I will say here is I think we're very

close. We think most of the substantive issues have largely been resolved. We're waiting for that final sign-off, going through some of the fine print. And as soon as we do have that final approval, we will give a full briefing to the MAAC. And I very much hope and expect that will be at our next MAAC meeting.

Moving on to the next policy update, I wanted to give a brief update on the implementation of S3455. This was legislation that was enacted and signed by the Governor last year to expand access to NJ WorkAbility.

For those who are not familiar, just as an update, NJ WorkAbility is a program that provides access to full Medicaid coverage to working disabled individuals who wouldn't otherwise qualify. And the legislation that was enacted last year, S3455, what it did was loosen and make more liberal a number of the eligibility requirements for this program. And we've talked about this in some detail before. I want to give a few quick status updates on the implementation of this bill.

First, as some of you will already know, we have divided implementation of this legislation into two phases. The first phase, Phase 1, includes several distinct elements. It will expand eligibility for

WorkAbility to older adults, so for adults 65 and over. It will remove consideration of a spouse's income when determining whether a member is eligible for NJ WorkAbility. And it will eliminate the limits on the assets that an individual can have and still qualify for this program. It also allows individuals to remain on the program for up to a year if they lose a job due to no fault of their own. So all of that is part of Phase 1. And that implementation, the work is actively underway, and we are expecting to go live. We're targeting April of this year for implementation of that Phase 1.

The rest of the legislation, namely, the expansion of the program to higher income levels will be implemented in Phase 2. And what I can say about Phase 2 is we are also very actively working on that, and we are expecting to have this go live as soon as possible during 2023.

I will just note -- I know there are some outstanding questions that are of a lot of interest to many of you around Phase 2 implementation, including around the exact timeline as well as some questions around premiums for some of the higher income eligibility groups. And I will just say we are continuing to work on those, and we'll share updates as

soon as they are available.

The last thing I want to call out on this topic is that we think in addition to implementing the technical change that's part of the legislation, its also very important to us to make sure that we're reaching everyone in New Jersey who could potentially benefit from the WorkAbility program and that they understand and have the opportunity to apply through WorkAbility.

So as part of the effort, we're convening a WorkAbility communications strategy subgroup which will be a group of stakeholders who will help support us in communicating and advise us on how to best communicate about this program and in an effective and dynamic and inclusive way. And the first meeting of that group is going to take place later this month. So that's another path we're working on in this space.

Then the last policy update I wanted to give today very briefly, I just wanted to note that we have increased our Fee For Service reimbursement rates to providers for maternity-related care across a few domains. And just to give context, this is something that was funded in the State Fiscal Year '23 budget, and it's an important part of the broader Nurture NJ Initiative under the First Lady's leadership. So some

of the specific reimbursement changes that we've implemented include we've increased midwife reimbursement to be equal to reimbursement to physicians for the equivalent service. For both physicians and midwives, we have increased Fee For Service rates for maternity services to parity with the Medicare fee schedule. And then we've also increased the reimbursement to community doulas for providing support during labor and delivery.

So all of those rate increases, as I said, they were funded as part of last year's budget, and they were all implemented effective retroactive to last July 1st.

With that, I will pause, Dr. Spitalnik. I don't if you want to stop for questions here.

DR. SPITALNIK: Thank you. And how good to have this rate increase update as last week was maternal health awareness.

There are a few questions on the chat. Working backwards to the earlier part of your presentation. Are there still plans to have a public dashboard to keep track of enrollment after the Public Health Emergency?

MR. WOODS: So I will just say we currently have the NJ FamilyCare public dashboard, and probably

someone can put that in the chat. And that does track, and we update it regularly, overall program enrollment. It is also the case that we will publically reporting as we move into the unwinding period, some additional, more granular data. We can talk about that a little more later. But I would expect that there will be specific public reporting around the unwinding period and how things are progressing there. So the answer is yes.

DR. SPITALNIK: Thank you so much.

Bev, you had a question.

MS. ROBERTS: Thank you.

Thanks, Greg. This is wonderful information. I have a quick question on the Phase 1 go-live for April for the Phase 1 aspects of the expansion.

Does April seem more like beginning of April, end of April, or is that not yet determined?

MR. WOODS: I'm not sure I have that granularity for you today, Bev. As we move to implementation, we will certainly communicate that.

MS. ROBERTS: The reason is that I know of at least one case of somebody who is going to be -- he has NJ WorkAbility. He is going to be 65 in April. And the way things had worked in the past, upon a

person's 65th birthday if they had NJ WorkAbility, I don't even think there was a termination letter. It was like, "Okay you're 65. You're done."

I don't know how many other People are going to be impacted in that way. But there is one that I specifically know of. So I just wanted to be sure that this person, upon his 65th birthday, since that is part of Phase 1, won't lose NJ WorkAbility.

MR. WOODS: Bev, I'm happy to follow up on that specific case. I think it's unlikely. I feel fairly confident that that person would not lose eligibility. I think this ties into the unwinding process that we're going to discuss in a few minutes. I'm happy to talk offline with you about a specific case, but I think we can be pretty confident that in a situation like that, the member would not lose eligibility.

MS. ROBERTS: Perfect. Thank you.

DR. SPITALNIK: Other comments or questions from members of the MAAC?

I'll just turn to one question in the chat that we can answer, which was a question about the communication strategies group, the membership for that for the WorkAbility communication. It was a question about membership for that group.

MR. WOODS: I'm sorry. I'm just trying to pull up the --

DR. SPITALNIK: The question was who are the members of the communications strategies group for WorkAbility? Has that been established?

MR. WOODS: Can we maybe take that one back and we can follow up offline on that one?

DR. SPITALNIK: Absolutely.

MS. JACOBS: Dr. Spitalnik, as you and a couple of other MAAC members know but maybe not everybody, we've been working with a community stakeholder group in the implementation of this WorkAbility expansion. So that's why we referred to it as a subgroup because we were expecting some of the individuals from that group would be interested and engaging in communications strategy and so sort of pulling in those individuals to have that conversation. We're also open to including others.

DR. SPITALNIK: Great. Thank you.

I'll now move on to our next -- Greg, thank you. I know you will be back in the course of the agenda.

And we'll now move on to a presentation on Naloxone 365. And it's my pleasure to welcome Reut Ghodsi. Thank you for being with us this morning.

MS. GHODSI: Thank you, and good morning. I'm really happy to be here today to discuss Naloxone 365, which is a new Naloxone initiative Governor Murphy announced in January.

Naloxone is a life-saving drug that can reverse an opioid overdose. New Jersey's Naloxone 365 Initiative is the first program in the country to allow residents to acquire Naloxone anonymously for free every day of the year and is available to any resident 14 years and older. Residents can walk into a participating pharmacy and acquire one package of any FDA-approved four-milligram Naloxone nasal spray. Pharmacies can choose to participate in this program and they can look at the Board of Pharmacy website for guidance. Dispensing at community pharmacies helps us ensure access to Naloxone in all communities across the state.

To bill the Naloxone, the State is using the existing Medicaid infrastructure for billing which decreases the burden on pharmacies and also allows the State to monitor program utilization.

As there's increased awareness on the program, we're seeing really, really good numbers coming out. And we're really excited to share that to date over 80 pharmacies have joined the program and

over 690 doses of Naloxone have already been dispensed. Each of those has the potential to save a life.

We're so honored to have a role in this program and have a part in combatting the opioid academic.

Thank you.

DR. SPITALNIK: Thank you so much for this exciting update.

Are there any questions or comments from the members of the MAAC?

Seeing or hearing none, we'll now move on to our next agenda item, which is behavioral health utilization for Division of Developmental Disabilities (DDD)-eligible adults in NJ FamilyCare. And I especially want to thank Jennifer Langer Jacobs and Greg Woods. This has been an issue of great interest and concern to MAAC members, and we appreciate your bringing this data forward.

MR. WOODS: Thanks, Dr. Spitalnik. I think I'm going to start off here and then I will hand off to Jen in the middle of this section.

So as Dr. Spitalnik said, we wanted to share the results of a data analysis we've done, looking at some of the trends in behavioral health care utilization among members who are eligible for services

from the Division of Developmental Disabilities. And some of you will remember, this is an analysis we had hoped to present to you at the last MAAC which, unfortunately, was not quite ready at that point, but we're happy to be able to present it today. And then after I present the results of the data analysis, as I said, I'm going to hand off to Jen who is going to go through a case study of a member in this population to give a more granular sense of how members of this category may be accessing services on the ground.

Before I dive into the substance of this data analysis, I just want to specifically thank a couple of people, particularly, Michele Andrews who is a member of the DMAHS analytics team, and Nate Myers who is with the Rutgers Center for Statehouse Policy and works closely with us under contract. I will just say I'm going to be presenting some summary data analysis here, but there was a ton of hard work that they both did to prepare for this presentation over the last few months. And I just want to acknowledge that really excellent work that they have done.

So just to frame this analysis and why we're presenting it, there are currently about 28,000 NJ FamilyCare adults who have a qualifying intellectual or developmental disability, and as such, have been

determined to be eligible for services from the Division of Developmental Disabilities. I will just note that the overwhelming majority of these members are actively receiving services, either through the Supports for Community Care programs, and then also included in this group are a smaller number who have been determined to meet the functional criteria to receive DDD services who may have receive DDD services in the past but are not currently doing so. So that's the universe we'll looking at here.

I will note, and you can see in the pie chart on this slide, just another important contextual fact about this population is that a slight majority of the members in this group, so around 15,000 of those members, are duly eligible for Medicare or and Medicaid which is helpful to keep in mind when looking at this data. And for those members who are duly eligible, Medicare will be the primary payer while Medicaid is responsible for covering services that Medicare doesn't and also assumes responsibility for co-pays and deductibles.

One important reason we wanted to look at the behavioral health (BH) experience of this population is that this population had many Medicaid behavioral health services carved into to managed care

in October of 2018. And so what that means is that behavioral health services that were previously directly reimbursed by Medicaid on a Fee For Service basis were incorporated into the managed care benefit. And the net result of that was that before the transition, the majority of Medicaid behavioral health expenditures on this population was outside through managed care. After the transition, the majority was through managed care. So that happened in October of 2018. It's obviously been several years since that transition. So we think it's fair to ask what has our experience been over that time period. And today's analysis is going take a high-level look at some of the data we have since then. And in particular, what has happened for this population with respect to behavioral health utilization and expenditures?

Before I dive into the meat of the analysis, I just do want to take a minute to define what we mean by behavioral health services. And on this slide, we have a list of the services that we are looking at. On the left side of the slide are services that were carved into managed care in 2018, and as I said, these represent the majority of behavioral health expenditures for this population. On the right of the slide, there are services that remain reimbursed by

Medicaid on a fee-for-service (FFS) basis, so outside of managed care. But for the purposes of today's analysis, we will be looking at both of these buckets together and looking at total behavioral health utilization and expenditures.

One other note before we dive into this. I will just flag prescription drug utilization and expenditures are not included in today's analysis. And I just want to acknowledge that. Obviously, drugs can be an important part of behavioral health treatment. That said, from a data perspective, it can often be challenging to identify and isolate which specific prescription drug spending should be classified as related to behavioral health, particularly for drugs that may have multiple indications or that may be prescribed off-label. So given that, we didn't include drug utilization or spend in today's analysis. So that's just a caveat to keep in mind.

So if we want to go ahead to the next slide, this is the first of a few data analyses that I'm going to present today. I just want to pause for a moment and explain what we're looking at here. So the blue line that you're looking at in this graph, this represents the percentage of members who are eligible for services from -- and I should say of adult members

-- who are eligible for services from the Division Developmental Disabilities who accessed at least one Medicaid behavioral health service in a given month. They could have accessed just one service, they could have accessed more than one; but either way, if they received some kind of behavioral health care during the month that was reimbursed by Medicaid, they count towards this percentage. And that's true whether the service was through managed care or outside of a managed care plan and was delivered and reimbursed on a Fee For Service basis. So that's the blue line that we see.

And then we have a dotted line, and that just represents the equivalent percentage for all adults in NJ FamilyCare, so not just those with intellectual or developmental disabilities, not just those for whom behavioral health services were carved in, but all adults in NJ FamilyCare. And to state the obvious, that's a very different population across a whole bunch of different dimensions, not just the delivery system for behavioral health.

So I will just say I would be cautious about drawing too many conclusions from comparing the two lines. That said, we thought it was helpful to show that dotted line just as a broad point of comparison

and to help contextualize some of the findings around our members who are eligible for services from the Division of Developmental Disabilities.

And for both lines, we are looking at the period from the beginning of 2018 to the middle of 2022. And we've included a vertical line at October of 2018 just to show when that behavioral health service carve-in occurred.

So with all of that preamble, what are we actually seeing in this graph? I think the key takeaway is that for this population that we're focusing on -- so again, this is the population of all adults who are eligible for services from the Division of Developmental Disabilities -- utilization generally increases over this time period. It's not a rapid or sharp increase. I think you can see on the graph it's pretty gradual. And it's not enormous, but I think it's a real and meaningful increase. And when you look at this, there's obviously a fair amount of month-to-month variation. We see a temporary decrease, as you would expect, in early 2020 at the beginning of the COVID-19 pandemic. But there is a gradual upward overall trend. And we've called out on the graph, you can see in the first six months of this period, so that's January to June of 2018, where each month about

6 and a half percent of members in this population were receiving at least one behavioral health service. And that increases to around 8 percent during the last six months, which is January to June of last year.

So then moving on to the next analysis. So what we just saw was the overall trend across the entire population, but as I said at the beginning, slightly more than half of those members are duly eligible for Medicare and Medicaid. And I will just acknowledge there are some challenges when we do this kind of analysis for those who are duly eligible. Our data can be incomplete since we don't always have direct access to Medicare claims data.

So for our remaining two analyses, we're going to focus a little more narrowly and we are going to zoom in on where we do have more complete data, namely, those members who are not duly eligible, so those who are not enrolled in Medicare and, therefore, Medicaid is their primary payer.

So this graph that we're looking at here is essentially the same analysis we just presented in the previous slide, but this time it's restricted to those members who are eligible for services from the Division of Developmental Disabilities who are adults and who are not enrolled in Medicare, so those for whom

Medicaid is the primary payor, as I said. And as a reminder, that's a population of about 13,000 members.

In here, the orange line represents the percentage of that population that has received at least one behavioral health service in a given month. And once again, we're showing the same comparison trend using the dotted line for all NJ FamilyCare adults. And, again, we're flagging the date of the carve-in with a vertical line at October of 2018.

So what do we see here when we restrict the analysis to those with Medicaid as the primary payer? I think what I would say is that the trend is similar to the previous slide, perhaps a bit smaller as a less gentler slope. Across all periods for this population, the utilization is a little bit lower but generally pretty comparable. So you'll see here over the time period, there has been that upward trend. We started a little bit above 6 percent of members at the beginning of the time period receiving a behavioral health service, at least one behavioral health service each month. And at the end of the period, we're closer to 7 percent.

So, again, I think this result is consistent with modest but meaningful increases in behavioral health utilization for the population.

If you look at the comparison between this population and all NJ FamilyCare adults, we do see some real convergence between the two. So that's to say at the beginning of the period, adults in this population -- so, again, this is adults who are eligible for services from the Division of Developmental Disabilities with Medicaid as the primary payer -- were slightly less likely to utilize behavioral health services in a given month than all NJ FamilyCare adults. By the end of this period, that gap had largely closed. And, again, I will just say there are a lot of factors to consider here, and those two populations are not comparable across a range of dimensions. So I wouldn't make too much of that single fact, but I do think it's one helpful data point to give some context to what we're seeing here.

And then if we can move to the next slide, there's one last analysis that we wanted to present here. I will take a minute because there's a lot going on in this graph, just to orient everyone.

So here, we're shifting away from looking at utilization, and instead, what we're looking at here is average Medicaid expenditures on behavioral health. So just to take a minute to talk through this. So, first, just to orient everyone, we are looking at the same

time period as before, so the beginning of 2018 through the middle of 2022. And here, too, we're looking at the same population that we looked at in the last graph, so only those members who are eligible for services from DDD who are adults who are not duly eligible and for whom Medicaid is, therefore, the primary payer.

So here, the area graph, so the orange shaded section of this graph, shows the average per member per month's expenditures on behavioral health for this population. So in other words, how much did Medicaid spend on behavioral health services on average for each member each month? And one really important caveat here, it's important to note that this calculation isn't limited only to members who actually received behavioral health services; rather, it's inclusive of everyone in the population. So when we calculate this average, it includes the majority of members for whom there wasn't a behavioral health service in a given month. So that will decrease the overall average. So that's just important context to consider as you're interpreting this graph.

I will also say within the area graph, so within the orange-shaded area, we further decomposed expenditures into managed care expenditures, so that's

the dark orange section; and fee-for-service expenditures, that's the lighter orange.

Lastly, we, once again, used the dotted line to show the comparable experience for all NJ FamilyCare adults. And here, of course, the dotted line is showing something a bit different than the previous slides. Rather than utilization here, it's showing per member per month expenditures to have an equivalent comparison between the two groups.

I know that's a lot. I know everyone is probably processing the slide, but as you do, I will just give a couple of thoughts about what this slide is telling us. So I will just say I think this slide, it's a little harder to eyeball than the previous ones and come away from any clear conclusions. I think everyone can see there is a fair amount of noise and variation from month to month, as you might expect. But I do think there are a couple of important things we can say from this slide.

First, as you'd expect, there is a sudden and significant transition in October 2018 for mostly Fee For Service expenditures to mostly Managed Care expenditures. And, again, that's not surprising. That reflects the carve-in that took place then. But I do just want to call your attention to that. So that's

where the share of the graph that's sort of taken up by the dark orange becomes much larger and the share taken up by the light orange becomes much smaller. So that's one point I'll flag.

Second, there is meaningful growth in per member expenditures for the group that we're focussing on, so for the adult members who have Medicaid as a primary payer and who are eligible for services from DDD over this time period. And specifically, as we've called out, per member per month expenditures grew about percent from the first half of 2018 to the first half of 2022. And that rate of growth -- this is a little hard to see on the graph, but that rate of growth is somewhat higher than the per member expenditures, the growth in per member per month expenditures we saw over the same time period for all NJ FamilyCare adults. And, again, that's an average which, as you can see, looking at the graph, represents the accumulation of lots of month-to-month variation and ups and downs.

So what I will say about this is this is one more way of looking at this data. And, again, I wouldn't want to put too much stock in any one data point, but I think when we look at the three analyses we've presented together, they generally represent a

consistent picture where we see gradual moderate growth in both utilization and expenditures for the average member in this population over the post-carve-in period.

And I will say I think this is helpful context to frame future discussions about the most appropriate delivery system for behavioral health care services. But I will also say, looking at this high aggregate level of analysis really just provides that context. It certainly doesn't tell you everything or even most of what you'd want to know about how the program is operating.

So in that spirit, I'm now going to turn it over to Jen who is going to present a case study that will hopefully give you a little bit more granular sense of how we see questions around behavioral health integration playing out on the ground.

MS. JACOBS: Thanks, Greg.

After a lot of data, it can help and pause and think about people because data does represent people but doesn't necessarily tell us the whole story. We wanted to give you a sense of how this partnership between managed care and behavioral health providers can work in the interest of our members and their families, and so we pulled what we thought was a

representative case study. With thousands of members we could pull thousands of case studies. We thought that this one was a good example of how a family and the member, in particular, had some specific needs, and the managed care organization (MCO) became involved engaged in the case and helped the family to navigate the system for this member Joseph. So we'll give a little bit of context here.

Joseph had a six-month psychiatric hospitalization. And after that hospitalization, he moved from his mother's home where he had not been stable to his grandmother's home in a rural area. And he's been enrolled with his MCO since 2017, so there is some extensive case file here that we were able to refer to to show how the partnership with Joseph and his family evolved over time. Importantly, Joseph's primary diagnosis is autism spectrum disorder. He also has PICA, epilepsy, language difficulties, ADHD, and a brain stem tumor. His behaviors included hitting and pinching and using his physical size to restrict others' movements, destruction of his home environment, and elopement, leaving the home unexpectedly. He was verbally aggressive and had engaged in sexually inappropriate acts.

Importantly, in the blue box on the

right-hand side, Joseph's grandmother was overwhelmed and worried when she originally made contact with the Managed Care Organization as he enrolled. He was growing very quickly and did not understand his size and strength. He would leave home and go missing; the elopement, I mentioned before, which was very stressful for her. And she really needed support and help coordinating these complex care needs as he had just recently come to live with her.

When the care manager connected with the grandmother, she conducted a clinical assessment. That's a comprehensive assessment. It included, of course, health and health care needs, cognitive and functional needs, but also asked questions about Joseph's history in the community, caregiver support and caregiver strain, language and communication preferences of the family, and health-related social needs, which come into play a little bit later.

So initially, they worked together on Joseph's health care needs. And, of course, this evolves over time, especially with a complex case. But some of the activities that they engaged in, the care manager helped Joseph's grandmother to establish him with a new primary care provider in her area and then coordinated with specialized providers, including the

psychiatrist, the neurologist, dental, lab, and ABA autism services in the home. They were working on avoiding readmission to the hospital. They were also working on medication management, diabetic nutrition counseling, and epilepsy management. There were some transportation needs to get to appointments. Ultimately, they ended up using the Personal Preference Program to hire a worker for about 25 hours a week of self-directed personal care for Joseph and providing some respite for the grandmother.

And then as that really health-care-focused discussion was happening and that care plan was being built, Joseph's care manager was also helping to connect the family to other community resources. And this is something that we would want to see. So they were having conversations about financial assistance, poison control resources related to pica, a summer recreation program and a kinship navigator program for socialization and respite for the family, home safety because of some things that had been happening and that were happening over time, and then really crisis protocols and coping strategy, deep ties there, we saw to the local community when you look in the case file.

And related to those ties, in addition to being in contact with the grandmother, Joseph's MCO

care manager was also participating in care team meetings with his medical and behavioral health care providers and his community care manager.

This is important because we want our MCO care managers to be connected to what providers are prescribing, to any follow-up care that is needed. That is the role of the care manager, to make sure the care is coordinated and that the family knows how to navigate and is able to manage the situation.

So when you look through Joseph's file, there's a lot going on there over several years. You see a care plan, and we would want to see a care plan that is unique to his specific needs and context and family relationships and community circumstances. Joseph's care plan demonstrates ongoing coordination between his family and his providers and folks in the community, with his MCO care manager staying closely connected to that. And over time in the file, you see as a result of that collaboration between providers, behavioral health, medical, the MCO care manager, and other community folks, you see significant improvement for Joseph around being able to establish and maintain those medical appointments, compliance with his medication regimen, some improvement in sleep patterns that had been challenging. Behaviors at home had

improved. Psychiatric appointments were being kept. He's participating in social and community settings and has had not any additional inpatient stays and emergency room visits. That is one of the goals of the care planning, right, to try to maintain stability and the services that are needed in the community to avoid those kinds of exacerbations.

And importantly, if you remember the blue box from the first slide, his grandmother now reports no needs at this time, and she stays in contact with the MCO care manager on a regular basis.

So this is really just a small snapshot to give you a sense of one case. We see cases -- first of all, there are many, many more details and much more to say about this individual case of Joseph, but across the board, we see cases where managed care's care manager may be more involved than in the Joseph case, may be less involved than in the Joseph, depending on the specific needs of the situation. But we thought that this was a good one for giving a sense of kind of just if you went down the middle what might an individual case look like, and this one seemed pretty representative.

Dr. Spitalnik, we are happy to take questions either on the quantitative analytics of this

as presented by Greg, or if I can be helpful on case study side.

DR. SPITALNIK: Thank you very much.

Beverly, I know you had a question.

MS. ROBERTS: Yes. Thanks very much.

Thank you for this example. This was an absolutely lovely successful case. I'd love to know who that psychiatrist is. What we see is it's really hard for folks within the Medicaid managed care networks to find psychiatrists who is in the network, taking new patients. All of that stuff has become really, really, really difficult for families. So great that this family was able to get the care that they needed for Joseph.

Another thing is I think Joseph wasn't -- it sounds like he's an adolescent. I don't know how old. But that he wasn't getting DDD services, he was probably an adolescent, maybe getting something from the CMO; it's not clear. So he's pre-DDD services, which is fine that he was able to get this help. I guess I wonder, as great as this example is, how representative it is of some of the folks that we hear about who are having so much difficulty finding a psychiatrist, getting an appointment, people who get connected to somebody but then still end up having to

go back to the emergency room having to be rehospitalized. But I love this successful example.

One other thing on the data question for Greg. So at one point, Greg was saying that it's DDD-eligible people and he gave a total number. But then there were also some things that sounded like the Care Management Organization (CMO). So I don't know if everything -- these are people that have a developmental disability, but I just wasn't clear with the data was it everybody, including people in PerformCare who are listed as DD even though they're not yet eligible for DDD services, or was it people who already have DDD services, being 21 or older?

MR. WOODS: Bev, as you say, there's a lot of subtlety around which population is included. I will say in order to make sure we were clear about who we were looking at, this particular analyses was focused exclusively on adults.

MS. ROBERTS: Okay, so 21 and over for purposes of the data that you have?

MR. WOODS: Yes.

MS. ROBERTS: Thank you. And, again, I love this example. And I would love to know who the psychiatrist is and if he or she is taking new patients.

MS. JACOBS: Fair point, Bev. As we move forward with discussions about how to do behavioral health integration the best way possible, we want to make sure that we are focusing on the patterns that we see in the community. One of the challenges of the existing carve-in is that it's very small. And in a behavioral health world where we have a workforce challenge in general regardless of payer, including private pay, it can be challenging to get providers to join networks and make their time available. So we've got to be sure that as we're implementing any changes in our program that we are constantly thinking about that experience on the ground and building the solutions into our contracts and our accountably work and the way that we're monitoring the program.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Any other questions from the members of the MAAC?

I also want to express my thanks. I know how difficult it is to put together this data and how appreciative we all are of the human face on the data through this.

A question that I would raise, this seems to be a wonderful example of robust case management by the MCO. But given the age and DDD eligibility, I would

also raise questions going down the road of looking at what other services on the DDD, on the long-term services side that someone is getting, both as a contribution to individual mental health and how we coordinate all of the Medicaid resources on behalf of individuals and the therapeutic nature of being involved in the community and what options -- what we learned from the behavioral health side also has implications for the long-term services side in terms of enriching both the services and the adequacy of the workforce.

Any other questions or comments?

Thank you so much. I know this data has been difficult. And to all those who participated in the analytics, our appreciation.

We now turn to an update on Cover All Kids, and we turn to Carol Grant.

Good morning, Carol.

MS. GRANT: Good morning. I'm really pleased to be here with everyone this morning, and we have quite a number of people listening. Happy to see that. I'm going to tell you a little bit about where we are with our important Cover All Kids Initiative.

This initiative has really been actively underway since July of 2021. And since that time, we

have added 51,245 members under the age of 19 to our New Jersey FamilyCare rolls. We're very proud of that. It really has taken a village to get there. We want to say thank you to all of our partners for helping us achieve these numbers. Our goal, of course, is to enroll every eligible child regardless of immigration status, and we are well underway.

Next slide. So where are we? Remember, that we have implemented this program in stages. The first stage was to reach every eligible but not enrolled child. And in the second stage, we are reaching out to all children regardless of immigration status. We are really pleased to report that our coverage for all income-eligible children went live, as we had planned, on January 1st of 2023. I want to make a brief shout-out to the Cover All Kids working group and all of our internal and external partners helping us to achieve this date.

The New Jersey FamilyCare website is now updated to show that all income-eligible children can apply regardless of immigration status. A special Cover All Kids site features application information, frequently asked questions, posters and social media, and translation instructions. We really encourage you to visit us at nj.gov/coverallkids and help spread the

word. This program will grow only as people know about it and are encouraged to apply and get enrolled if they are eligible.

Next slide, please. For outreach, for awareness of the program, we have posters and social media content that are available to share in person and online. Content is currently available in English and Spanish, with 19 more languages on the way. And to help spread the word even further and to use trusted source partners in the community, New Jersey FamilyCare is working on community outreach grants. A draft RFP is under internal review and nearing completion. There will be a notice of funding availability that will be posted onto the DHS website as soon as this is available. And the State wishes to award the community outreach grants in early spring of 2023. So we are really looking forward to that.

Some of us on our internal team have been out and about talking to the various community partners and stakeholders about this initiative and really understanding the enthusiasm there is for making sure we're reaching every eligible New Jersey child.

Next slide, please. I think the next slide is really just pointing out the importance of community partnerships. We have begun to do -- we want to make

sure that everyone is aware that New Jersey FamilyCare offers coverage now for all income-eligible children regardless of immigration status. We have started doing numerous trainings that have included health benefits coordinators, our New Jersey FamilyCare presumptive eligibility providers, outreach coordinators in the Office of New Americans, another very valuable partner to these initiatives; county welfare agencies on a weekly basis. We have made a number of individual presentations to community groups, including the Community Child Care Solutions, Human Services directors meetings, county welfare agency directors meetings, Human Services Advisory Council meetings, and the Department of Health, and, again, another valuable partner, the Federally Qualified Health Centers (FQHCs).

So we're doing everything we can to make sure that wherever we have partners that touch children and families, that they are, in fact, aware of New Jersey FamilyCare, of the Cover All Kids initiatives, and can assist in getting kids and families to apply and get enrolled if eligible.

Next slide, please.

Here, we're just giving you an example of the kinds of outreach events that we have been doing

and plan to do.

Again, our goal is to touch as many people and make as many contacts as we can to make sure we're finding every eligible child. I'm not going to go through this whole list, but I am going to ask all, I think, 287 of you to help us spread the word. And I appreciate the opportunity to talk with you about this this morning.

That's it.

DR. SPITALNIK: Carol, thank you so much. It's so exciting that this is in place.

Mary Coogan had a question.

MS. COOGAN: It's not a question, it's just a comment. I just want to say kudos to Carol Grant and her team. I've been part of some of those meetings. And I think, Carol, you've really been very inclusive. You've welcomed a lot of community organizations to putting these materials together and really welcomes the input. So thank you for doing this. I think they look tremendous and I just hope everybody who is listening today really shares the information so that we can accomplish that goal of enrolling every child.

MS. GRANT: I really appreciate that, Mary. I think we have had an excellent group that have worked together. I'm afraid almost to mention sort of the

people that are in part of the internal team that have helped this happen lest I leave someone out. But I do have to do a shout-out for Maria Terlecki and Phyllis Melendez, Lauren Koenig and Jen Kramer, Cathy Martin; our own leadership, Jen Jacobs and Lisa Asare. There's no way this happens without a village helping it happen. So I really do appreciate the comments. Thank you.

DR. SPITALNIK: Thank you, Carol.

Bev Roberts, you had a question or a comment.

MS. ROBERTS: Yes, very quickly.

Thank you, Carol. This is wonderful information. Very excited about covering all kids in New Jersey regardless of immigration status is wonderful.

I think I mentioned this before, but just to keep in mind so if we're talking about kids with intellectual and developmental disabilities who would be part of getting covered as kids but then at this point they would lose that coverage as soon as they're not a child anymore; meaning, they would not have access to getting DDD services because you have to have Medicaid to get DDD services. So just to keep in mind if there is a way for those kids that are covered

coverable under Cover All Kids to be able to have Medicaid and their DDD services at 21, that would be terrific.

MS. GRANT: Duly noted. There's nobody who is going to forget that more than me, but I appreciate the comment and we will make sure that we're watching and growing the program as we need to. We're just going to need to all think this through together, I think, about how we make sure we get kids covered and keep kids covered.

DR. SPITALNIK: Thank you so much. It really speaks to the North Star of equity that's characterized the program.

MS. GRANT: Absolutely.

DR. SPITALNIK: We now move on to a fairly large topic about the Medicaid eligibility checks which resume April 1, 2023. And, again, we turn to Greg Woods and Jennifer Langer Jacobs.

MR. WOODS: Thank you, Dr. Spitalnik. Just to frame this topic -- and I think I will probably be repeating what many of you already know, but so just to make sure. So as I think most of you know, since March 2020, we've been operating under the continuous coverage requirement that I referenced earlier. In short, what that has meant is that members have

maintained their coverage in NJ FamilyCare even if their income has increased or other circumstances have changed over the past now almost three years.

As I think many of you will also know, as part of the omnibus budget appropriations bill that Congress enacted at the end of last year -- so this is the bill that keeps the federal government running -- Congress mandated that that policy, that continuous coverage requirement, would end, effective on April 1 of this year. And I will say -- and this gets a little confusing, so apologies. Part of what Congress did is we had been operating under the assumption that the continuous coverage requirement would end when the federal health emergency ends. Part of what Congress did last year was to separate those two things so that the continuous coverage requirement would end starting in April regardless of the status of the Public Health Emergency.

Those of you who have been reading the news over the last couple of days will have seen that the Biden Administration has also announced that the Public Health Emergency is ending in May, so that is also happening. But at this point, we are working under the timeline that Congress set in the Appropriations Act and the requirement that Congress set which means that

the end of continuous coverage requirement will be on April 1st of this year.

And so this is going to require us, like all states, to transition back to normal eligibility operations over the course of the next year, plus. In particular, we're going to need to redetermine the eligibility for our programs of all 2 million-plus NJ FamilyCare members. And I will just note this represents the largest single renewal exercise in the history of our program. So today, we're going to give some updates on how we're planning for that and information about how it will work.

So if we want to go to the next slide, before we get into some more detail, there are just a couple of core messages I want to make absolutely sure that we convey. And I'll say these are not new messages, but it's important and so I'm going to repeat it a couple of times. So first of all, if you are an NJ FamilyCare member, if you are interacting with FamilyCare members in the community, there are really two simple messages that are most critical. One, we need members to ensure that we have the correct mailing address for them. If a member needs to update their address or if they're not sure whether we have the correct address, what they should do is call our

hotline. And that number is there, it's 1-800-701-0710. They should do that right away and provide their updated address. This is just really important because it will ensure that as we send out information to our members about the renewal-related processes and send out requests for information from our members, that they are going to the right mailing address and reaching our membership. So that's really critical.

And then, two, and related to this and equally important, members need to promptly open and respond to mail from NJ FamilyCare. That really is critical and will ensure that as we go through this process nobody will lose coverage due to failing to respond or failing to give us the documentation that we need. And I will say I think we've all been in the situation where we get something like this, get an envelope from your health insurer, get an envelope from a utility, you just put it on the counter and don't open it. So a lot of sympathy for that, but it is going to be very important that as we go through this unwinding process that members do open their mail and respond promptly. And we would appreciate assistance from the members of MAAC and from all of the folks on the call today to get that message out. Those are

really the most critical pieces for our members. And I think we'll probably repeat those two points a couple of times during today's presentation.

So with that said, before we get into some of the operational details of unwinding, I do want to just pause for a moment and talk about the North Star principles that are guiding us as we undertake this work. And we've shared these before, but I think it's really important to pause and restate this. And I would encourage everyone to read these principles. Just to quickly highlight a couple of key points, first, as we resume eligibility renewals, we will focus on the quality of our work and support for our members and, in particular, we are going to focus on being as accurate and effective as possible, making sure we get the details right and making sure that every member receives the coverage that they're entitled to.

Second, we are going to emphasize shared understanding. I will just note we acknowledge this is a complicated topic. It can be hard to understand sometimes how the broad principles, the broad rules, may apply to individual circumstances. We have more than 2 million members. Each of their circumstances is unique in one way or another. And, obviously, when we are doing a massive undertaking like this when we are

renewing eligibility for more than 2 million people, that's work that needs to be automated and systematized just by its nature. But at the same time, we recognize that every member, as I say, is unique and there will be circumstances that may not anticipate or exceptions to rules, and we are committed to doing everything we can to help members navigate that and to communicate in a crisp and clear way about how this unwinding affects all of our membership.

Third, it's critical that we're going to rely on our operational partners to be successful in this effort. This is not something that we within DMAHS can accomplish alone. We'll need to rely on the counties that we work with, on our MCOs, on our vendors, on our sister agencies, on the regional health hubs within we work. And we're going to need them to work with us in a creative and innovative and outcome-focused way.

And then similarly, we're going to rely on our community stakeholders, which is to say all of you on call, to play an active role and to partner with us to raise awareness and communicate information about this unwinding effort and also to let us know when things go wrong or if there's confusion so that we can correct course quickly and learn as we go.

And then, last, we intend to approach all of this work with empathy, with positive energy, and in a spirit, as I said, of collaboration.

So if we want to go to the next slide. I wanted to spend a moment on this slide. This is an updated timeline for the unwinding effort. And I just want to give a loud PSA at the beginning. We have presented a version of this slide at several previous MAAC meetings. And every time we have presented it before, we have said "This is a hypothetical timeline. We don't know exactly what the timeline is going to be because we don't know when the continuous coverage requirement is going to end."

Now this is no longer hypothetical. This is the real timeline. This is actually happening in April. So I just want to emphasize this point. What you see here is no longer speculation. This is actually the process that we expect to go through.

I want to start by focusing on April 1, 2023, so that's two months from today. And that's when the unwinding will really kick into action. So what do we mean -- there's language, I think, in the legislation and some of the guidance the federal government has put out that says that states need to begin unwinding operations by April 1st. So what does

that mean? I'll talk through for New Jersey what that's going to mean. So that's the day we will begin eligibility renewal processing for 1/12 of our membership. And the reason I say 1/12 is that unwinding is going to be a 12-month-long process. In order to manage workload, we are intending to spread the renewals evenly across that time period. So each month during those 12 months, we will begin the process for 1/12 of our total membership.

So when we begin that process for the 1/12 of our membership in April, the first step of that renewal process is initiating what we call ex parte renewals. And that's a Latin phrase that just means that for some of our members, we expect to be able to confirm that they remain eligible based on information we already have access to, so things like tax data or potentially data from if they've applied for SNAP benefits. And so for members who fall into that category, we'll confirm their eligibility, we'll send them a notification, and their eligibility will continue.

But then for all members who were not able to renew on an ex parte basis, so members who we don't have the information to confirm their continuing eligibility, mailings will go out for those members in

the middle of April. And this is where, just to harken back to the point I made earlier, it will be very important for members to open their mail and respond quickly and provide all of the needed information. Members will have 30 days to respond to the mailing. It just really will be critical that they do so.

Once that information is returned, our eligibility-determining agencies will determine whether a member is still eligible for NJ FamilyCare. And I will just note, that will include looking at whether a member may be eligible on a new basis. So that is to say as part of a different eligibility group than they were in perhaps before the pandemic or the last time we confirmed their eligibility. We recognize that people's circumstances have changed over the last three years and we will be looking not just whether they continue to qualify for Medicaid on the same basis that they did before, but whether they may qualify under a new eligibility group.

For members who go through that process and are determined ineligible, we will then send the member a notice 10 days in advance that their coverage will end at the end of that month. A couple of important points here that I want to make. So in that situation where a member is found to be ineligible, there are

some important things to know.

First, if a member is found ineligible because they didn't respond to our mailing, so we don't have the information we need, and they are able to subsequently provide us with that required information within 90 days of the disenrollment and are found eligible based on the information they then provide, they're eligibility will be retroactively reinstated. So there won't be any gap in their coverage. There is that 90-day period if someone misses the initial mailing and is found ineligible on that basis.

Second, I just want to note if a member is found ineligible due to income and appears to be eligible for coverage instead through the GetCoveredNJ Exchange -- this is the Obamacare coverage -- we will automatically transfer that member's information to GetCoveredNJ in order to facilitate their potential enrollment there.

And third, it's important to note -- and I think Jen is going to talk about this more later -- all members have the right to request a fair hearing if they disagree with the determination that they're ineligible for coverage.

I'm calling these things out because I think they're important and also to say, in general, our goal

54

here as we go through the process is make sure that everyone maintains access to appropriate coverage, whether that's through Medicaid or another source such as GetCoveredNJ.

So with that said, going back to the timeline. If a member is determined ineligible, as I said, we would send them a notice at least 10 days in advance. When we look at the timeline for those members for whom we started, initiated the process in April, the earliest possible date we think that members could be disenrolled would be the end of May. And for that to happen, the entire process would need to work relatively quickly at each step. The member will have to respond promptly to our mailing, and we would need to process that response quickly. So we think there will be some members who will fall into that bucket, but we really think the majority -- I should say, the first month where we're going to see significant disenrollments as a result of the unwinding will be at the end of June, so the beginning of July. So that's the basic timeline for the members who we are going to initiate renewals in April. I will just say, again, that's 1/12 of our membership. And we would expect that same process to play out each month for the following 12 months, so through March of 2024. And as

55

I said, we are expecting to divide our membership evenly across the 12 months to manage workload. So it will continue over the course of the year. And then we are expecting by the end of May of 2024 the lion's share of renewals or redeterminations will have been completed and we will be back on normal footing. I will say there may, of course, be a relatively small number of cases that extend beyond May of 2024. That could be because of a fair hearing request or other specific circumstances. But for the most part, we expect this process to be complete by May of 2024.

If we want to go to the next slide. I want to just quickly note on this slide, the renewal process will look a bit different for different categories of members. And I will say this was the case before the COVID-19 pandemic and it will be the case during our unwinding period. So some eligibility groups have different renewal requirements. For some groups, we look at income only. For other groups, we look at assets in addition to income. For some eligibility groups, there's a clinical component of the eligibility determination process. Over the coming weeks and months, we will be working on targeted outreach and education for some of those specific groups. So aged, blind, or disabled members, members with developmental

56

disabilities, members who may be enrolled in our MLTSS program, members who may have become eligible for Medicare during the Public Health Emergency. But in the meantime, I'm going to say again, for all of these groups, the most critical advice applies the same. Please do make sure we have that updated address. If you're not sure, please call our hotline and then please be sure to promptly respond to any mail that you receive. So that really is the most important message at this moment for all eligibility groups. But I did want to acknowledge that the process will look a little different for different groups.

And then if we go to the next slide. I just want to quickly acknowledge that -- and I think we've discussed with the MAAC on the previous occasion, the actual work of processing renewal applications is spread in New Jersey across eligibility-determining agencies. So there are county welfare agencies in each of our 21 counties who process many of our applications and renewals and collectively they're responsible for about half of the total population, so about 1 million. And then there is the NJ FamilyCare health benefits coordinator. That's a vendor, the conduent of the State, and they are responsible for the other half.

I will say in both cases, the basic process

57

and guidance for members is the same, but it will be depending on the member, it may be a different party on the other side of that transaction. I will say both county welfare agencies and conduent, our health benefits coordinator, will have their redeterminations evenly spread across the 12-month period so as manage workload. And in those cases, we will be closely monitoring and making sure that they are staying on track across all eligibility groups. That's something we are going to be looking at closely on a weekly and monthly basis as we move forward.

So with that, I think I'm going to hand off to Jen who is going to give a couple of examples of how this process may play out in different scenarios. MS. JACOBS: Thanks, Greg.

So last year when we initially started preparing for this process, we introduced you at one of our MAAC meetings to four members, and we're bringing them back here today to talk through in a little bit more detail how we will support a couple of these members.

So just as a reminder for anybody who does not clearly remember this slide, and that's fair, Halima and Hector on the left are members who received the outcome that they would have wanted from the

eligibility renewal process. In Halima's case, she was determined eligible and her eligibility continues. In Hector's case, he was determined ineligible. He didn't want to remain enrolled. His eligibility ends, and he is also comfortable with that outcome.

The couple of members that we were concerned about in this group were Samuel and Sophia. So we wanted to spend a little time today with Samuel and Sophia as we prepare for the resumption of eligibility renewals here in New Jersey.

Let's talk about Samuel for a moment. Samuel responded to his eligibility mailing and he ultimately was determined ineligible due to his income or assets and he received a disenrollment notice and his account, his information that Medicaid has about him, was transferred to our state-based exchange, Get Covered New Jersey for people who don't qualify for Medicaid based on income. And so here's the thing. Samuel is not happy with the decision that was made, and he wants to remain enrolled with NJ FamilyCare. So let's talk a little bit more about -- this is what we told you last year. Let's talk a little bit more about what happened with Samuel.

Important to know, prior to receiving that termination notice, Samuel received a request for

information from his eligibility agency saying that they had verified his income at a level above the eligibility threshold. And Samuel provided some additional information to the County, but later he received this termination notice and he disagrees with the decision. It's important to know that his notice, the notice he received in the mail, includes his fair hearing rights and tells him the steps that he can take to request a fair hearing, which he needs to do pretty promptly after receiving that message.

What happens next? The Medicaid legal office will receive and review that fair hearing request and they will submit the request to the administrative courts. Sometimes, based on the information that's provided, the legal office is also going to go back to the eligibility agency and let them know that this hearing was requested and ask them to take another look at the case. If it's possible, the eligibility agency is going to try to resolve the fair hearing issue prior to the court date. This is important because if we can resolve a problem for Samuel quickly, obviously, we want to do that. The fair hearing process will proceed in the appropriate manner, but if we can solve the problem faster, we want to.

Meanwhile, because Samuel was determined income ineligible, his information was transferred over to GetCoveredNJ, as I mentioned before. And so he may at the same time receive outreach from GetCoveredNJ to assist him in applying for premium assistance for an affordable health plan. So there's a couple of potential touch points there where Samuel has filed for a fair hearing, the County may be looking to resolve the problem that Samuel has described, and he may also hear from GetCoveredNJ. This is all in the interest of making sure that his rights are respected, obviously, on the fair hearing side, and also that we're insuring coverage for him as we go forward here. So Samuel was one example that we wanted to share with you, income ineligible by the eligibility determination, but not agreeing with the decision that was made.

And then the second example, our friend Sophia, this is a case where Sophia did not respond to the eligibility mailing in the first place. I'm in the blue box right now. She did not respond to the mailing. She was determined ineligible because of that nonresponse. She received the disenrollment notice. Now, we don't know her income level. She may still be eligible for Medicaid. But it provides, in any case, some information about GetCoveredNJ. And Sophia now

says she would like to remain enrolled in NJ FamilyCare.

The letter that Sophia receives tells her that her coverage will end because she didn't provide the information that was needed to complete her eligibility renewal. And the notice also tells her that she can submit that information in order to have her application reconsidered. She needs to do that within 90 days. The notice gives her fair hearing rights, the same way it did for Samuel. But it's important to note that Sophia should get that information back to her eligibility agency so that they can set her back up with coverage if she's still eligible on a retroactive basis in the way that Greg described to you a few minutes ago. So she needs to respond to that renewal as soon as possible.

And then the County will take another look at the information she provides. If she's still eligible, they can restore her eligibility without any gap in coverage in the same MCO which can connect her to the same primary care provider. And we need to do all of that in that 90 days. We need to get that information back from her so we can do that.

If Sophia has questions, and certainly this applies to Samuel and all of our members, she can call

our 800 number and speak with an NJ FamilyCare representative. Or if she realizes in the process that she's not eligible and she just wants to go over to GetCoveredNJ, then that is absolutely an option for her as well. The important thing is we're trying to make sure that her fair hearing rights are respected, that our problem-solving is in place for her, and that she has resources and information available to her as she works through this.

So those were a couple of examples that we wanted to share with you about individual members. And then we wanted to talk to you a little bit about how we expect our MCO partners will support outreach to the broad population. So there are a few things to know here.

One, in the spring of '22, we started working with the MCOs to collect member contact information that they have that's been updated and verified by our members. If you remember, I told you at the time, this is something that was not previously permitted by federal rules but that CMS was enabling states to do in these unique circumstances. So we have been collecting updated member contact information from our MCOs and we will continue doing that.

In addition, the MCOs will be supporting us

with what you could call "get ready outreach," which is we're going to flag for them their members, each of the five MCOs will get information about their members who are set to renew in the coming month. And we're working together on the mailings and outreach that will encourage those members to, in particular, keep an eye out for renewal mail in the month ahead. So that's our "get ready" group. And we anticipate starting that outreach specifically in March of '23, March of this year.

And then finally, non-responder outreach, as you know or may recall from prior discussions, we have been continuing our eligibility mailings throughout the pandemic here but, obviously, not making the determinations that will result in anyone losing eligibility. In doing that, in continuing that exercise, we have been noting which members were not responding to mail and we've asked the MCOs to help us outreach those individuals. We will continue to do that in sort of this new reality and with some new federal requirements in play. So we're updating the nature of the outreach that we've asked the MCOs to do to that group. We're updating that now in accordance with the new guidance coming out from our federal partners, and we'll be continuing that in months ahead.

So those are just some specific examples of how we're working with the MCOs to outreach their members on a broad basis.

And then finally -- and I think this is our last slide, Dr. Spitalnik, on the unwinding. The key message is, which Greg has already shared, making sure that folks are updating their address with us and responding to any mail they receive from us. As we move forward in the year here, we will also be emphasizing that they have appeal rights and can file the fair hearing request. That if they lost eligibility because they didn't answer the renewal packet, we can get them back in the system if they provide the information within 90 days that demonstrates their eligibility and that that will be uninterrupted coverage, which is great.

And then finally, that GetCoveredNJ is an option for people who have incomes that now exceed the Medicaid thresholds.

So many thanks to our community partners. As Greg said before, this is really a critical set of relationships. It's an ecosystem. We work together very closely, and we do appreciate your ears on the ground and quick sharing of information where we may need to be responsive.

Back to you, Dr. Spitalnik, for any questions.

DR. SPITALNIK: Thank you so much. I know that Mary Coogan has a question and then Beverly. And I will keep up with the chat from members.

Mary.

MS. COOGAN: Thank you.

So thank you for all the information. I appreciate all the planning and appreciate the fact that the MCOs are helping to engage everybody in this process to make sure everybody keeps their coverage.

Question: Greg, when you talk about 1/12 or dividing people into groups, monthly groups, how are you determining who is in each 12th? Is that by their annual renewal date or alphabetical, random?

MR. WOODS: That's a good question, and I'll give a quick answer. And I know we had talked about this a little bit, I think, at a previous MAAC meeting. So first of all, I would say when we say we're dividing by 1/12, it's not just across our entire program, though that's true. We are also dividing within each eligibility determining agency, so within each of our counties, within conduent cases. Those will be evenly divided into 12 equal groups. And even more granularly, within each eligibility determining agency,

we're going to also make sure that we divide certain categories of cases equally, because we know that some bucket of cases will be more challenging on average than others to complete the processing. So that's one general principle.

A second principle that's really important is -- and I think we said it before, but I'll repeat it now. For members who -- as Jen just alluded to, we have been going through the redetermination process during the pandemic, obviously without people being disenrolled if the didn't complete that process. But for members who have in the year before the unwind, so from April of 2022 to March of 2023, have successfully completed that redetermination process and have been found to be eligible, they will stay on their normal schedule. So if you redetermined your eligibility, let's say, in January of 2023, then your redetermination would be in January of 2024. So we're keeping them on that timeline.

For everyone else, like I said, we're looking at different eligibility groups differently. As a general rule, we will be looking at those who -- those who the last time we determined their eligibility was longest to go first. That's probably a bit of an oversimplification because, as I said, we're looking at

each group individually across each county. And we're, again, making sure that the spread the even for each month within each eligibility group and within each county or conduent.

MS. COOGAN: Thank you. That's helpful.

DR. SPITALNIK: Mary, thank you for that question and an intuitive question from the stakeholder. So thank you so much for raising that.

Bev Roberts.

MS. ROBERTS: Thank you. And I actually have more of a comment, a couple of comments, rather than a question because I think there are probably a significant number of people at this meeting representing people with IDD, and I want to try to prevent anxiety attacks amongst some of the people that may be watching and listening today. So I wanted to thank you for saying the requirement that if somebody -- and I'm concerned primarily with the ABD population. If they are not at this point eligible for the Medicaid category that they were eligible for previously, they will be reviewed for any other Medicaid category for which they are eligible. So it won't just be sending a termination notice, there will be a review of other possible categories, including possibly of somebody -- I guess to inquire if they're employed, for example.

NJ WorkAbility could be a possibility. And then there are also higher thresholds within the DDD world that I think, I'm hoping, are going to work for just about everybody even if the actual Medicaid office threshold is not going to be suitable for a particular person.

And then the other thing with regard to Medicaid fair hearings for anybody that needs to request that, when you make that request, you can also request continuation of the coverage that you currently have. So during that process, until the fair hearing is scheduled and held and everything else, by requesting continuation, they will continue to have their Medicaid services. So thank you.

DR. SPITALNIK: Thank you.

Any other comments or questions from the MAAC?

Greg, could I ask you also to review that you had spoken, I think at our last meeting, about how people who are now on WorkAbility, about their redeterminations.

MR. WOODS: Thank you for the reminder, Dr. Spitalnik. So just quickly, and I think I responded to one question in the Q&A about this, but because of the new legislation that I discussed earlier around WorkAbility eligibility that we are in the process of

implementing, we're going to do something specific with existing WorkAbility members. And what we're going to do is we're going to put them in the last quarter of the unwinding period. So for members who are currently in WorkAbility, their redetermination will sort of be at the end of the period, so that will mean January through March of next year. And that's just to give additional time to allow us to put all those changes in place before we do those redeterminations. So that's a special case where those members, rather than being spread evenly across the 12 months will be all in the last 3 months of that period.

DR. SPITALNIK: We very much appreciate the sensitivity to that and the thoughtfulness that's gone into anticipating and now beginning this process and, as always, your collective ability to take an incredibly complex set of requirements and program and make them accessible to all of us.

So we have been focused, as we typically are, on moving ahead and the future. A tradition that Director Jacobs has started, which we very much appreciate, is to also look at the past and to recognize the accomplishments and the magnitude of the program in the past year. So I turn to Jen for a review of 2022 in the New Jersey FamilyCare program.

Jen.

MS. JACOBS: Thanks, Dr. Spitalnik.

At DMAHS, we have to be very deliberate about tracking our goals and priorities as the year races by us. Our priorities, as you know, shift constantly. New requirements come into play and new circumstances arise. We operate a massive program in a real world that is constantly changing, but we also know we have to keep all those priorities, all that innovation, all that troubleshooting, in motion with a rhythm that guarantees we're bringing both velocity and stability, those really key tenants of leadership, and that we're making continuous progress across the breadth of the program. So today, as I've done in prior years, I want to talk to you about what we've accomplished and specifically what we accomplished in 2022 that merits your attention, whether you knew it was happening or not. So let's dive in here a little bit.

Just as a reminder, there are three kinds of work that we do at DMAHS. We think of it like this: There's action on the basic; that's the A's and B's. This is what we do every day no matter. It's the essential work that leads to members getting services and providers getting paid.

Change and disruption, the C's and D's, this is what's happening that's new and different for better and for worse that needs to be managed. The pandemic was a good example back in 2020; significant change and disruption.

Evaluation and enhancement, the E's. This is about what's being measured how, what needs to improve, what does success look like. And you'll see examples of each of these kinds of work as we walk through our four overarching goals.

So Goal 1, if you've been with us for discussion in past years, this has not changed. Goal 1, every year, we want to serve people the best way possible. And we break that down into three parts. The first is about improving maternal/child health outcomes, the second about helping members with physical, cognitive, and behavioral health challenges get better coordinated care. And the third, supporting independence for all older adults and people with disabilities who need help with daily activities. So we'll dive into each of those three pieces for just a minute.

In maternal/child health outcomes, very significantly led by our First Lady and her Nurture NJ strategy, we did implement this year 12 months of

postpartum eligibility. Some of you will recall that we got approval for that the year before. We had to do the technical work of implementation this year.

We've already talked today about the increased rates for maternity care, and we also expanded provider access to include all licensed midwives.

Also in this zone, we talked about Cover All Kids, how we worked with the workgroup to coordinate outreach and awareness expanding enrollment of kids who were already eligible but unenrolled and then implemented coverage for undocumented children, beginning January 1st. Significant outreach work there and also deep technical systems work.

We implemented coverage for dispensing of contraceptives up to the 12-month supply.

We increased the number of doula-assisted births. This is still a program that's kind of growing from a seed, and we've been collaborating with of the Department of Health and community groups to expand the doula workforce to further increase access to doula care.

We set standards for distribution of breast pumps and breastfeeding supplies, and we were glad to see that this led to an increase in utilization of

breast pumps year over year, from State Fiscal Year '21 to State Fiscal Year '22. That's an example of evaluation where we're looking to see the numbers move.

And then we initiated payments for contraceptive care and community doula benefit for undocumented women who were eligible under the NJSPCP program. So all of this under the goal of improving maternal/child care outcomes.

In the space around better coordinated care and complex care, we increased the number of members accessing autism services by 40 percent in State Fiscal Year '22. And we see utilization continuing to rise in the current fiscal year.

We also saw a 25 percent increase in the number of facilities, SUD facilities, that were participating in interoperability. So what is that? That's electronic information exchange between behavioral health care providers and physical health providers. Talking about better integration there, so to see more than 2,000 clinicians engaged in that way is significant.

Unexpectedly, we partnered with a number of sister agencies, including Department of Health, aging services, mental health and addiction services, the really great folks at the LTC Ombudsman Office, and our

MCOs around closure of a nursing facility that was housing a very complex population. There were 400 people living in that nursing facility. All residents were moved to new settings with person-centered care planning.

We also began implementation of the WorkAbility expansion, which we have already talked about today. And we supported the "End the Epidemic" strategic plan, which involved eliminating all prior authorization, including step therapy for treatment of HIV.

So pretty broad across the board. A lot happening in that space. But you can see some of the results, and we're excited about those.

And then third under Goal 1 was supporting independence for older adults and people with disabilities. Here, we increased rates for TBI residential services and we introduced a tiered rating system for assisted living facilities to encourage those facilities to accept more residents who are beneficiaries of our Medicaid program.

We also made a transition where we took 2,000 nursing facility residents who had long ago been grandfathered in Fee For Service and therefore did not have a care manager through our MCOs. We brought 2,000

new members into the MCOs so that they all now have a care manager. And four out of our five plans were able to complete that initial visit with all those new members, with greater than 90 percent of those members by the end of the calendar year. So that was an important shift for those people who did not previously have a care manager involved in their care planning.

We also -- and this was really an important one -- implemented new MCO accountability for PCA and PDN staffing. So we are hearing about unstaffed cases where people were not getting the services that they needed. We got together with the MCOs. We have a team that said, here's the reporting that we need you to do to give us assurance that people are getting the services they need. We also, as you may recall, had some notable provider rate increases. So between new reporting and process and those provider rate increases, we're now in a place where less than 1 percent of our PCA cases are unstaffed and less than 5 percent of PDN on a statewide basis as of the end of 2022.

We saw growth in our integrated Medicare and Medicaid health plans in 2022 so that we have a total enrollment now of more than 78,000 members who are in those integrated Medicare/Medicaid plans. We call them

FIDE SNP.

And I think it's important to note that our DMAHS team is really seen as national leaders in thinking about dual's integration and have been very active in some of those national collaboratives.

And then finally, I wanted to mention the Healthy Homes Program which has not yet fully rolled out but made a lot of progress over 2022 in partnership with the Department of Community Affairs. This is our investment in housing dedicated specifically to Medicaid members at risk of homelessness or institutionalization. And we're looking forward to talking to you more about that program in 2023.

So that's all under Goal 1.

Goal 2, every bit as important because it facilitates everything in Goal 1. Goal 2 is experiment with new ways to solve problems. We don't intend to solve problems with the same old way of doing things. We need to be thinking in new ways. So that includes value-based models. It includes systems and technology upgrades and engaging in troubleshooting where we just see issues popping up and we need to get on them.

So a few examples here for you. Our quality-driven perinatal episode of care pilot launched this year with 16 hospital-affiliated and community

practices. These practices are providing care for about 10,000 Medicaid births statewide on an annual basis. We're really excited about this model. It is Year One and so there's more to come on this, but certainly, a lot of work went into it to get to this point. And this also was also done in partnership with community groups like we've described for WorkAbility, for Cover All Kids, for unwinding, like other important initiatives. Just a ton of work done by our policy team to get that one launched this year.

And speaking of the policy team, I would also mention extensive discussions with CMS about our 1115 Proposal, which Greg has mentioned to you before and we'll be bringing back to you in the spring. This proposal is exciting because it will help us improve integration of behavioral health benefits and also introduce new services that address health-related social needs. So we're really excited about that. It's an extensive process still in motion, as Greg described, but coming across the line very shortly.

This slide -- we agreed for each of our sub-goals one slide for each of our sub-goals. This was the hardest one to put on one slide, the way that we are using systems and technology to make our program more efficient and more effective for the people we serve.

We spent a lot of time in 2022 getting ready for unwinding the Pubic Health Emergency and using new technology to do that.

We amended our call center contract to allow any member to call that one toll-free number with their address update. I think I described to you last year that was not something that was in place before.

We used new flexibility from CMS, as we have said to you to be able to gather the address updates that the MCOs were able to share with us. That's making our return mail rate lower and improving our ability to reach our members.

We launched the StayCoveredNJ website. This is a new user-friendly format. If you go to the Cover All Kids website, you will see a similar format. It's different from the rest of the DMAHS and NJ FamilyCare web pages, but it is our step into the future of the Internet, and we're excited about it. So this website, StayCoveredNJ, has the toolkit and the printables to help community partners help us as we go into this unwinding period.

We experimented -- this is technical and not something that you need to understand in detail, but I just want you to have a sense of it. We experimented with some strategic bundling of technical coding. So

it takes a lot of time to build things in our system. Medicaid is very complex. And the team said, you know, maybe there's some different ways that we can go about this and try to bundle efforts together in new ways. And in doing that, they did find that they were able to improve efficiency a little bit, also made testing more complicated. But the experiment did bear fruit, and we were excited to see where we could take that. So worth noting even though it's technical and most of us don't fully understand it at a level of detail.

And then finally, really significant upgrades to our eligibility system, some of which are described in the blue boxes on the right. And so I just want to call out, for example, prior to 2022, you could not complete your eligibility renewal online. Now, many members will be able to do that. Not every single member type is going to receive the invitation to renew online at this time, but many of our members will be able to do that. So that's an advancement for members who would like to, would prefer to do that online.

We've also -- as we talked a little bit, we've upgraded eligibility screening for all programs. For example, Medicare savings plans, there was deep technical work involved in that as well.

We've significantly increased in partnership with our health benefits coordinator, the automated eligibility approvals that Greg mentioned. So that will mean that we're able to make more determinations kind of behind the scenes less needing to get members directly involved, which is great. Part of that is accessing SNAP data. Again, this is a flexibility that CMS has provided us that we didn't have in the past, so we jumped on that. And our partners at the Division of Family Development were really terrific in helping us set up a data-sharing agreement to be able to use their SNAP eligibility determinations to say, "Aha, here is the income associated with this household. We can make a Medicaid eligibility determination on that basis."

And then finally, a number of other enhancements, including race and ethnicity data collection to help us in our health equity goals.

A lot happening on the technical side of Medicaid, always. And it literally, figuratively runs behind the scenes but is worth calling out because it enables so much important work.

And then in terms of operational troubleshooting, I would just point out to you free Naloxone was not a project that we expected to be working on. Paying claims for anonymous humans is not

part of the Medicaid day-to-day, but when we were asked if we could do it, the team took a really solutions-oriented approach and they said -- I said, "Technically, I don't know if that's possible."

And they said, "We think we maybe could," and then they did. And it's awesome.

So this was not expected. It's not a Medicaid program, per se. It's for everybody, as Reut described. And we're really excited about it, so leveraging that Medicaid infrastructure to support the state on a public health basis.

We also finalized re-procurement for our health benefits coordinator. Why does it matter to you? Why is it new ways? Because when we go out and recontract, we have the opportunity to say, "We would like more value from you in the years to come." And in this case, that means we will have more efficient mail handling in partnership with the counties. Basically, we'll have a digital mail room, and eligibility processing will be improved, member experience will be improved.

And then I also wanted to mention the National Association of Medicaid Directors set up a Health Equity Advisory Council and asked us to join. We're all beginning to really deep dive into some of

the equity analysis where the numbers are telling us and also the voices of the community are telling us there are real challenges in these programs and we need to think in new ways about how to tackle those challenges and ensure that we're providing health care in an equitable way.

Goal 3, a little bit more behind the scenes, but we need to focus on integrity and real outcomes in this program. That means when we're working with operational partners, we need to hold them accountable for ensuring a stable accessible continuously improving program. We need to be thinking about program integrity and compliance with state and federal requirements. And we constantly need to monitor fiscal accountability and manage risk.

So what did that mean for us in 2022? We updated the contract with our transportation broker. This will be important to you if you are working with folks in the community who are saying they've had trouble getting their Medicaid rides on time. And we recognize this is a challenging benefit to administer nationwide, but we met with our transportation broker and said we need to amend this contract to get a better result here. And so we're starting to see the benefit of that. We've had some very good feedback from

providers who previously were telling us on a regular basis they had issues. So more to do there.

We have also been working to improve the provider enrollment process with the vendor responsible for that. They had a backlog in 2022 which they worked down significantly to bring their productivity into the service levels that we expect. That will never make a headline but is really, really important to our providers to make them available to our members.

We've also implemented some new requirements around MCO pediatric networks. We have addressed some concerns about dental preventative care and treatment. And we conducted a couple of important surveys. So if you look at the blue box on the right, you'll see two surveys described here. One is the CAHPS consumer survey that goes to all of our NJ FamilyCare members. They come back to us with things we need to know. So, for example, we're not always getting an A right now, and we really want to be getting an A. So we're keeping an eye on these results as we are working with our MCOs, as we are amending our contracts, as we are looking at other Fee For Service and other ways that we're administering this program. What are people telling us that we need to know? And so you see a few of the important results there.

And then on the MLTSS side, there's a special survey that is referred to as the NCI-AD survey. That's specifically for our MLTSS members. It's a real deep dive, and we don't yet have the results from 2022. But in prior years, we were seeing significant improvement in member choice and involvement in plan of care decisions, and we want to see that continue.

Briefly, I will touch on program integrity, some corrective action needed around audit concerns on our end and on the county's end. In our implementation of EVV, we've added a unique ID requirement that will help with program integrity reviews, and we've worked very closely with the Medicaid fraud division in other areas of program integrity.

I would also be remiss if I did not mention on the compliance side there's sort of a complicated system of measuring Medicaid data quality. Our team has made a ton of progress on that in the past couple of years and really specifically in '22. Being in a higher data quality bracket is really important here for our compliance with federal requirements. And I would also point out to you the re-adoption of some administrative code to support service delivery. Again, it's not exciting, but for those of you who

participate in it, it's really, really critical.

And then I would also mention the HCBS settings rule which has to do with ensuring an appropriate environment for people to live with independence in the community. We did receive final approval of our plan just in January here, so a lot of progress happened in 2022.

And then finally, under Goal 3, and then I want to jump to Goal 4, fiscal accountability. We have comprehensive rate studies underway. We did some really important work you will never want to know about around 1115 budget neutrality. That matters because it lets us implement all the programs that matter to you. So just a ton of hard work done behind the scenes there and then also related to the county option program and FQHC reimbursement.

The last thing I wanted to touch on, as I know we're getting close to the top of the hour, is Goal 4. This is even further behind the scenes. You will never see it in the headlines or a newspaper, but this is about showing people we care. This is our organizational culture goal. It's who we are. We collaborate with positive energy and compassion. We're going to simplify and clarify to solve problems. And we're going to advance the true-true. You've heard me

say it a thousand times, because that is what helps us succeed. And so I just want to briefly cover for you how we do that.

We had a number of activities over the course of the year to energize and re-energize our team. That included Lunch & Learns and charitable events, the "Take a hike, DMAHS!" lunchtime walks that help folks just get up from their desk for a couple minutes and breathe a little fresh air.

We started a new tradition called, "making the magic happen," which I'll show you in just a minute. And we had more than 70 employees who were recognized in that process. And we are really mindfully advancing diversity, equity, and inclusion within our organization. We think about that in really broad ways like making sure that everyone's in the room where it happens, so we have a weekly "touch base" that 90-plus people attend. The helps us make sure we're all on the same page as we start off our Mondays and we're building a diverse leadership team and the Center for Health Care Strategies has been really helpful to us in that regard.

I wanted to show you very quickly the "making the magic happen" survey. This is a little internal tool that we use to give folks a chance to

recognize someone else on the team who is making a difference for the communities we serve in the context of our four overarching goals. And when they answer that survey, and particularly question number 3, share how others are making an impact, if you make a word cloud out of all the responses that we have received on that survey, you see words like the ones in front of you on this slide. And I love the way it lined just randomly was "teamwork always" for our members, right? This is really important to who we are culturally and it's important to you because it enables us to get the rest of that work done.

So I realize this has been a lot to listen to. It's been a lot of work to do. And I would like to please take a moment to recognize the people of DMAHS who have done this works. DMAHS team members, they represent the diversity of New Jersey and our NJ FamilyCare communities. Our folks live in North Jersey, South Jersey, they live in the existentially debatable Central Jersey. DMAHS staff come from families of all shapes and sizes and from diverse cultural backgrounds and faith traditions. We are women who gave birth with Medicaid coverage. We are people with chronic illness and disabilities that are visible and nonvisible. We're new Americans. We're

dedicated caregivers, doctors, dentists, nurses, social workers, people who have experienced bias in inequitable systems. We've got fiscal experts who make the funding happen and lawyers, policy analysts, program specialists, who make new things possible. And importantly, we're people who answer the phones every day to help our members navigate America's complex health care system.

We serve the people of New Jersey and we take that respondent seriously. So as I wrap up here, I want to acknowledge the challenge ahead. We're now unwinding the three-year COVID-19 Public Health Emergency. Looking back, 2020 was a tough year. The pandemic hit New Jersey early and hard in ways we never would have imagined. We worked to ensure access to critical health care services and address health-related social needs.

Then in 2021, our challenge was to support vaccine access across our communities and recalibrate health care delivery while we innovated to solve problems that existed long before the pandemic. 2022 was a really demanding year for all the reasons we just talk about. And clearly, 2023 will be a challenging year as we restart eligibility renewal processes for our 2 million members.

So, Dr. Spitalnik and members of MAAC, thank you for your deep partnership in all of the work we've described. And thank you for this opportunity to report out on our progress. We're well aware that history has its eyes on us in 2023. And we'll stay close to our community as we, again, deliver the best way possible for the people we serve.

DR. SPITALNIK: Thank you so much for this presentation, but most enduringly, for all the work that has been done, is being done, and will be done.

I regret that the press of time doesn't leave us additional time for questions or comments. But I have been keeping notes and I will request that members of the MAAC send me an e-mail with their request for items to be considered for the next meeting where we will convene on Wednesday, April 26th. Our immediate plan is that this will be a virtual meeting, but we are in discussion about how we might return to a more interactive format that we've prided ourselves as a Council.

So with great kudos and gratitude to our colleagues and all you do for New Jersey, I will ask for a motion for adjournment.

MS. ROBERTS: Motion to adjourn.

DR. SPITALNIK: Thanks. It does not require

a vote or a second.

Thank you. Be well, everyone. And we look forward to seeing you go in April. Thank you to the members of the MAAC, to DMAHS, and to our New Jersey FamilyCare community for participating. Thank you all and be well.

CERTIFICATION

I, Lisa C. Bradley, the assigned transcriber, do hereby certify the foregoing transcript of the proceedings is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate non-compressed transcript of the proceedings as recorded.

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Lisa C. Bradley, CCR

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