NEW JERSEY HUMAN SERVICES

Meeting of the Medical Assistance Advisory Council

July 17, 2025

Agenda

- Welcome and Call to Order – Dr. Deborah Spitalnik
- Federal Updates – Gregory Woods and Natalie Kotkin
- New Jersey Enacted Budget: State Fiscal Year 2026 Updates – Gregory Woods
- Managed Care Contract Changes – Lynda Grajeda
- Presumptive Eligibility for Home and Community-Based Services – Kristine Byrnes
- Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) Updates – Gregory Woods
- Doula Program Update – Jon Tew
- 1115 Comprehensive Demonstration – Jon Tew
  - Housing Supports Services – Jon Tew
  - Behavioral Health Integration – Shanique McGowan
- Planning for the Next Meeting – Dr. Deborah Spitalnik
- 1115 Comprehensive Demonstration Post-Award Forum – Jon Tew and Stacy Grim

MAAC and Post-Award Forum Logistics

- We are running the Medical Assistance Advisory Council meeting and the 1115 Comprehensive Demonstration Post-Award Forum back-to-back today.
- We will post the recording of these two events on the MAAC page for people to watch if they are unable to attend.
- Everyone is welcome to attend both meetings today. The formal MAAC will adjourn prior to the Post-Award Forum. No one will have to log out of the MAAC to log back in for the Post-Award Forum.
- People who are not able to stay for the Post-Award Forum or have technical difficulties are welcome to send comments on the implementation of the 1115 Comprehensive Demonstration to DMAHS.CMWcomments@dhs.nj.gov by August 22, 2025.

NEW JERSEY HUMAN SERVICES

H.R. 1 – Federal Reconciliation Bill

Key Medicaid Impacts

H.R. 1 (“One Big Beautiful Bill”): What does it mean for NJ FamilyCare?

Bergen Record

When will Medicaid cuts take effect in NJ now that the 'Big Beautiful Bill' has passed?

NPR

5 ways Trump's megabill will limit health care access

The New York Times

Why a G.O.P. Medicaid Requirement Could Set States Up for Failure

WSJ

How Healthcare Cuts in the ‘Big, Beautiful Bill’ Will Affect Americans

Medicaid Impacts: Key Themes

1

Net impact: large cuts to Medicaid

- CBO estimates total impact **>$1 trillion** over ten years
- Largest sources of cost savings:
  - **Lost coverage** due to new **eligibility requirements** and associated paperwork burden
  - Cuts to **provider payments**

2

Targeted focus on Affordable Care Act Medicaid expansion

- Affordable Care Act expanded Medicaid for working age adults
  - Bill imposes significant new **eligibility and paperwork** requirements **only on this population**
  - Bill imposes **new cost-sharing** (co-pays) **only on this population**
  - Bill gives **large financial benefits to states that have chosen not to expand Medicaid** – including far greater flexibility in directing Medicaid dollars to hospitals and other providers

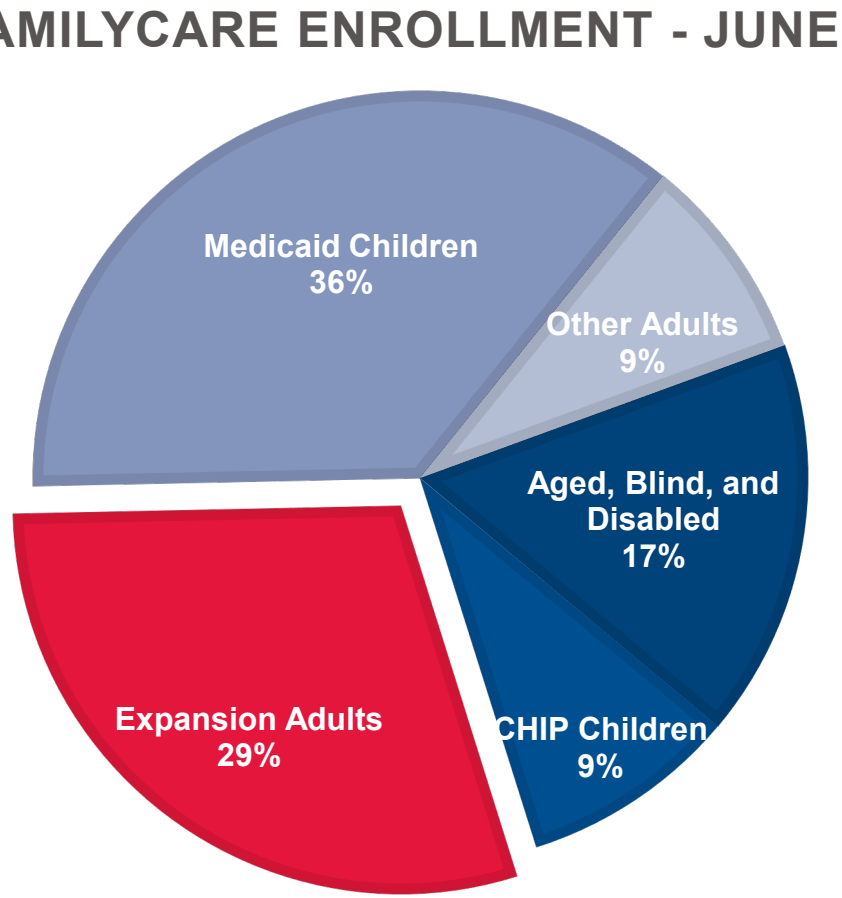
3

Provisions with largest impact are not effective immediately

- Key eligibility changes take effect at the **end of 2026**
- Cuts to provider payments **begin in 2027**, and gradually ramp up

NJ FamilyCare Enrollment

- As of June 2025, total enrollment in NJ FamilyCare was around **1.85 million** members.
- Of these, nearly **550,000 (29%)** are adults in the Affordable Care Act expansion group.



Key Medicaid Provisions

Eligibility Changes

- Mandatory “Community Engagement Requirements” (**Work Requirements**)
- Increased **frequency of eligibility checks**
- Changes to **"retroactive" Medicaid / CHIP eligibility**
- **Elimination** of Medicaid eligibility for many categories of **documented immigrants**

Financing Changes

- Restrictions on **Provider Taxes**
- Restrictions on **State-Directed Payments**
- **Reduced federal financing** for **“emergency Medicaid”**
- Mandatory **federal recoupment** of funding flagged by **audits**
- Stricter “**budget neutrality**” requirements for 1115 demonstrations

Other Changes

- Mandatory **cost-sharing** (co-pays) for certain members
- Prohibits federal Medicaid funding for **Planned Parenthood**

Eligibility Provisions

Deep Dive

Mandatory Work Requirements

Background

- Currently, there are no **“community engagement”** or **work requirements** for most NJ FamilyCare applicants

Enacted Bill Provisions

- Requires **working age adults** enrolled in **Affordable Care Act expansion group** to meet “community engagement” or **work requirements** (see subsequent slide for more detail)
  - **Certain populations** are **exempt**
- Work requirement **can not be waived**
- States must implement by **December 2026** (Deadline can be extended at federal discretion to 2028)

Likely New Jersey Impacts

- Up to **300,000 individuals lose (or fail to obtain) Medicaid coverage**
  - Based on experience of other states, majority are likely to be ineligible based on **difficulty producing required documentation**
- Could result in **$2.5 billion** in **lost federal investments** in New Jersey’s healthcare system each year.
- Extensive administrative burden and cost

Next Steps

- Develop **NJ-specific policies** around how members can demonstrate they meet the requirement
- **Identify / reconfigure** data sources and systems to verify member compliance
- **Hire and/or repurpose eligibility staff** or **vendors**
- Begin member **outreach and education**

Work Requirements: Deeper Dive

Who is subject to the work requirement?

- **Working age adults (19 – 64)** enrolled in the **Affordable Care Act expansion group**
  - Currently, approximately **550,000 members**

How can individuals comply with the requirement?

- **Working** 80 hours / month
  - NB: Earned income equal or greater to **80X the federal minimum wage** is considered sufficient evidence of compliance
- Completing 80 hours / month of **community service**
- **Attending school** 80 hours / month

How frequently must Medicaid members comply with this requirement?

- At least **once every six months**

Work Requirements: Deeper Dive (cont.)

Who is exempt?

- **Pregnant** and **postpartum** members;
- **Foster youth** and **former foster youth** under the age of 26;
- Members of a **Tribe**;
- **Veterans** with **rated disabilities**;
- Individuals who are considered **medically frail,** likely including individuals with serious mental illness, substance use disorder, and intellectual / developmental disabilities;
- Individuals receiving care in certain **substance use disorder treatment programs**;
- Individuals who have shown compliance with work requirements under **TANF** or **SNAP**;
- **Parents** or **caregivers** of dependent **children under 13** and **individuals with disabilities**; and
- **Incarcerated** or **recently incarcerated** individuals.
- Certain other groups may qualify for temporary hardship exemptions, including:
  - Residents of counties experiencing **natural disasters**
  - Residents of counties with **high unemployment rates**
  - Individuals **seeking care out-of-state**

Increased Frequency of Eligibility Checks

Background

- Currently, NJ FamilyCare redetermines eligibility for all members **once per year** (i.e., every 12 months)
- New Jersey has worked to make it easier for eligible individuals to remain enrolled, but **eligible individuals** can **lose coverage** during redeterminations (i.e., “churn” off coverage)

Enacted Bill Provisions

- Medicaid agencies must **redetermine eligibility for ACA adult expansion group once every 6 months**
- Because the adult expansion group is subject to work / community engagement requirements, **most expansion adults will need to prove they meet work requirements at least twice per year**
- This provision becomes **effective for redeterminations occurring on or after December 31, 2026** (coinciding with work / community engagement requirements)

Likely New Jersey Impacts

- Up to **50,000 lose Medicaid coverage** due to inability to prove eligibility every 6 months
- Could result in **$400 million in lost federal investments**
- Extensive **burden on impacted members as well as state and county eligibility workers**

Next Steps

- Hire and/or repurpose **eligibility staff** or **vendors**
- Begin **member education**

Changes to Retroactive Eligibility

Background

- Currently, new Medicaid enrollees are generally eligible for **three months** of "**retroactive coverage**"
- Includes coverage of **unpaid medical bills** from three months preceding application

Enacted Bill Provisions

- Effective January 2027, **reduces retroactive eligibility period to**:
  - **One month** for Medicaid Expansion enrollees
  - **Two months** for all other members

Likely New Jersey Impacts

- Increased **medical debt**, with burdens on both beneficiaries and providers, including nursing facilities

Next Steps

- Reconfigure data systems
- Begin provider and member education

Loss of Eligibility for Some Documented Immigrants

Background

- Currently, **certain groups of non-citizen immigrants** are eligible for **full Medicaid benefits** under federal law

Enacted Bill Provisions

- Effective October 1, 2026, **only Lawful Permanent Residents, Cuban/Haitian entrants, and Compact of Free Association migrants** (from certain Pacific Island nations) will **qualify for Medicaid**
- Various **other immigrant groups** will **lose eligibility** (see next slide for more detail)

Likely New Jersey Impacts

- Approximately 15,000 to 25,000 individuals will **lose Medicaid coverage**

Next Steps

- Update eligibility systems and policies
- Begin member outreach and education
- Assist in identifying **alternative sources of coverage** for individuals no longer eligible for Medicaid

Medicaid Eligibility for Documented Immigrants

Non-Citizens Currently Potentially Eligible for Full Medicaid Benefits

- Legal Permanent Residents
- Refugees
- Individuals granted asylum
- Cuban / Haitian entrants
- Victims of domestic violence, applying under the Violence Against Women Act
- Trafficking victims
- Temporary humanitarian parolees
- Compact of Free Association migrants (from certain Pacific Island nations)

Non-Citizens Potentially Eligible for Full Medicaid Benefits after October 1, 2026

- Legal Permanent Residents
- ~~Refugees~~
- ~~Individuals granted asylum~~
- Cuban / Haitian entrants
- ~~Victims of domestic violence, applying under the Violence Against Women Act~~
- ~~Trafficking victims~~
- ~~Temporary humanitarian parolees~~
- Compact of Free Association migrants (from certain Pacific Island nations)

Fiscal Provisions

Deep Dive

Restrictions on Provider Taxes

Background

- Provider Taxes are targeted taxes on health care providers and health plans
  - Revenue from these taxes are eligible for **federal matching funds**
  - These funds **are reinvested** in the healthcare system**.**
- Current federal rules generally allow such taxes to total **up to 6%** of provider / health plan revenue.

Enacted Bill Provisions

- **Prohibits** all **new provider taxes**
- Gradually **lowers the cap on most** existing provider taxes, from 6% of plan/provider revenue in Federal Fiscal Year 2027, to **3.5%** in Federal Fiscal Year 2032 and beyond
  - NB: This change **only** applies to states that have **expanded Medicaid**

Likely New Jersey Impacts

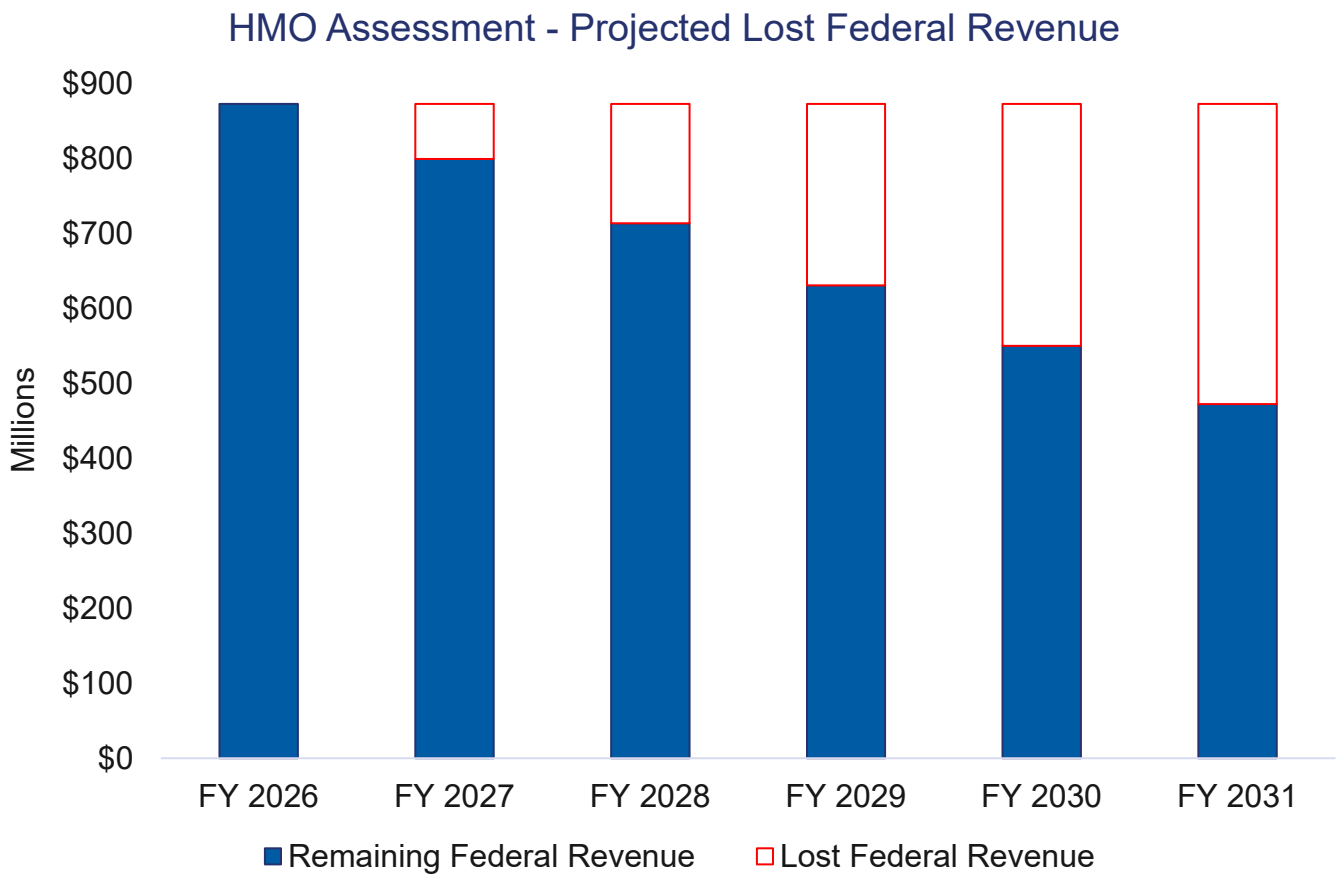
- **Billions of dollars** in lost federal revenues over several years (see subsequent slides for additional detail)

Next Steps

- Identify **options for maximizing federal revenue** under new federal rules
- Analyze budgetary options for **offsetting lost revenue**

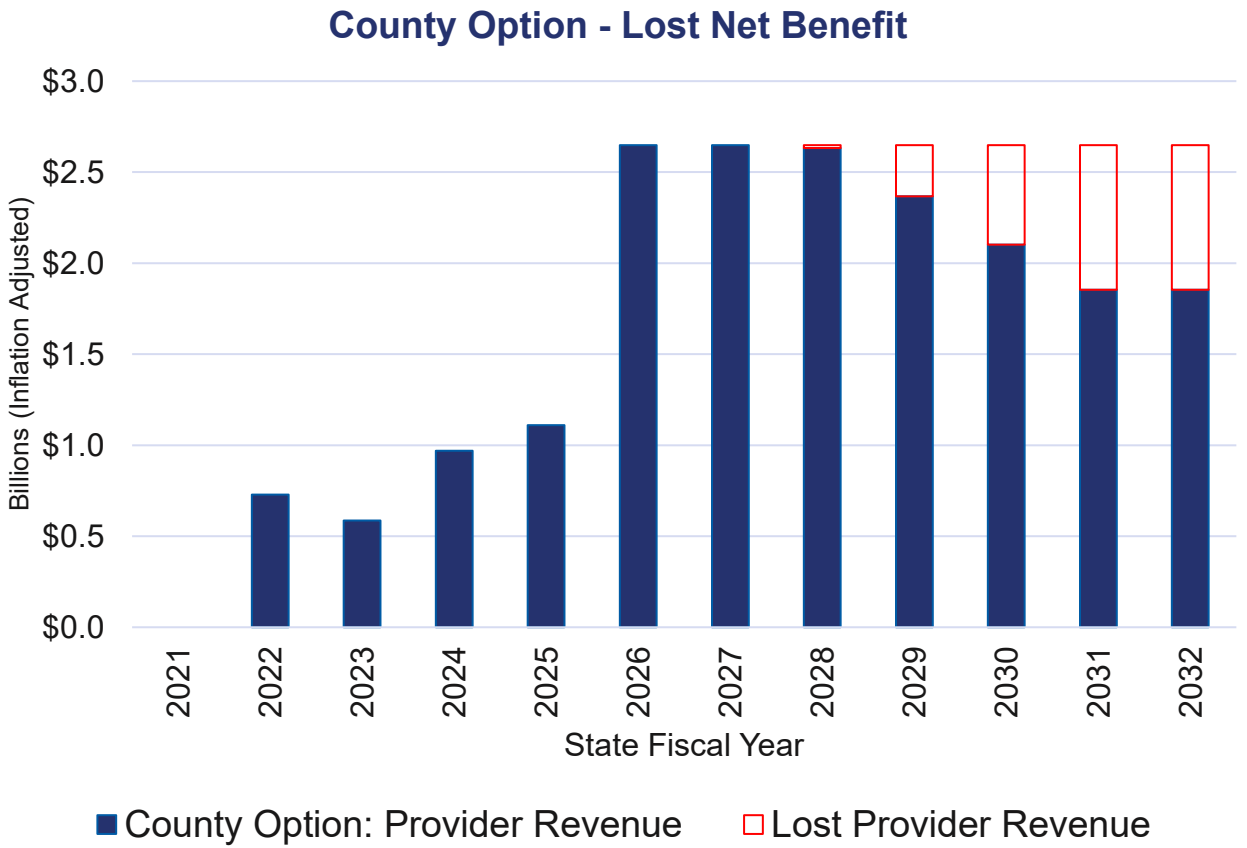
Provider Tax #1: HMO Assessment

- Currently, Medicaid payments to managed care organizations are subject to a 6% “HMO Assessment.”
  - This assessment is projected to generate approximately **$875 million** in federal revenue in SFY 2026.
- By the end of the provider tax ramp down period in 2032, nearly **$400 million** of this revenue will be lost.
  - This **lost funding** currently supports general Medicaid expenditures



Provider Tax #2: County Option Program

- Program that was created in 2021, to allow certain counties to direct additional federal dollars to their hospitals.
  - Currently, 14 counties participate.
- In SFY 2026, County Option is projected to generate **$2.6 billion** in net federal funding.
  - Of this total, vast majority (**~$2.4 billion**) goes directly to participating hospitals.
  - Most of remainder goes to county governments.
- By the end of the provider tax ramp down period in 2032, roughly **$800 million** of this federal revenue will be lost.



Restrictions on State-Directed Payments

Background

- New Jersey (like most states) requires **managed care plans** to make certain add-on payments to health care providers, known as "directed payments"
- Directed payments in New Jersey incentivize **high quality care**, support **training** of new providers, or support **safety net providers**

Enacted Bill Provisions

- Sets new **cap** on **total provider reimbursement** under state-directed payments:
  - **100%** of **Medicare** rates for **expansion states**
  - **110%** of **Medicare** rates for **non-expansion states**
- New directed payments **must comply with the cap** immediately
- Existing directed payments must **be reduced by 10% each year**, starting with rating periods beginning on or after 1/1/2028, until they comply with cap

Likely New Jersey Impacts

- Significant **loss of funding for providers**
  - **Largest impact on hospitals** (see subsequent slide for details)

Next Steps

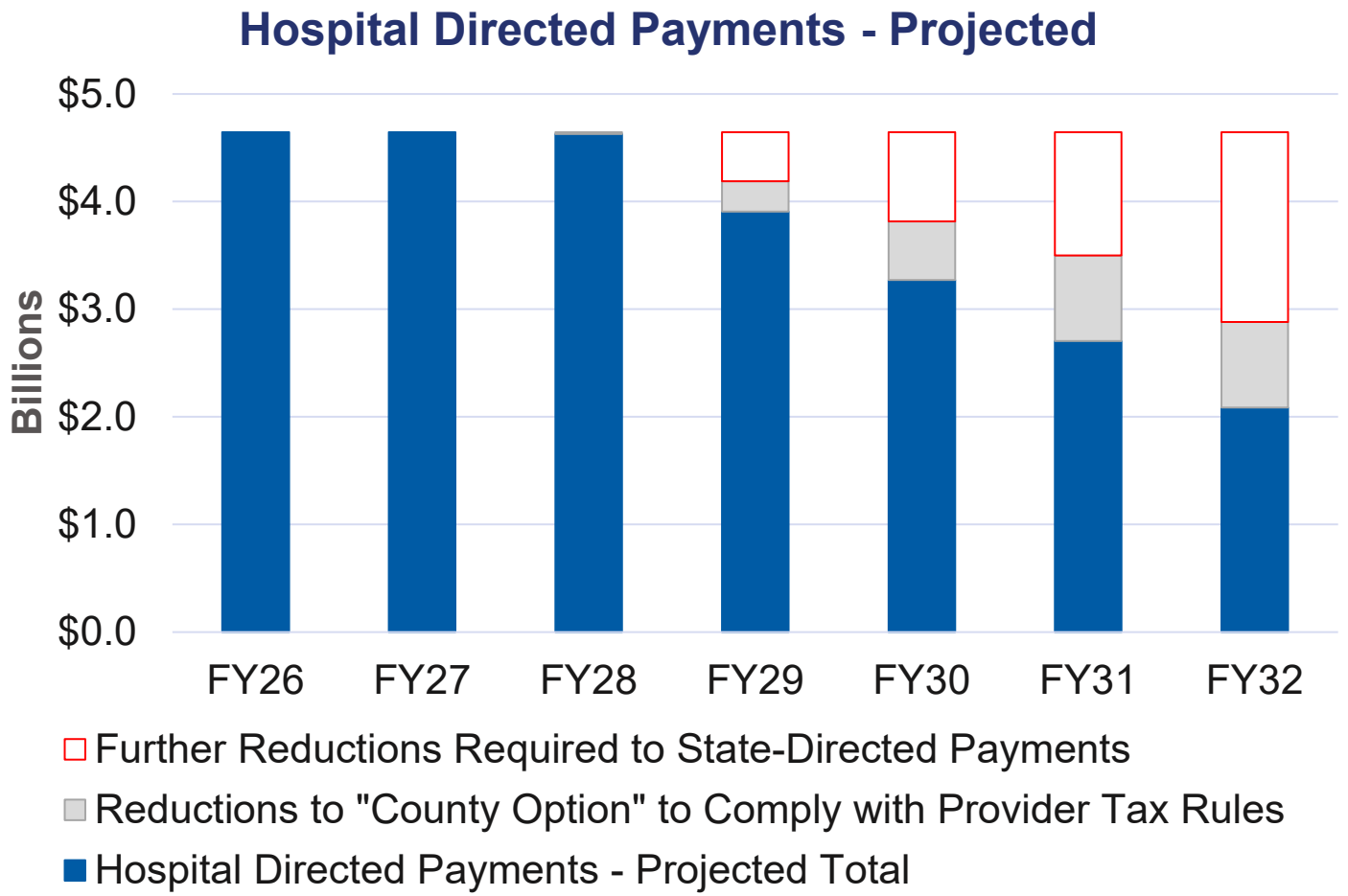
- Identify alternative approaches to provider reimbursement

Restrictions on State-Directed Payments: Hospital Impacts

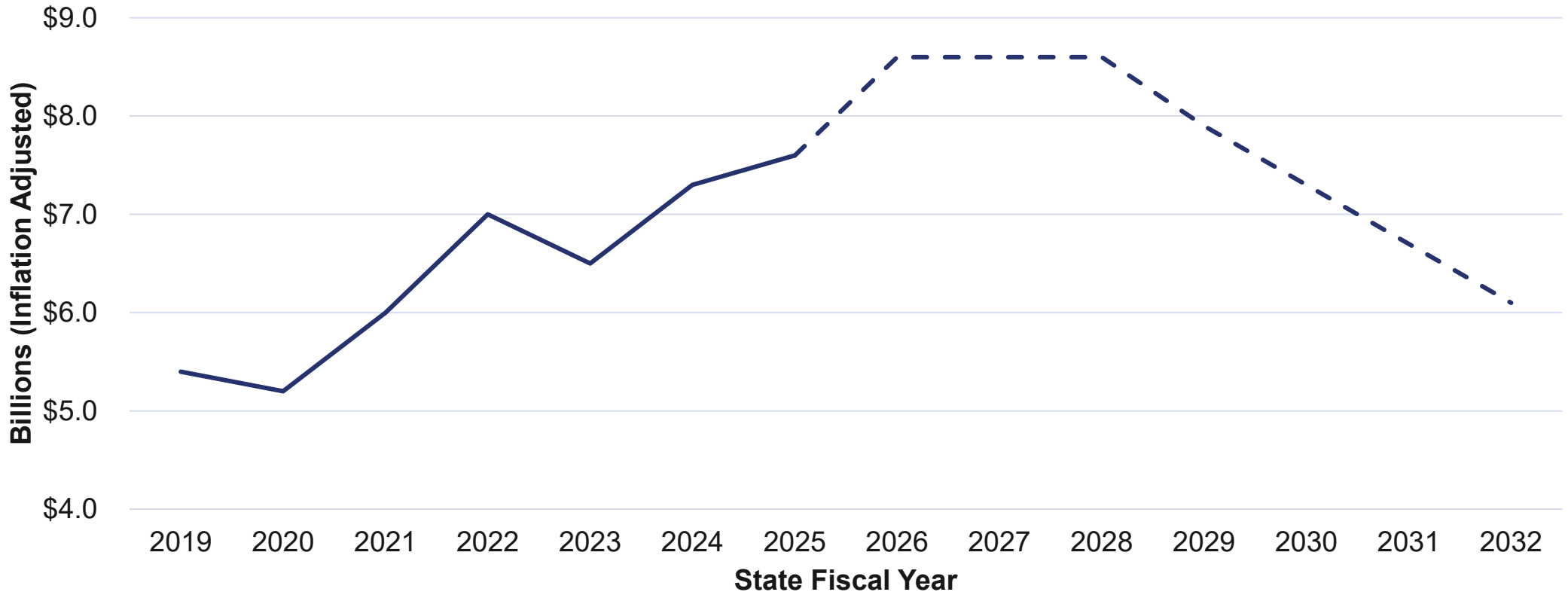
- New Jersey hospitals currently benefit from several distinct state-directed payments, including:
  - **County Option Program** (Discussed in “provider tax” slide)
    - Funds are generated via a provider tax and distributed via directed payment
  - **Outpatient Hospital Supplemental Payments**
    - Redirection of former state “charity care” dollars to maximize federal match
    - Estimated SFY 2026 payments: $592 million
  - **Quality Improvement Program (QIP-NJ)**
    - Pay-for-Performance program tied to quality of maternity and behavioral health care
    - Estimated SFY 2026 payments: $210 million
- Total hospital state-directed payments (inpatient and outpatient) for SFY 2026 are projected at **$4.6 billion**.
- Complying with new federal rules will require reductions to hospital payments that will gradually ramp up to **~$2.8 billion of annual losses** in FY 2032

Hospital Directed Payments – Projected Trajectory

- The reductions to the County Option program described above (to comply with new "provider tax" rules) will also help comply with new "directed payments" rules.
- **However…**
- Taken alone, these reductions will be insufficient. An estimated **$1.8 billion** in **further** hospital payment cuts would be required by SFY 2032.



NJ FamilyCare Net Hospital Expenditures:
Historical and Projected



Reduced federal financing for “emergency Medicaid”

Background

- **“Emergency Medicaid”** offers **limited coverage** for individuals who **lack qualifying immigration status**
  - Covers **emergency services delivered in an inpatient hospital setting**, including labor and delivery
- Today the federal share for emergency Medicaid expenditures is **equal to a comparable individual** who **qualifies for full Medicaid benefits**

Enacted Bill Provisions

- Starting in **October 2026, reduces** federal financial share for “emergency Medicaid” to state’s “base rate”
  - In New Jersey, federal match for most emergency Medicaid adults goes from **90%** to **50%**

Likely New Jersey Impacts

- Loss of approximately **$46 million** in annual federal funding, due to lower match rate

Next Steps

- Analyze **budgetary options** for offsetting lost revenue

Stricter “budget neutrality” requirements for Section 1115 demonstrations

Background

- Large parts of NJ FamilyCare operate under the authority of a federal **“Section 1115” demonstration**
  - Allows **waiver of standard Medicaid rules**, to support innovative program and benefit design
- Historical CMS practice: require 1115 demonstrations be **“budget neutral”** – i.e., not result in higher Medicaid expenditures
  - Calculations / assumptions have traditionally been **negotiable**

Enacted Bill Provisions

- Demonstrations may not be approved or renewed unless they **are certified by the Chief Actuary of CMS** as being **budget neutral**

Likely New Jersey Impacts

- New Jersey’s 1115 Demonstration **must be renewed / extended in 2028**
- More stringent budget neutrality requirement may **delay or prevent renewal** of **key demonstration elements**

Next Steps

- Develop / strengthen **evidence base** for cost efficiency of existing 1115 demonstration elements
- Closely **track further guidance / action from CMS** on implementing new requirement

Mandatory recoupment of federal funding flagged by audits

Background

- CMS conducts **Payment Error Rate Methodology (PERM)** audits of each state once every three years
  - Audits are intended to identify **inappropriate** or **inadequately documented** payments
- States are **required to repay funds** for error rates **above 3% - however**, federal government has typically granted **"good faith waivers"** to states that are taking corrective action to address errors

Enacted Bill Provisions

- Effective October 2029, CMS's ability to offer **"good faith waivers"** of federal recoupment is limited
- Bill language is ambiguous – but appears to **require** CMS to recoup federal funding from states for many types of errors
- **Other audit findings** (both federal and state) may also be considered and **count towards states' error rates**

Likely New Jersey Impacts

- Highly uncertain – but could be **significant loss of federal funds** depending on how CMS implements new requirements

Next Steps

- Await **further federal guidance** on interpretation / implementation of this provision

NEW JERSEY HUMAN SERVICES

Other Provisions

Deep Dive

Mandatory cost-sharing (co-pays) for certain members

Background

- Today**, NJ FamilyCare does not impose any cost-sharing** on most individuals enrolled in Medicaid
  - i.e. most individuals enrolled in Medicaid **do not have to pay co-pays** to access care

Enacted Bill Provisions

- Starting October 2028, states **must impose cost-sharing for most services for ACA expansion enrollees** with incomes between 100% and 138% of the Federal Poverty Level
- Cost sharing must be between **$0 and $35 per service**, and **may not exceed 5% of an individual's family income**
- **Certain services are exempted from this requirement**, including primary care, prenatal care, pediatric care, and emergency care, as well care delivered in an FQHC or CCBHC

Likely New Jersey Impacts

- Cost-sharing requirement **may reduce use of routine healthcare services**, and **may increase individuals delaying care** until their needs are emergent
- Extensive **burden on Medicaid program** to establish co-pay amounts, educate providers, and update systems

Next Steps

- **Define services** that will require cost-sharing and establish **schedule of co-pays**
- Identify and implement necessary **system changes** required to establish cost-sharing

Prohibits federal Medicaid funding for Planned Parenthood and other abortion providers

Background

- **Federal funding may not be used to cover abortion care**, including through Medicaid, due to the longstanding "Hyde Amendment"
- However, **abortion care services are a covered benefit in New Jersey FamilyCare**; the State fully funds these services

Enacted Bill Provisions

- Federal Medicaid funding **may not be used to pay certain family planning providers that provide abortion care and received at least $800k in Medicaid payments in FFY2023** for a one-year period beginning at enactment
- While this provision does not reference specific providers, it is **generally understood to target Planned Parenthood**

Note: *This provision has been halted for a 14-day period beginning 7/7/25 for Planned Parenthood as part of ongoing litigation*

Likely New Jersey Impacts

- New Jersey is still calculating the impact of this provision.
- Planned Parenthood indicated that **200 clinics in 24 states are at risk of closure** due to this provision, **most of which are in states like New Jersey** where abortion care is legal

Next Steps

- Monitor ongoing litigation
- Conduct analysis of provider impact

H.R. 1 – Federal Reconciliation Bill

Medicaid Recap

Provisions that were considered, but not included in final legislation:

- Reduce the federal share for ACA expansion adults from 90% to 80% in states that use state-only dollars to provide coverage to certain groups of immigrants
- Eliminate the 50% “floor” for the share of Medicaid & CHIP costs paid by the federal government (federal share)
- Eliminate the 90% federal share for ACA expansion adults
- Set caps on the amount of federal Medicaid funding that can be spent on an individual (per capita caps)

Summary of Key (projected) New Jersey Impacts

Enrollment Impacts

- Up to **350,000 individuals** at risk of losing coverage due to work requirements and more frequent eligibility checks
- Estimated **15,000-25,000 individuals** lose coverage due to more restrictive immigration eligibility criteria

State Financial Impacts

- Loss of estimated **$400 million** generated annually by HMO assessment
- Loss of approximately **$45 million** due to reduced federal support for emergency Medicaid
- Need for **large investments in new eligibility systems and resources**

Provider Financial Impacts

- Hospitals' loss of **$2.8 billion** annually due to restrictions on provider taxes and directed payments
- Additional losses (likely billions in total) across the healthcare system, due to lower NJ FamilyCare enrollment

Other Impacts

- Potential **reduced utilization of services** due to new cost-sharing requirements
- Potential **loss of access** to **services** provided by Planned Parenthood
- Significantly **increased member burden** to prove eligibility
- Increased **eligibility workload** and **reduced County Option revenue** for county governments

Key Provision Due Dates

July 4, 2025

- Restrictions on Provider Taxes begin with a cap on new tax approvals of 6%
- Restrictions on State-Directed Payments (SDP) begin with a cap on new SDPs of 100% of Medicare rates (for expansion states)
- Stricter “budget neutrality” requirements for new 1115 demonstration approvals
- Delays Biden era nursing facility minimum staffing rule and eligibility rules
- Prohibits federal Medicaid funding for Planned Parenthood

2026

October 1, 2026

- Elimination of Medicaid eligibility for many categories of documented immigrants
- Reduced federal financing for “emergency Medicaid”

December 31, 2026

- Mandatory “Community Engagement Requirements” (Work Requirements)
- Increased frequency of eligibility checks

January 1, 2027

- Changes to retroactive Medicaid / CHIP eligibility

Key Provision Due Dates (cont.)

Oct 1, 2028

- Mandatory cost-sharing (co-pays) for certain members
- Existing Provider Tax Phase Down begins: 6% ceiling moves to 5.5% (rate of reduction is 0.5% per year)
- Existing SDPs begin to phase down at a rate of 10% per year until they reach the new 100% of Medicare rate cap)

Oct 1, 2029

- Mandatory federal recoupment of funding flagged by audits
- Provider Tax Phase Down continues: moves to 5%

Oct 1, 2030

- Provider Tax Phase Down continues: moves to 4.5%

Oct 1, 2031

- Provider Tax Phase Down continues: moves to 4%

Oct 1, 2032

- Provider Tax Phase Down continues: moves to 3.5%

NEW JERSEY HUMAN SERVICES

New Jersey Enacted Budget: State Fiscal Year 2026

Enacted FY 2026 Budget: Key Medicaid Highlights

- Significant year-over-year **organic cost growth** (consistent with national Medicaid trends)
- New **administrative savings and efficiencies**
  - Includes repurposing other financing streams, and maximizing federal revenues
    - Includes changes to **directed payments / provider taxes** – long term sustainability highly uncertain
- Provider Investments
  - Significant **rate increases** for **primary care**
    - Managed care rate floor of 70% of Medicare for many codes
  - Targeted rate Increases for **assisted living**, **self-directed personal care assistance services**, **adult medical day care**, and **nursing facilities**
- Budget language **prevents implementation** of Any Willing and Qualified Provider policy for nursing facilities in SFY 2026

Managed Care Contract Changes

MCO Contract Changes: Utilization Management Guidance

- DMAHS issued **new guidance** to MCOs in May around the management of **private duty nursing**, **personal care assistance**, and various other benefits received on an ongoing basis
  - These requirements were also incorporated in the **July 2025** MCO contract update.
- Key elements of guidance include:
  1. When MCOs **terminate** or **reduce** services, the denial letter **must** include a detailed, **plain language**, explanation of the reason for the termination/reduction
     - Must include an explanation of **how the member's condition has changed since the previous assessment**, such that a lower level of benefits is now medically appropriate.
  2. Such letters must also include detailed information on how the member can **request Care Management** to ensure their needs are being met with the reduction in services.
  3. Add rights/protections for members who **successfully appeal** an MCO's reduction or termination of services.
  4. Member appeals of denials / terminations / reductions must be accepted by **phone, fax, mail**, and **secure online portal**
  5. If a member **appeals** (i.e. requests a fair hearing) of a denial / termination / reduction in service, the MCO must respond to member requests for supporting information within **five (5) business days**

Additional MCO Contract Changes

Any Willing Qualified Provider (AWQP)

- Enacted State budget language precludes inclusion of AWQP language currently; prior Any Willing Provider (AWP) language reinstated

Quality

- More stringent requirements for MCO follow-up related to missed EPSDT (preventive services for children) appointments
- More stringent performance expectations for lead blood level testing

Pharmacy

- Various technical clarifications added to improve operations/streamline processes

Program Integrity

- Notification and reporting timeframes/requirements updated
- Recoupment language for monies paid to ineligible providers enhanced

Presumptive Eligibility (PE) for HCBS and PACE: Status Update

Background

State legislation enacted in 2024 (P.L. 2023 c.306) authorized New Jersey to implement **“presumptive eligibility” (PE)** for individuals receiving **Home and Community Based Services (HCBS)** or participating in the **Program of All-Inclusive Care for the Elderly (PACE)**

- Definition: Presumptive Eligibility (PE) offers **temporary fee-for-service** Medicaid coverage for individuals who are likely to be eligible, and awaiting full Medicaid eligibility determination.

Today, PE is available only to **low-income (“MAGI”)** eligibility groups

- Coverage begins when an **individual receives services** at a hospital, community health center, clinic, family planning center, or certain behavioral health providers.

Intent of legislation is to **expand PE** to **aged/disabled** individuals receiving long-term care via HCBS or PACE

Progress to Date

- Legislation set an effective date of July 2026 but implementation is **contingent on necessary federal approvals**.
- Since enactment in early 2024, DMAHS has done extensive work on implementation, including **engagement** with key partners:
  - CMS
  - Other states (Washington, Pennsylvania)
  - Key advocates / provider groups
- However, **key unsolved challenges** remain, in two broad domains:
  1. Operational Issues
  2. Federal Authority

Operational Issues

- PE for HCBS/PACE will need to vary from the MAGI PE framework due to:
  - **Necessity for clinical eligibility determination:** Unlike existing PE populations, HCBS / PACE members must demonstrate that they meet a required level of clinical need.
  - **More complex financial eligibility rules:** Aged/blind/disabled ("ABD") eligibility groups typically have more complex financial eligibility requirements, including limits on assets / resources.
  - **Need for new payment structures:** In current PE model, all services are provided fee-for-service during the PE period but PACE and many HCBS services are not delivered on a fee-for-service basis
  - **Need to identify and onboard new provider types:** HCBS and PACE providers would need to be onboarded into the program and trained to assess the significantly more complex eligibility requirements described above.
- Each of these differences will need to be reflected in updated policies and systems.

Operational Issues (cont.)

- Current PE system can **only support MAGI applications.**
  - Current PE system **does not have the capacity** to implement ABD programs.
  - Implementing ABD programs will require **significant technical investments** to create new workflows to support clinical and financial eligibility.
- Comprehensive effort is underway to **modernize** DMAHS' eligibility systems to support improvements to MAGI and ABD programs, however:
  - Timeline for **full implementation** of new systems is **several years away.**
  - Implementation of work requirements, more frequent eligibility checks and other federally mandated program changes may require reallocation of resources.

Federal Authority

During technical consultations with New Jersey, CMS has advised that **two separate** authorities are likely necessary to implement PE for HCBS/PACE:

1. For HCBS members:

   Demonstration ("waiver") authority under **Section 1115 of the Social Security Act**

2. For PACE members:

   Waiver under **Section 903 of the Benefits Improvement and Protection Act (BIPA)**

Federal Authority: Section 1115 Demonstration (HCBS)

- NJ's current 1115 waiver is scheduled for renewal in **2028.**
  - Implementing **HCBS provisions of legislation** before 2028 would require a **mid-cycle 1115 demonstration amendment**.
- Key considerations for 1115 demonstration / amendment:
  - Impact of new **budget neutrality rules** for 1115 waiver.
  - **Unclear policy preferences** of new federal administration.
  - Significant **delays** for federal approval of waiver amendments.
    - No 1115 amendments were approved nationwide from January to June 2025
    - Currently a large backlog of pending amendment requests
- **Note**: CMS approval of 1115 demonstrations / amendments is **discretionary.**
  - No guarantee of positive outcome.

1115 Demonstration Amendment Timeline: Historical Experience

Previous NJ Amendment Timeframes					
Amendment	**State Public Notice Date (30 days)**	**NJ Amendment Submission**	**Federal Public Notice Date (30 days)**	**CMS Approval**	**Total Time**
SUD Demonstration	January 9, 2017	March 1, 2017	March 9, 2017	October 31, 2017	10 months
NJHV & OPG	April 10, 2018	August 22, 2018	September 7, 2018	July 25, 2019	11 months
Postpartum Extension	January 2, 2020	March 3, 2020	March 31, 2020	October 28, 2021	20 months

Federal Authority: BIPA Waiver (PACE)

- CMS has indicated that a BIPA waiver is most likely vehicle to authorize PE for PACE.
  - However, CMS is "**still deliberating** on whether there is authority for PE for Medicaid for an individual enrolling in PACE as it is worded in NJ's legislation" (CMS email June 23, 2025).
- Per CMS, even if vehicle can be determined, **PACE organizations would not be compensated** for providing PE services to individuals ultimately found ineligible.
- CMS has yet to provide clear guidance, technical assistance, or templates on next steps, especially on clinical eligibility determination issue.
  - DMAHS has no historical experience utilizing BIPA authority, requiring further guidance and technical assistance from CMS on path forward.

Next Steps

- Given federal authority challenges, **earliest likely implementation date** of legislation is **2028**.
  - Tied to scheduled renewal of New Jersey's comprehensive 1115 demonstration.
- DMAHS will concurrently work through operational and IT systems challenges.
- DMAHS focus in the interim: reducing **ordinary eligibility processing times** for Aged, Blind, Disabled (ABD) applications through close monitoring and collaboration with County Social Service Agencies.

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

Beneficiary Advisory Council Membership

- DMAHS invited all current and former members, as well as their caregivers, to apply for the Beneficiary Advisory Council (BAC). DMAHS staff:
  - Emailed 500,000 people who had an email on file from their application;
  - Posted the BAC application survey on the MAAC website; and
  - Advertised the BAC application survey at the 4/30/2025 MAAC meeting.
- Over 1,000 NJ FamilyCare members and their caregivers applied to be on the BAC. Of them, 34 interviewed with state staff.
  - The Division of Medical Assistance and Health Services thanks all the applicants for their interest, time, and dedication to making NJ FamilyCare serve its members in the best way possible.
- We are close to finalizing initial Beneficiary Advisory Council (BAC) members, who come from all across the state, have children of all ages, and receive services from many Medicaid programs.
- The BAC will meet four times per year. Members will share their experience and provide feedback on the implementation of new and existing programs.

Next Steps

- The Beneficiary Advisory Council is expected to convene for the first time before the next MAAC meeting in October.
- The BAC will pass bylaws controlling the governance of the council.

- The Medicaid Advisory Committee selection will be finalized by DMAHS.
- The MAC will include advocates, providers, health plan leaders, fellow state agency employees, and BAC members.
  - Existing MAAC members will be invited to continue serving for at least short / medium term
- The MAC will continue meeting four times per year.

Doula Program Update

Feedback Requested: NJ FamilyCare Doula Benefit

- Doula coverage has been a NJ FamilyCare benefit since 2021.
  - Community doulas provide emotional, physical, and informational support during pregnancy, labor and delivery and beyond
  - New Jersey was the third state in the nation to offer statewide Medicaid doula coverage, a key initiative of NurtureNJ
- A primary goal is to increase the number of doulas serving Medicaid members.
- As part of that goal, the state has been developing a new process for approving doula trainings, a key part of a provider becoming a Medicaid doula.
  - DMAHS has been working closely with NJ Department of Health and NJ Maternal and Infant Health Innovation Authority (NJMIHIA) on the process. We are now seeking stakeholder feedback on the proposed process.
  - Visit https://nj.gov/njmihia/ for posted information about the new process and to learn how to give feedback.
  - The deadline to give feedback is **July 31**.
- We plan to announce the finalized process in August and implement this year.

NEW JERSEY HUMAN SERVICES

1115 Comprehensive Waiver Demonstration

NEW JERSEY HUMAN SERVICES

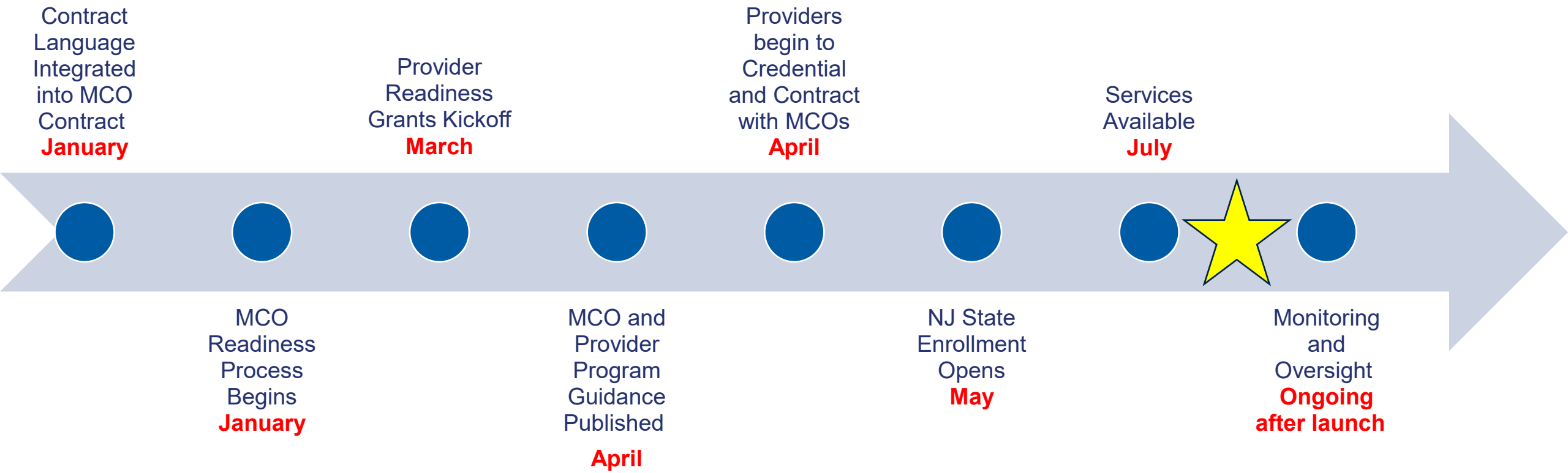
1115 Comprehensive Demonstration Annual Post-Award Forum

July 2025

Housing Support Services

Under the 1115 Comprehensive Waiver Demonstration

Housing Support Services began to come online starting July 1st



NJ Family Care Housing Support Services

Pre-Tenancy Services	Services that support beneficiaries obtain housing
Tenancy Sustaining Services	Services that support beneficiaries maintain safe and stable tenancy
Move-in Supports	Services that pay for the set-up of the new housing unit and/or pay for the move and the supporting the details of the move
Modification and Remediation	Services that provide remediation services, including air filtration devices and/or modify the home environment (e.g., ramps, handrails, grab bars) and provide medically necessary heating and cooling services

The Housing Supports program launched on July 1st; members and providers should contact the State or MCO contacts below for assistance

State

Assistance and resources website for providers

Provider guidance packet

DMAHS.HousingSupports@dhs.nj.gov

Health plans

aetna	Fidelis Care	Horizon	United Healthcare	Wellpoint
Network contact: Join network	Network contact: Join network	Network contact: Join network	Network contact: Join network	Network contact: Join network
NJHousingServices@aetna.com	Marlene.G.Mercado@fideliscarenj.com	Alana_McDonald@horizonblue.com	NJ_HCBS_PR@UHC.com	NJHousing@wellpoint.com
Website	Website	Website	Website	Website
Member portal	Member portal	Member portal	Member portal	Member portal
Member services contact: (1-855-232-3596)	Member services contact: (1-866-309-8447)	Member services contact: (1-800-682-9090)	Member services contact: (800-941-4647)	Member services contact: (855-661-1996)

Behavioral Health Integration

Under the 1115 Comprehensive Waiver Demonstration

Phase 1 of BH Integration went live January 1, 2025 and is taking a phased approach to integrating BH services into managed care

Jan 1, 2025

Phase 1

Outpatient BH Services
(for both adults and children)

- 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
  - Peer support services
  - SUD care management
- SUD partial care

TBD but no sooner Jan '26[1]

Phase 2

Residential & Opioid Treatment Programs

- Adult mental health rehab (AMHR) / MH supervised residential
- SUD short-term residential
- SUD — medically monitored inpatient withdrawal management
- SUD long-term residential
- Opioid treatment programs (OTPs)

TBD[1]

Phase 3

Additional BH services
TBD

- Opioid Overdose Recovery Programs (OORPs)
- Psychiatric Emergency Screening Services (PESS)
- Behavioral Health Homes (BHHs)
- Community Support Services (CSS)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted case management (TCM):
  - Program of Assertive Community Treatment (PACT)
  - Children's System of Care (CSOC)
  - Intensive Case Management Services (ICMS)

1. Scope and timing of Phase 2 and 3 to be determined after Phase 1 go-live based on additional analysis and stakeholder input

Goals for NJ FamilyCare BH Integration

- **Access for members:** Increase access to services with a focus on member-centered care
- **Whole-person care:** Integrate behavioral and physical health for whole person care, with potential to improve healthcare outcomes
- **Care coordination:** Provide appropriate services for members in the right setting, at the right time

The State implemented a Phase 1 transition period to ease the shift

Key priorities for the transition period include…

- Promote continuity of care for members served by providers not yet contracted with the MCOs
- Provide additional time for MCOs to expand and stabilize provider networks
- Give providers time to learn and practice how to submit prior authorization requests in line with MCO and State guidelines and ensure timely processing of these requests
- Minimize barriers to timely and accurate claims submission and MCO payment to providers

Providers are encouraged to join all 5 MCO networks to prepare for the end of the transition period

- Ensure members have adequate access and do not experience disruptions in their care
- Guarantee at least fee-for-service (FFS) reimbursement rate, rather than single case agreement (SCA)-specific rates
- Limit prior authorization (PA) submissions to only BH services that require them

Note: Out-of-network (OON) provider requirements may vary by MCO. Providers are encouraged to coordinate with each MCO to understand specific expectations

DMAHS has extended some transition period flexibilities past June 30, 2025

In response to provider concerns and to minimize any risk of disruption of access to care, DMAHS is **temporarily extending some of the transition period flexibilities**. These modified transition period policies will be in effect until at least October 31, 2025.

Beginning July 1, 2025:
• Providers must submit prior authorization (PA) requests   • However, **PAs must be automatically approved and will <u>not</u> be denied for medical necessity** • Claims for PA-required services will be denied if no PA is on file

• MCOs have chosen to continue to **pay out-of-network providers** using Medicaid FFS rates until October 31st
• These claims must:
  - Be submitted with **no errors**
  - Have a **PA on file for a PA-required service** (*out-of-network PA requirements vary by MCO)*

The State will continue to assess each MCO's readiness to determine an end date for their transition period policies.

Need help? Visit the state's BH Integration Stakeholder website or contact the member's MCO; if you cannot reach a resolution, outreach DMAHS

BH Integration Stakeholder Information website[1]

The BH Integration stakeholder website has the following materials for providers and additional resources:

- Provider guidance packet – updated!
- Prior DMAHS training materials and recordings
- Additional resources with information on program processes

nj.gov/humanservices/dmhas/information/stakeholder/

Member's Managed Care Organization

For specific member inquiries and MCO-related questions, please contact the member's MCO:

Aetna **Fidelis Care** **Horizon NJ Health**

UnitedHealthcare **Wellpoint**

Refer to key MCO points of contact here or also in provider guidance packet

DMAHS – Office of Managed Health Care (OMHC)

If your issue is related to **contracting & credentialing**, **claims & reimbursement**, **appeals,** or **prior authorizations**, then contact **OMHC**:

mahs.provider-inquiries@dhs.nj.gov

- Include specific details regarding your claims
- If multiple claims are impacted, the information should be summarized using an Excel file
- All Protected Health Information (PHI) must be sent securely

DMAHS Behavioral Health Unit

If your issue is related to **policies & guidelines**, **access to services**, or **general questions**, then contact DMAHS **BH Unit**:

dmahs.behavioralhealth@dhs.nj.gov

1-609-281-8028

1. https://www.nj.gov/humanservices/dmhas/information/stakeholder/

Planning for the Next Meeting

October 30, 2025

NEW JERSEY HUMAN SERVICES

1115 Comprehensive Demonstration Annual Post-Award Forum

July 2025

Purpose of This Public Forum

Federal requirements mandate a post-award forum to solicit comments on the progress of the demonstration where the public has an opportunity to provide verbal or written comments and those comments must be summarized and included in the annual reports submitted to CMS by DMAHS.

NJ's 1115 Comprehensive Demonstration Special Terms and Conditions (STC) state:

"12.13 Post-Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration."

Today's session will provide a brief summary of Demonstration activities this year and provide the public with an opportunity to comment.

1115 Demonstration Renewal: April 1, 2023 through June 30, 2028

On March 30, 2023, the Centers for Medicare and Medicaid Services (CMS) approved a renewal of New Jersey's 1115 Demonstration.

This renewal includes innovative NJ FamilyCare projects designed to address priorities such as:

- addressing members' housing-related needs;
- integrating behavioral and health services; and
- providing new and creative approaches to care.

The renewal extends federal authority for the state to operate large parts of the NJ FamilyCare program.

The renewal is effective from April 1, 2023 through June 30, 2028.

1115 Comprehensive Demonstration Timeline To Renewal

Important Context:

- CMS rescinded two guidance letters issued by the previous administration that defined and provided framework for state Medicaid programs related to HRSN.
- Since NJ's HRSN program is already approved under our current demonstration, NJ does not expect this guidance to directly affect us.
- NJ is monitoring for any incoming policy changes to federal reporting, oversight and evaluation expectations.

1115 Demonstration Elements

The 1115 Demonstration includes a wide array of authorizations, programs and pilots that contribute to NJ FamilyCare. They include:

Authorization	Programs	Programs, continued	Pilots

• Managed Care Authorization
• Post-Partum Eligibility Extension
• Quality Improvement Strategy (QIS)
	• Managed Long Term Services and Supports (MLTSS)
	  • Nutrition Services
	  • Caregiver Supports
	• DDD Programs:
	  • Community Care Program (CCP)
	  • Supports
	• SUD/OUD Services
	  • SUD HIT
		• Integration of BH into Managed Care
		• BH Promoting Interoperability Program (PIP)
		• Children' Support Services Program (CSSP) I/DD and SED
		• Premium Support Program (PSP)
		• Housing Support Services
			• NJ Home Visitation (NJHV)
			• Community Health Worker (CHW)
			• Medically Indicated Meals (MIM)
			• Adjunct Services Autism Spectrum Disorder (ASD)

Notable Achievements

- CMS approved NJ's services protocol, implementation plan and payment methodology for new HRSN initiatives.
- Utilized practical strategies and strategic partnerships to facilitate stakeholder engagement throughout the design and implementation of Housing Support Services, Behavioral Health Integration, and both the Medically Indicated Meal (MIM) and Community Health Worker (CHW) Pilots.
- Housing:
  - Allocated $10 million to 43 organizations to support capacity building and integration into Medicaid. The grant program, “Housing Supports Provider Readiness Program,” provided grants of up to $250,000 to each organization.
  - Facilitated the integration of healthcare and housing by successfully integrating the Housing Supports program and MCOs into the HMIS database.
- Launched Phase 1 of BH Integration, which now allows MCO coverage of most outpatient BH services.
- Implemented use of the NJ Substance Abuse Monitoring System to enable SUD provider to use one portal to electronically submit service authorization requests to all five MCOs.

Implementation Highlights from the Past Year

Initiative	Recent Progress	Next Steps
Demonstration-Wide Efforts	• Worked with sister agencies and divisions to track and increase the share of Medicaid members who are enrolled in SNAP, TANF, WIC and federal and state housing programs • Worked with CMS on a proposed HCBS Quality Improvement Strategy pilot that will replace existing HCBS audits	• Finalize approaches to increase Medicaid members who are enrolled in other state programs • Finalize HCBS Quality Improvement Strategy and prepare for first reporting cycle
Behavioral Health Integration	• Implemented Phase 1 with a transition period that includes safeguard policies for members and providers • Co-facilitated BH provider trainings and engagement opportunities with the MCOs to answer questions and support provider readiness	• Continue to monitor MCO progress with continuity of care, network development, and provider prior authorization support to ensure quality submissions
Behavioral Health PIP	• 7 Behavioral Health facilities attested to one or more milestones for which payments were disbursed • Announced program updates during various stakeholder meetings	▪ Continue building awareness of the Program to increase participation

Implementation Progress Made to Date (cont.)

Initiative	Recent Progress	Next Steps
Caregiver Support Services	• Finalized billing codes and units of service • Continuing to assess best technical approach to process benefits for non-members.	• Explore administration of benefits via MCO system reconfiguration or third-party vendor
Children Support Services Program (CSSP)	• Launched CSSP I/DD waiver expansion in fall 2024 • Clarified that individuals do not need to complete a formal disability determination to enroll in CSSP programs	• Continue implementation of CSSP I/DD waiver program by proactively reaching out to eligible individuals and streamlining enrollment and disenrollment processes
Housing Support Services	• Developed and published Provider and MCO Guidance allowing provider enrollment to begin • Completed intensive MCO readiness process • Successfully integrated program into HMIS database	• Continue to build provider network • Closely monitor program rollout • Engage in member and community outreach to spread awareness of the new benefit
New Jersey Home Visitation Program (NJHV)	• Implemented systems changes necessary • Two home visiting providers are operational and currently enrolling and serving families • Held multiple provider information sessions to answer questions and gather lessons learned from initial providers	• Add additional providers to the pilot as requirements for participation are met • Develop formal community of practice for participating providers on a bi-monthly basis

Implementation Progress Made to Date (cont.)

Initiative	Recent Progress	Next Steps
Nutrition Supports	• Completed MCO readiness process • MCOs have notified members via updates to benefit handbook and their web pages.	• Monitor rollout and address issues as they arise

Pilot Implementation Progress Made to Date

Initiative	Recent Progress	Next Steps
Community Health Worker (CHW) Pilot	• Final stage of MCO proposal review underway at DMAHS	• DMAHS to grant Preliminary Approval to approved MCO proposals • DMAHS to submit MCO proposals to CMS for approval
Medically Indicated Meals (MIM) Pilot	• Continued stakeholder conversations with interested MCOs, MIM vendors and state partners • Received CMS approval of member eligibility, covered services, provider qualifications, and processes	• Release pilot guidance and rates • Recruit 1-2 MCO partners, partnering MCO(s) will identify MIM vendor(s)

Public Comments

- If you wish to speak, please state your **name** and **organization** (if applicable) in the **Q&A** box at the bottom of your screen. Your name will show up in the order it is received. When you are called on, please keep your statement to two (2) minutes or less to allow for all voices to be heard.
- If you have dialed in to this meeting, press ***9** on your phone to raise your hand. When it is your turn, we will ask you to unmute, which you can do by pressing ***6**.
- The DMAHS team thanks you for offering your comments. We will be in listening mode as we hear from you. In addition to helping us serve people the best way possible, we will pass all of your comments to CMS as part of our reporting.
- Written comments or questions will also be accepted by email to DMAHS.CMWcomments@dhs.nj.gov. Written comments must be received by August 12, 2025.