NEW JERSEY HUMAN SERVICES

Meeting of the Medical Assistance Advisory Council

January 30, 2025

Agenda

- Welcome and Call to Order – Dr. Deborah Spitalnik
- Service Updates
  - Maternal and Infant Health – Shin-Yi Lin
  - Behavioral Health Integration Status Update – Shanique McGowan
  - 1115 Demonstration Highlight: Housing Supports – Jonathan Tew
  - Oral Health – Gregory Woods
- Managed Care Contract Changes – Gregory Woods
- Eligibility Topics
  - Eligibility Updates – Gregory Woods and Kristine Byrnes
  - Legislative Update: Presumptive Eligibility for Home and Community-Based Services – Kristine Byrnes
- Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) Updates – Gregory Woods
- Planning for the Next Meeting – Dr. Deborah Spitalnik

Maternal and Infant Health

NURTURE NJ

- NurtureNJ is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities.
- Today, we will share NJ FamilyCare updates on
  - Transforming Maternal Health (TMaH)
  - HealthySteps coverage

Vision: To become the safest and most equitable state in the nation to deliver and raise a baby

New Jersey Selected to Participate in TMaH

- On January 6, 2025, the Centers for Medicare and Medicaid Services (CMS) announced New Jersey as one of 15 states selected to participate in the Transforming Maternal Health (TMaH) model.
- TMaH is a CMS Innovation Center Model that provides states with up to $17 million over 10 years to support whole-person maternity care and drive quality improvement,
- A critical element of the Model will be creating a payment model for NJ FamilyCare providers of maternity care.
    - We expect TMaH to build upon lessons from our existing maternity payment model (the **perinatal episode of care** pilot).
- Other Innovation Center Models that NJ FamilyCare currently participates in are Integrated Care for Kids (InCK) and Making Care Primary (MCP).

New Jersey Selected to Participate in TMaH

- Primary **goal** of TMaH participation:
  - Improve the **experience** and **quality** of maternity care for NJ FamilyCare members.
- **Member**, **community**, and **provider** engagement will be a key factor to our success.
- We will also be closely collaborating with other state government, managed care, and non-profit partners.
- Key potential areas of **investment** include:

Value-based payment reform	Coverage of community doula services	Coverage of midwifery care	Coverage for at least 12 months after pregnancy
Coverage of lactation supports	Supports for health related social needs (HRSN)	Coverage of reproductive healthcare	Perinatal Risk Assessment

- Register to attend our **NJ TMaH Public KickOff** on Wednesday 2/13 2-3pm here.
- Questions? Email mahs.njtmah@dhs.nj.gov

HealthySteps Coverage within NJ FamilyCare

- HealthySteps is a pediatric primary care model for children under the age of four and their caregivers.
  - **Goal**: Support healthy early childhood development.
  - Currently **ten** HealthySteps practices serving NJ FamilyCare children are supported by alternative funding sources.
- Enacted budget includes funding for NJ FamilyCare to support practices participating in HealthySteps through **enhanced reimbursement** of well-child and sick visits for members ages 0 - 3.
- DMAHS has been working closely with *Zero to Three* (national organization that oversees HealthySteps model fidelity) to implement this enhanced reimbursement.
- Enhanced reimbursement will be effective **7/1/2025.**

NEW JERSEY HUMAN SERVICES

Behavioral Health Integration Status Update

NJ's Behavioral Health Integration Phase 1 went live on January 1

Main Goals of the Integration

1. **Access for members**
   Increase access to services with a focus on member-centered care

2. **Whole-person care**
   Integrate behavioral and physical health for whole person care, with potential to improve healthcare outcomes

3. **Care coordination**
   Provide appropriate services for members in the right setting, at the right time

Phase 1 – Integration of Outpatient BH Services

- MH outpatient counseling / psychotherapy
- MH partial hospitalization
- MH partial care in outpatient clinic
- MH outpatient hospital or clinic services
- SUD outpatient counseling
- SUD intensive outpatient
- SUD outpatient clinic
  - Ambulatory withdrawal management
  - Peers support services
  - SUD care management
- SUD partial care

Many New Standards Have Been Introduced to Drive Behavioral Health Integration Goals

Program Area	New Contract Standards (non-exhaustive)
• Network adequacy, access, and continuity of care	• **MCOs must accept any willing provider for first 24 months** • **MCOs must contract all active FFS providers** • Established time & distance standards by BH service category
• Enrollment and credentialing	• Reduced maximum credentialing turnaround time from 90 to 60 days • Required MCOs to integrate data from third-party platform, CAQH
• Prior authorization	• **MCOs must auto-approve all BH authorizations for the first 90 days of integration** • Established minimum authorization durations • **Reduced non-urgent turnaround times from 14 to 7 days** • Required MCOs to use NJSAMS for SUD prior authorizations
• Care management	• **Adapted CM screening/assessment tools** • Strengthened care management caseload and outreach requirements
• Payment	• Reduced BH claims payment processing from once every 2 weeks to weekly • Reduced BH claims processing turnaround times to align with MLTSS • **Set FFS rates as a floor for MCO reimbursement of BH services**
• Quality monitoring	• Required MCOs to submit annual BH integration quality report
• MCO staffing	• Required hiring of BH medical director, BH care management supervisor, BH quality monitoring supervisor, and BH network relations director

Behavioral Health Integration – Experience to Date

Early Successes

- Members and providers have thus far flagged **minimal concerns** related to the integration
- Successful launch of NJ Substance Abuse Monitoring System (SAMS) capability to allow streamlined SUD provider prior authorization submission to MCOs
- Managed Care Organizations have already contracted and credentialed the **majority of active fee-for-service providers**
- Behavioral health providers are largely **receiving paid claims** in a timely fashion
- MCO behavioral health care management teams are actively staffing up to meet increased demand

Early Challenges

- Providers have reported serving members **without MCO benefits cards**, requiring provider outreach to MCOs to locate MCO ID numbers and submit claims
- MCOs are working to contract and credential all **non-participating fee-for-service providers** to ensure continuity of care for all members
- Stakeholders continue to share recommendations for improvements to NJSAMS
- MCOs and the State are working to communicate billing policies for out-of-network providers during the 90-day transition

Past and Upcoming Member and Provider Trainings to ensure Integration Preparedness

Past Events

Cross Stakeholder

- Bimonthly Advisory Hub – 11/22 & 1/24

Provider Events

- Achieving Success in Managed Care Forum – 10/16
- Claims Provider Training – 10/24
- Prior Auth Provider Training – 11/21
- NJSAMS Training – 11/26 & 12/3
- In-Person Provider Office Hours – 12/5
- Virtual Office Hours – 12/12
- Care Management Training – 12/28

Member Events

- NAMI Presentation – 11/4
- Member Meeting – 12/17

Upcoming Trainings and Forums

Cross Stakeholder

- Bimonthly Advisory Hub – 3/28

Provider Events

- Virtual Provider Office Hours – 2/11
- Claims Provider Training – 2/25
- Prior Auth Provider Training – 3/12

Member Events

- Member Advisory Groups – Biweekly, beginning 1/31

Click here to
register for upcoming trainings

State and MCO Contact Information for Members and Providers

State

Contact Line:
1-609-281-8028

Stakeholder Website

Provider Readiness Packet

Dmahs.behavioralhealth@dhs.nj.gov

Health Plans

Member: 1-855-232-3596 (TTY: 711)

BH Provider:
1-312-342-0439

Website

Member Portal

Member: 1-888-343-3547 (TTY: 711)

BH Provider:
1-862-229-3493

Website

Member Portal

Member: 1-800-682-9090 (TTY: 711)

BH Provider:
1-973-466-6327

Website

Member Portal

Member: 1-800-941-4647 (TTY: 711)

BH Provider:
1-732-623-1044

Website

Member Portal

Member: 1-833-731-2147 (TTY: 711)

BH Provider:
1-732-713-7636

Website

Member Portal

Full directory of BH integration points of contact by MCO and department (e.g., contracting, credentialing, network, etc.) is available here

1115 Comprehensive Medicaid Waiver Demonstration Highlight:
Housing Supports

Housing Supports Overview

Goals	• Help **find & maintain housing** for housing insecure members to **improve health outcomes** • Drive greater connection of the housing and health care ecosystems
Authority	• 1115 demonstration approved by CMS through June 2028
Geography	• Statewide
Services	• **Pre-tenancy services**: case management supports to help member find housing • **Tenancy sustaining services**: case management supports to help members maintain housing • **Residential modification and remediation**: modifications or repairs to home to ensure health & safety • **Move-in supports**: payment to support the setup of new housing or a move, including security deposits • **Does not include payment for rent or housing production**
Eligibility	• MCO enrolled • At least 1 clinical risk factor (e.g., chronic health condition, mental health condition) • At least 1 social risk factor (e.g., homeless, at risk of homelessness)
Provider qualifications	• Pre-tenancy and tenancy sustaining services: organizations with experience serving housing insecure populations; can demonstrate experience via participation in other comparable government programs • Modification and remediation services: licensed home contractors will deliver • Move-in supports: housing supports providers or MCOs can pay directly and be reimbursed for these costs
Admin model	• MCOs responsible for building network, paying claims, authorizing services, and MCO care management • Housing supports providers responsible for delivering services

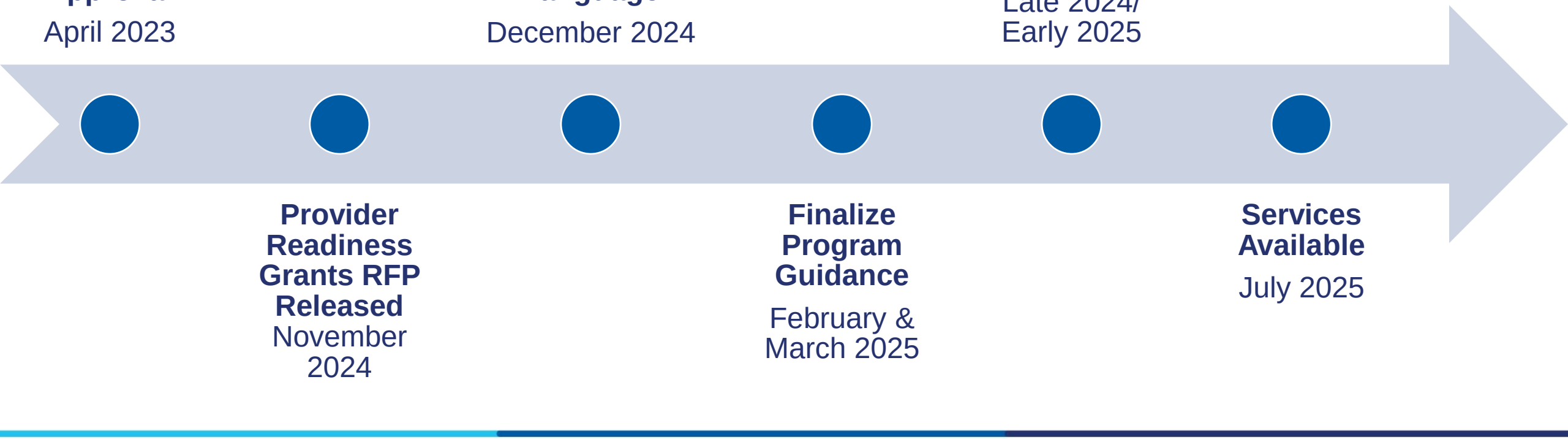
Implementation Update

- **Finalizing program design**
  - Completed drafting MCO contract language for the January MCO Contract
  - Program guidance for the MCOs, which will be public, is in draft form and will be released soon
  - Program guidance for Providers will be released publicly in Q1
  - Service will go-live **July 1, 2025**
- **CMS Approvals**
  - With the recent approval earlier this month of NJ's Housing Payment Methodology, including the rates for new services, NJ now has necessary CMS approvals for launch of services.
- **Significant investment in training and capacity building**
  - Partnership with DCA to provide grants/start-up funding - "*Provider Readiness Grants*"
  - Partnership with the Regional Health Hubs (RHHs) to provide trainings and technical assistance
- **Meaningful stakeholder engagement**
  - Hosted MCO Meet & Greet in August to bring together program partners
  - Continue meeting with housing agency partners and all other stakeholders regularly

Provider Readiness Grants

- DMAHS and DCA are partnering to distribute Provider Readiness grants to eligible housing organizations to incentivize provider readiness and cover startup costs
  - The RFP closed in December and awards up to $250,000 to successful applicants will happen soon
- Housing organizations will **complete "milestones" demonstrating** key steps towards provider readiness (e.g., apply for NPI, contract & credential with MCOs)
- To be considered, housing organizations had to, among other requirements, **prove engagement with at least one MCO** through a **Letter of Intent (LOI)**

Tentative Timeline



Oral Health Update

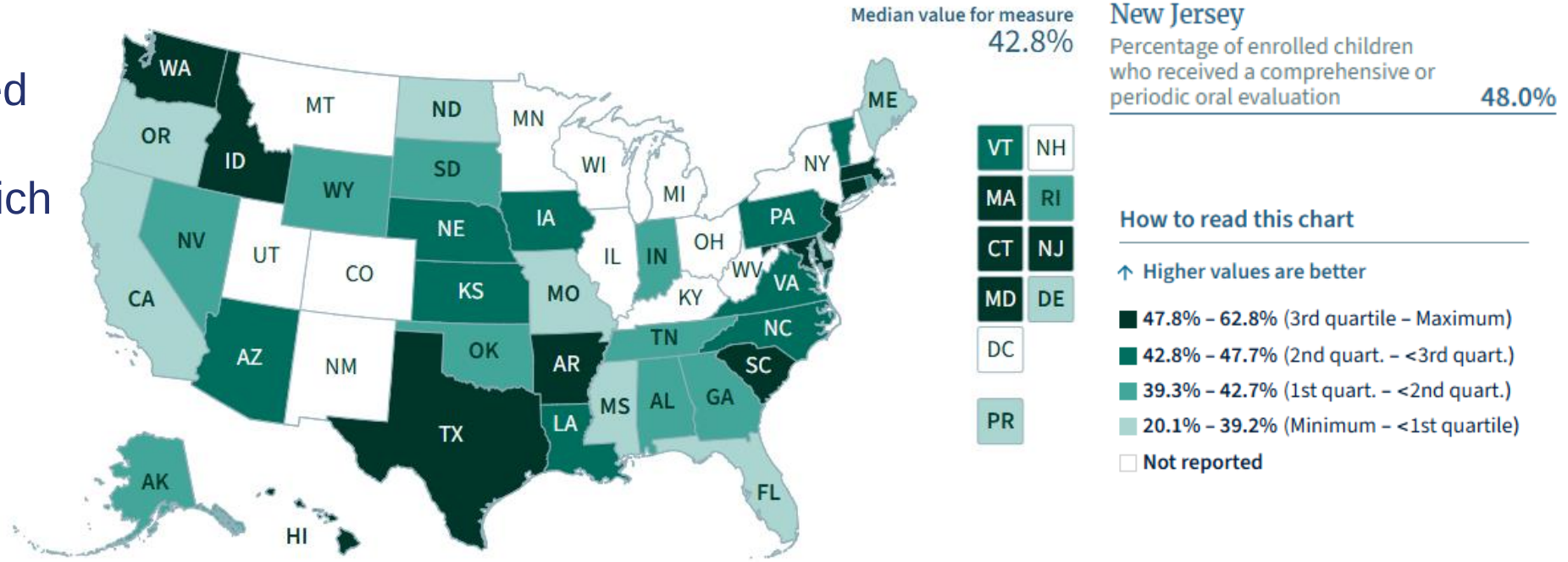
Oral Health: Progress Update

- **Oral health** is an essential component of an individual's well-being, beginning at birth and continuing throughout their lifespan.
- Access to **preventive** dental care is important for all children and necessary for any needed treatment to follow.
  - Key **data-driven** focus area for DMAHS: Improving access to pediatric preventive dental care.
  - Two data updates:
    - Recent **national scorecard** data
    - New Jersey internal time series data – updated to **include 2024**

CMS Medicaid and CHIP 2024 National Scorecard:

Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation

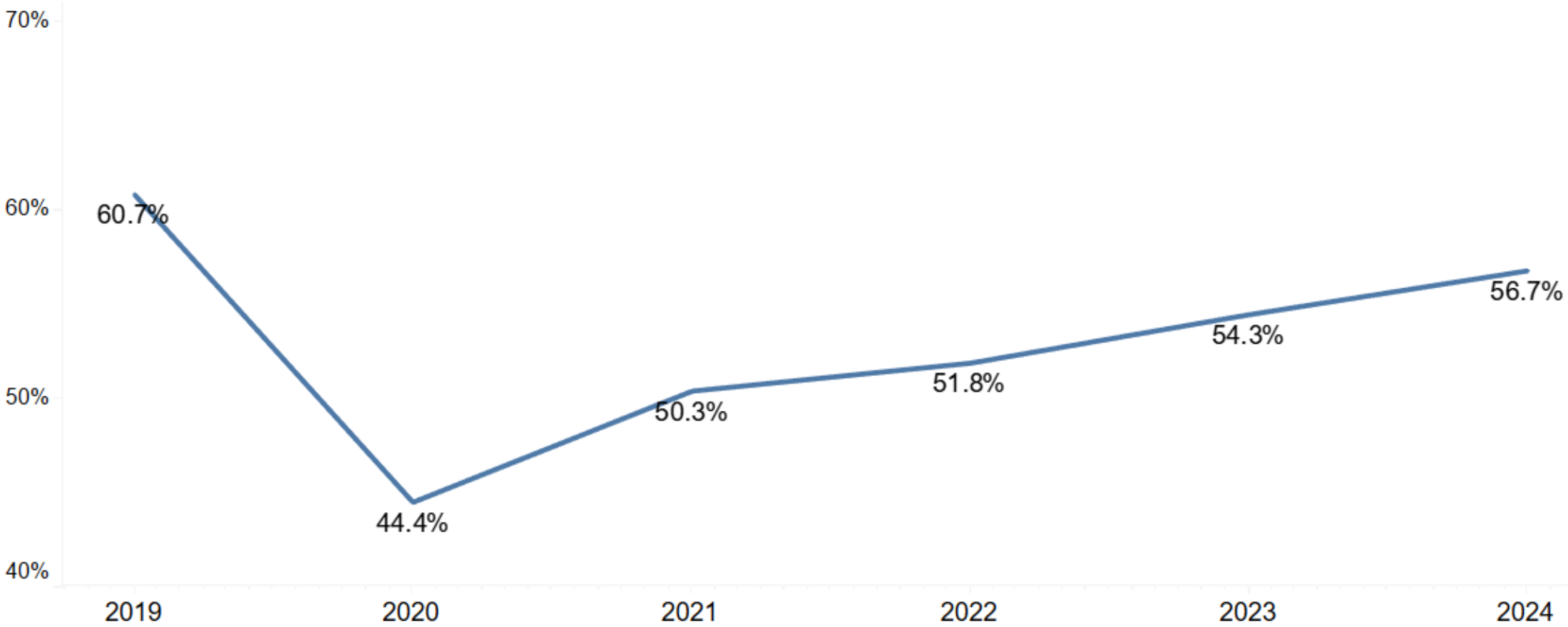
- CMS recently released **2024 Medicaid and CHIP Scorecard**, which includes a pediatric dental measure.
- New Jersey performance:
  - **Above national average**…
  - But still **inadequate** – below 50%.



NJ FamilyCare:

Pediatric Preventive Dental Service Utilization, CY 2019 – CY2024

Percentage of Children in Managed Care Receiving Preventive Dental Service



Source: NJ Medicaid Claims data; accessed 1/6/25
Notes: Preventative dental services defined in current and subsequent slides as procedure codes D1000-D1999, D0120, D0145, D0150 & D0180. CY24 percentages may contain claims lag.
Excludes new recipients not yet assigned to an MCO in the anchor month (Dec of each year).

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Pediatric Preventive Dental Service Utilization, CY 2019 – CY2024

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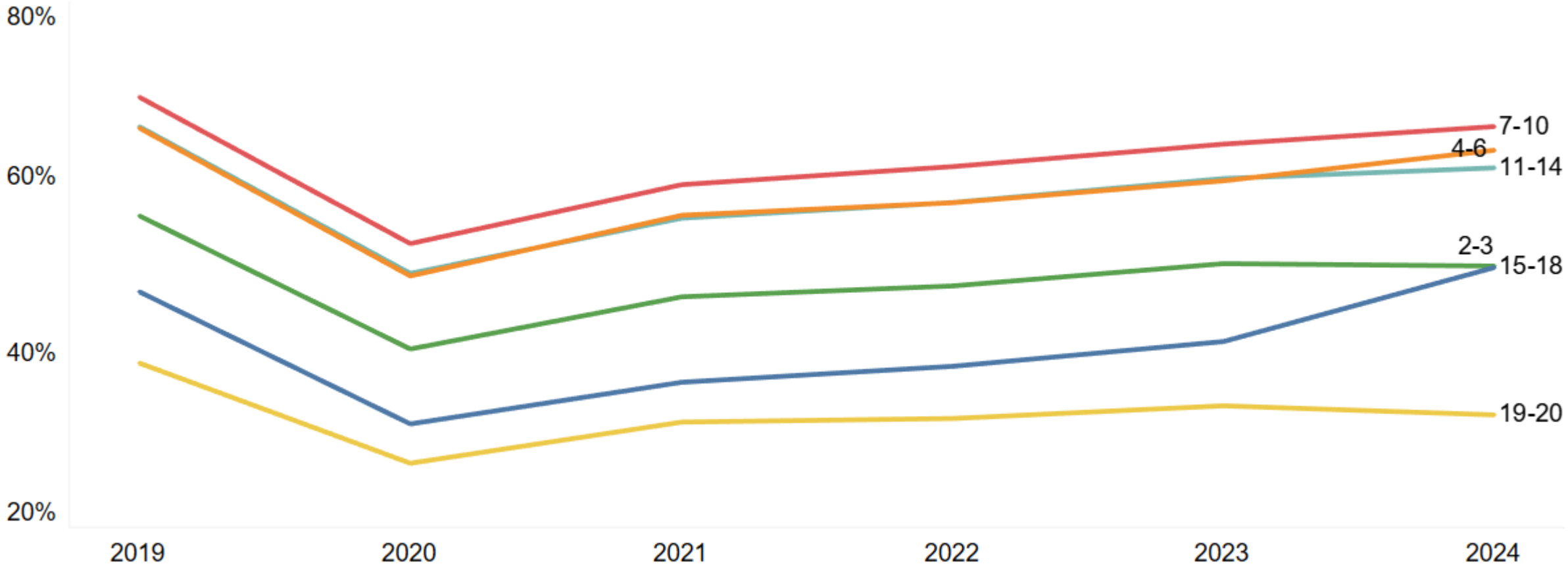

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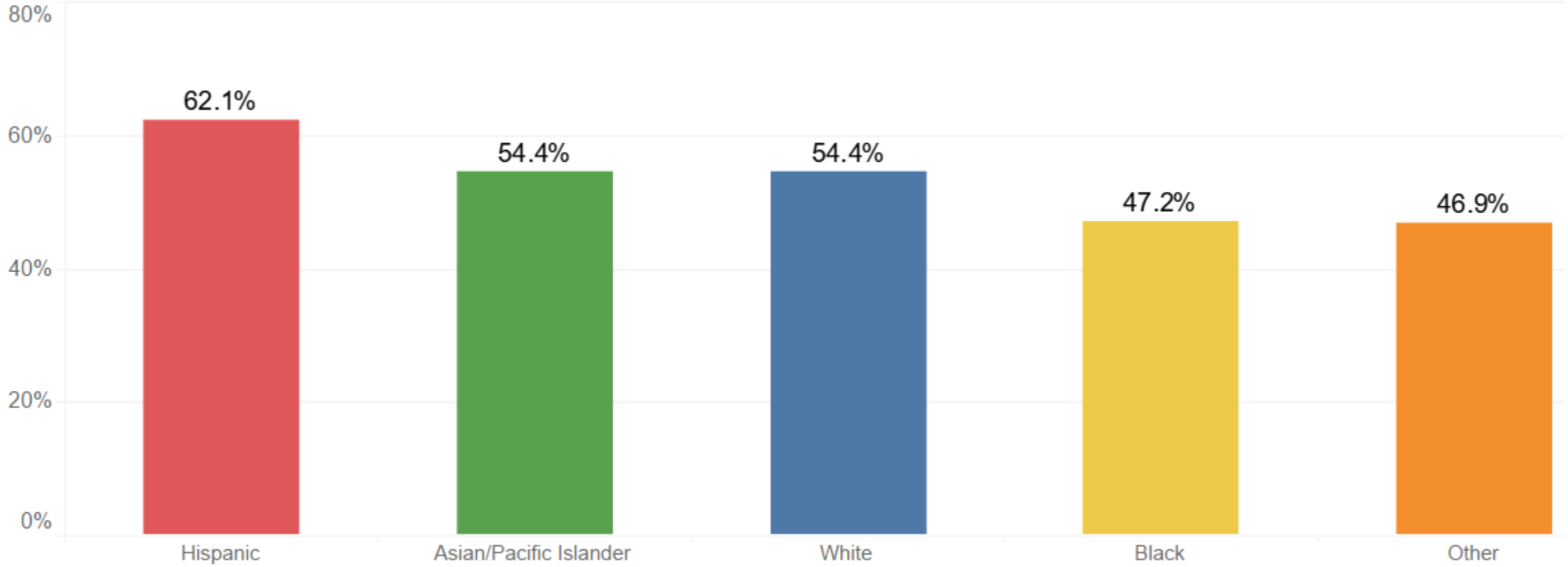
Excludes new recipients not yet assigned to an MCO in the anchor month (Dec of each year). Age as of December of the given year (June for CY24).

NJ FamilyCare:

Pediatric Preventive Dental Service Utilization, CY 2023

Percentage of Children in Managed Care Receiving Preventive Dental Service



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Notes: Notes: Preventative dental services defined in current and subsequent slides as procedure codes D1000-D1999, D0120, D0145, D0150 & D0180. CY24 percentages may contain claims lag. Excludes new recipients not yet assigned to an MCO in the anchor month (Dec of each year). 'Other' includes Native American, Indo-Chinese/Refugee/Cubans admitted after 9/30/78, SSA Classification, Cuban/Haitian (Refugee Act of 1980), and undefined races

Oral Health – Next Steps

- Continue to **strengthen standards** for **financial sanctions** for MCOs not meeting preventive pediatric dental standards:

FY 2024 MCO Contract	FY 2025 MCO Contract
$48 per child up to the **40%** utilization threshold	**$96** per child up to the **40%** utilization threshold
$48 per child up to the **45%** utilization threshold	**$60** per child up to the **45%** utilization threshold
$12 per child up to the **50%** utilization threshold	**$24** per child up to the **52%** utilization threshold

- Active review of MCO compliance with **dental network adequacy** and **member dental directory** standards.
- MCOs with poor performance have been required to develop and implement **corrective action plans**, including:
  - Increased provider rates
  - Incentives for children who have missed needed care
  - Enhanced phone / text / mail outreach

MCO Contract Changes

Effective January 1, 2025

Major MCO Contract Changes – January 2025

Housing Supports

- Defined covered populations
- Specified provider enrollment / credentialing processes
- Defined roles of Housing Specialists / Managers
- Established quality and data reporting requirements

Behavioral Health Integration

- Established stronger utilization management guardrails
- Defined timely processing of provider applications
- Requirements around online provider directories
- Established quality and data reporting requirements

Member Notices

- Required plain language, detailed explanations for certain service denials, terminations, and reductions

MCO Accountability

- Strengthened network adequacy requirements
- Established financial penalties for failure to provide needed MLTSS services
- Strengthened requirements around provision of urgent dental care
- Enhanced pharmacy benefits (CGM, self-administered contraceptives)
- New NF quality and network standards

The January 2025 contract will be posted to “Hot Topics” on the DMAHS website when it has been approved by CMS.
The July 2024 contract, as approved by CMS, is posted here.

Eligibility Issues

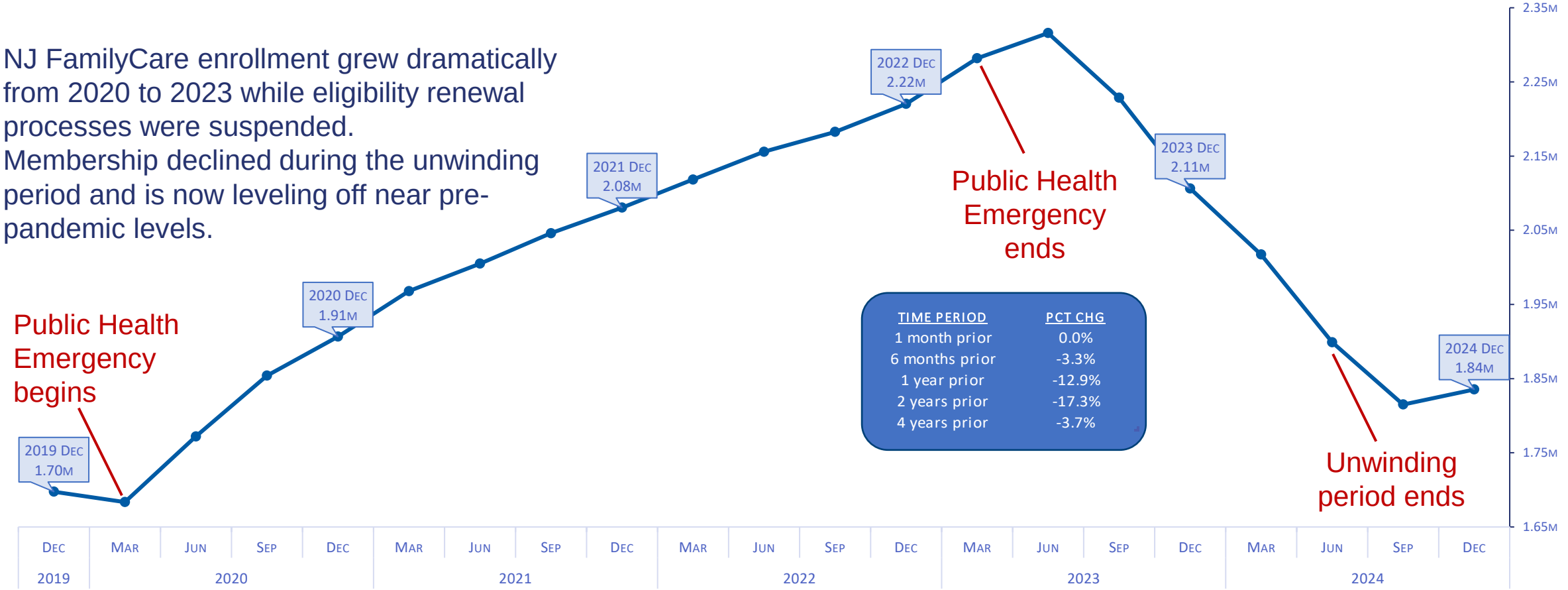
Eligibility Updates

Topics for discussion today:

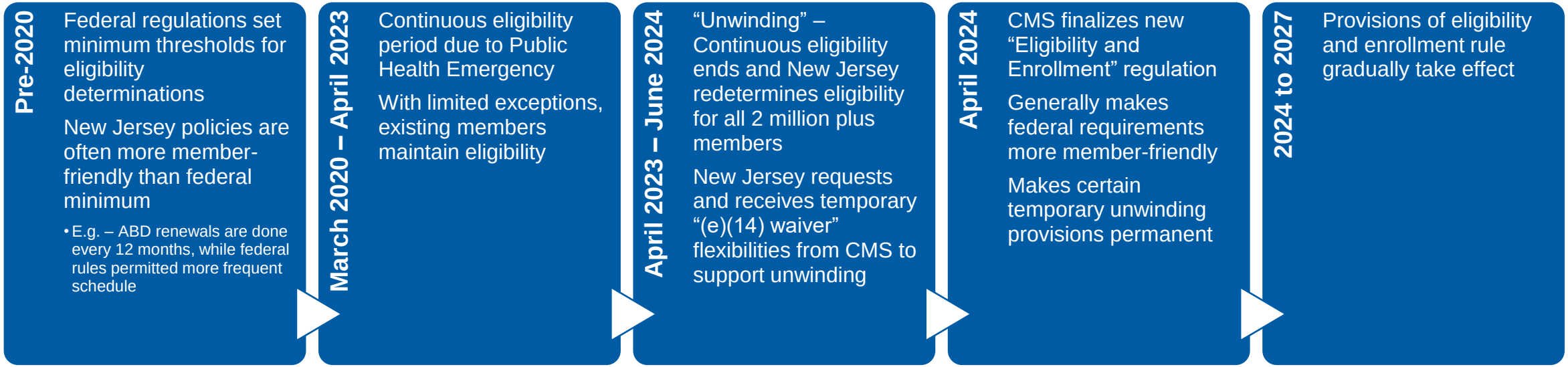
1. Status update on **temporary flexibilities** New Jersey received from CMS during “unwinding”
   - Which will expire in 2025, and which are likely to continue?
2. Status update on New Jersey’s progress addressing gaps in meeting **existing federal eligibility requirements**
   - How has the state addressed issues or gaps identified at the beginning of unwinding?
3. Status update on New Jersey’s work to comply with **new federal eligibility requirements**
   - What has been implemented already?

Background: NJ FamilyCare Enrollment

- NJ FamilyCare enrollment grew dramatically from 2020 to 2023 while eligibility renewal processes were suspended.
- Membership declined during the unwinding period and is now leveling off near pre-pandemic levels.



Background: Medicaid Eligibility Policy - How did we get to here?



Topic 1: Temporary Flexibilities to Support Unwinding

- CMS provided states with **temporary waivers** of existing eligibility and enrollment rules, known as "**e(14) waivers,"** to ease process of renewing members' eligibility during unwinding.
- Waivers generally expire on **June 30, 2025**. However:
  - Some flexibilities were made permanent through the recent **eligibility and enrollment final rule**
  - Some flexibilities **may be extended** at states' discretion through other mechanisms (e.g., state plan amendment)
  - Some flexibilities **do not have a pathway for extension**

Topic 1: Temporary Flexibilities to Support Unwinding

Flexibility	Status
Allows more time for resolution of “fair hearing” requests	Extended through June 30, 2026
Treats initial decision by Administrative Law Judge on certain fair hearings as final Medicaid decision	Extended through June 30, 2026
Allows the state to use updated member mailing addresses provided by USPS and managed care organizations	Made permanent by CMS Eligibility and Enrollment Final Rule
Allows state to use income data from SNAP (food stamp) application to automatically renew members’ Medicaid eligibility	Currently expires June 30, 2025 - however, there is option to extend via State Plan Amendment. DMAHS currently reviewing.
Allows state to automatically renew members who had previously attested to zero income or had income of <100% FPL and for whom no income is found in other data sources	Expires June 30, 2025
Allows state to automatically renew members with stable income sources (such as Social Security or pension) without requesting additional documentation	Expires June 30, 2025

Topic 2: Compliance with Existing Federal Eligibility Requirements

- In 2023, prior to “unwinding” CMS assessed states’ compliance with **existing federal Medicaid requirements**.
- 36 states, including New Jersey, identified areas where improvement was needed, and implemented **“mitigation strategies”**
- In December 2024, CMS requested states provide progress updates on progress towards full compliance with all requirements

Topic 2: Compliance with Existing Federal Eligibility Requirements – Current Status Overview

Ex parte renewals	Renewal forms	Timeline to return renewal forms ☑	Renewal Modalities
Reconsideration period at renewal ☑	Determine eligibility on all bases ☑	Transfer to other programs (e.g. GCNJ) ☑	Renew eligibility once every 12 months ☑

Topic 2: Compliance with Existing Federal Eligibility Requirements – Current Status Overview

- New Jersey is compliant with **vast majority** of eligibility requirements.
- Areas still under development:
    1. *Ex parte* (automatic) renewals:
        - Ensure **all possible data sources** are used when attempting *ex parte* renewal
            - Pilot program with one county planned for Winter 2025
            - Statewide roll-out anticipated by Summer 2025
    2. Renewal Forms
        - Ensure members are not required to provide **duplicative information** on renewal forms
            - Gradual implementation – 2025 to 2026
    3. Renewal Modalities
        - Allow non-MAGI members to renew **via phone**
            - Target statewide availability by December 2025
        - Allow non-MAGI members to renew **online**
            - Pilot currently underway, statewide renewal targeted for availability in Summer 2025

Topic 3: New Federal Eligibility Requirements

- In 2024, CMS finalized new federal **eligibility and enrollment** regulations.
  - Full title: “Medicaid Program: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes"
- Final rule went into effect on **June 3, 2024**
  - Effective dates for individual provisions of the rule are as late as 2027
  - However, some provisions have already taken effect.

Topic 3: New Federal Eligibility Requirements

- The following provisions of the eligibility and enrollment rule are already in place or will take effect by the end of 2025:
  - Eliminates **waiting periods** for CHIP
    - ✓ New Jersey is compliant
  - Requires **seamless transition** between Medicaid and CHIP
    - ➢ New Jersey is compliant with transition requirements and working on updating related member notices
  - Requires states to accept **reliable third-party** (MCO, USPS) information about **address changes**
    - ✓ New Jersey is compliant (implemented during “unwinding” via a waiver)
  - Requires states to make **good faith effort** to contact beneficiaries with **returned mail**
    - ➢ New Jersey is developing a process to outreach to affected beneficiaries (using two forms of contact; for example, phone call and text) and send confirmation notice

Legislative Implementation Update

A4049: Presumptive Eligibility for Home and Community Based Services

Background: Presumptive Eligibility

- What is Presumptive Eligibility?
  - Provides **temporary health insurance coverage** for certain individuals who receive services from certain provider types:
  - Application is submitted by **certain eligible provider** types:
    - FQHCs
    - Hospitals
    - Behavioral health providers
    - Family planning centers
  - Coverage is **fee-for-service** (no managed care enrollment), and time-limited
    - Intended as a **"bridge"** – covers services, while eligibility for full Medicaid/CHIP is assessed.
  - Currently **limited to low-income children, parents, and working age adults** – does not include aged, blind, disabled eligibility groups.

A4049: Key Elements

Intent of Legislation

- Expand presumptive eligibility to individuals requiring Home & Community Based Services (HCBS)
- Allows temporary coverage of services, while full eligibility is determined

Implementation Date

- July 2026 (30 months after enactment)
- Contingent on relevant federal approvals

Eligible Population

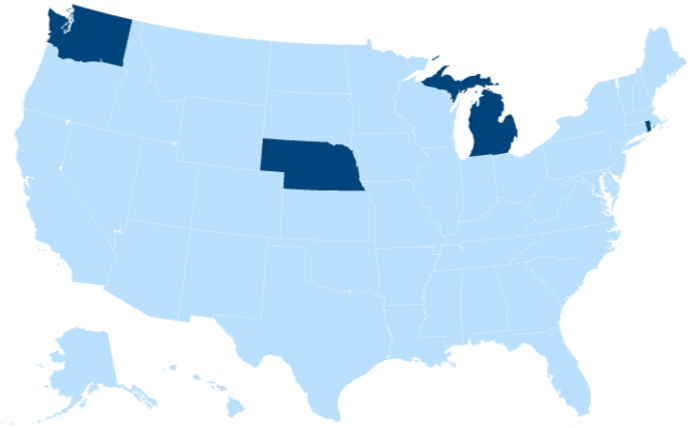
- Individuals who require HCBS and live in the community
- Likely to be clinically and financially eligible for MLTSS or PACE

Duration of Coverage

- Begins when presumptive eligibility is granted
- Ends either (1) when full eligibility determination is made OR (2) end of month after presumptive eligibility is granted if no application is filed

Presumptive Eligibility – Peer States

- Four other states have some version of presumptive eligibility program for HCBS.
  - Washington: PE for Home & Community Services (HCS)
    - Clinical eligibility **must be determined** by screening interview by HCS case manager, social worker or Area Agency on Aging
    - Not yet fully approved by CMS; in Phase II of implementation
    - Federal approval through 1115 waiver
  - Rhode Island: Expedited Eligibility
    - PE with **limited services** begins **after full application is submitted** and **clinical eligibility is established** by treating physician and verified by RI Department of Human Services
    - Federal approval through 1115 waiver
  - Michigan Presumptive Eligibility for MI Choice Waiver
    - Presumptive Eligibility begins **upon verification of clinical eligibility** by waiver agency
    - Federal approval through 1915(c) waiver
  - Nebraska Waiver While Waiting
    - Presumptive Eligibility begins **after full application is submitted** and service coordinator **confirms functional and clinical eligibility**
    - Federal approval through 1915(c) waiver



Presumptive Eligibility for HCBS: Major Challenges

1. Providers

- ❑ **Key question:** which provider types should be eligible to submit HCBS presumptive eligibility applications?
- ❑ **Key question:** Which services / provider types should be covered?
  - Some peer states limit to certain services; likely would not make sense to include certain services (e.g. assisted living) before full eligibility is confirmed.

2. Clinical Eligibility

- ❑ **Key question:** how to integrate clinical eligibility determination into presumptive eligibility process?
  - As part of application for MLTSS / PACE services, members must be assessed for clinical level of need. Generally, nursing home level of care is required to qualify.
  - Peer states generally require clinical eligibility to be **fully established** before presumptive eligibility begins

Presumptive Eligibility for HCBS: Major Challenges *(continued)*

3. Service Reimbursement

❑**Key question:** How to reimburse for managed care only services, before eligibility is confirmed?

- Current presumptive eligibility program services are provided through **fee-for-service**. However, PACE and many MLTSS services are **not available** through fee-for-service.

4. CMS Authority

❑**Key question:** How to receive federal authority for implementation?

- All four peer states have relied on **waiver authority** – likely timeline for approval of amendment to **New Jersey 1115 demonstration** is ~2 years

A4049 Implementation: Next Steps

- Develop **options** around key **open policy** questions.
  - Identify and engage key stakeholders for feedback.
- Begin **IT systems development** planning.
  - Current PE process is specific to MAGI application – will need to be adopted / upgraded for ABD.
- Begin **conversations with CMS** around pathways timelines for federal approval.
- Begin developing **guidance / training materials** for providers, applicants, and county social service agencies.

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) Updates

MAC/BAC – Background

- Background: In 2024, CMS finalized rulemaking that:
  - Established new requirements around **Medicaid Advisory Committees (MACs)**
  - Required states to establish a **Beneficiary Advisory Council (BAC)**
- October 2024 MAAC meeting included active discussion NJ implementation of requirements.
- Key takeaways:
  - DMAHS should ensure BAC and MAC members represent **varying perspectives and lived experience**
  - DMAHS should review best practices from other states around **BAC member engagement**
  - BAC members should be **reimbursed** for time and expenses
  - MAC and BAC member terms should be **staggered** to support institutional knowledge and continuity, while supporting fresh perspectives
  - DMAHS should consider both **virtual** and **in-person** formats for MAC and BAC meetings
  - DMAHS should **engage local stakeholders** when recruiting MAC and BAC committee members

MAAC and BAC Bylaws

- Based on MAAC member feedback, DMAHS is developing **Bylaws**.
- Draft/provisional **elements** include:

Key Focus Areas

Services

Providers

Care Coordination

Quality

Eligibility and Enrollment

Communications

Cultural Competence

Membership:

MAC: Up to 15 voting members (25% from BAC)

BAC: Up to 9 voting members

Staggered 3-year terms

No consecutive terms for members

Public Postings:

Governing Bylaws

Meeting minutes and recordings

Membership lists

Meetings:

Quarterly meetings

Mix of virtual and in-person

Public comment periods twice / year

BAC Member Compensation:

Payment of $75 per meeting, plus expense reimbursement

MAC and BAC Nominations

MAC Members:

- Open to all members of community, including:
  - State or local consumer advocacy groups or community-based organizations that represent or provide services to Medicaid members
  - Clinical providers or administrators
  - Participating MCOs or health plan association
  - Ex-officio State agencies serving Medicaid members

BAC Applicants:

- Must be:
  - Current or former NJ Medicaid members; or,
  - Individuals with direct experience supporting Medicaid members (family members, paid or unpaid caregivers)

MAC and BAC Nominations:

- Nomination form is available here.

Next Steps

1

Complete drafting of **Bylaws** and share with existing MAAC members for review.

2

Conduct **additional public and stakeholder** outreach for MAC and BAC member nominations.

3

Select **new MAC members** and **convene BAC.**

- Target Date: **July 2025**

Planning for the Next Meeting

April 30, 2025