NEW JERSEY HUMAN SERVICES

Meeting of the Medical Assistance Advisory Council

July 18, 2024

Agenda

- Welcome and Call to Order – Dr. Deborah Spitalnik
- Human Services Updates to Staffing and Budget – Commissioner Sarah Adelman and Deputy Commissioner Valerie Mielke
- Policy Updates – Gregory Woods and Natalie Kotkin
- MCO Contract Changes – Lynda Grajeda
- Unwinding the Public Health Emergency – Gregory Woods
- 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 19, 2024.

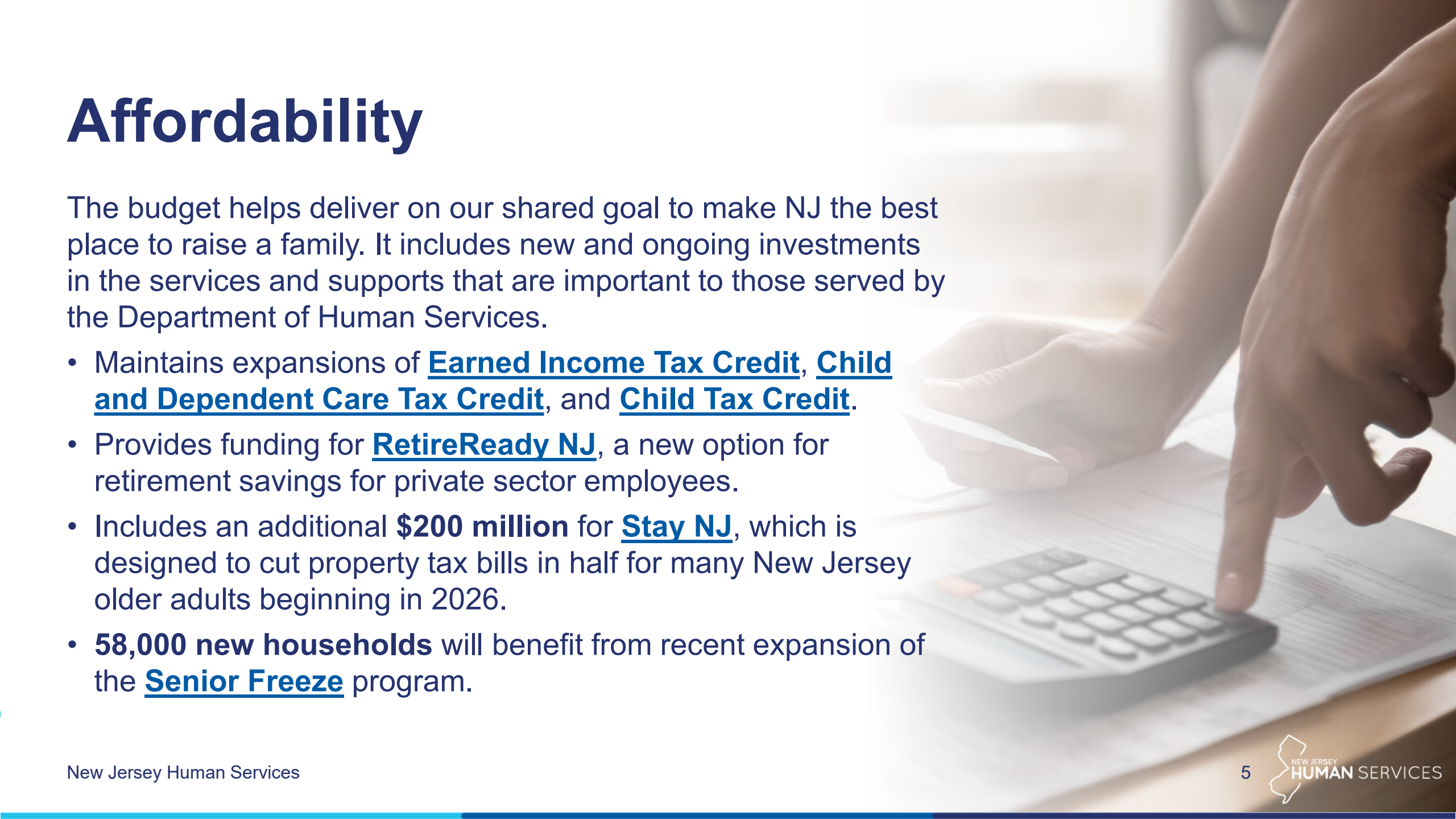
Making New Jersey the Best Place to Raise a Family

Fiscal Year 2025 Budget – NJ Human Services

Affordability

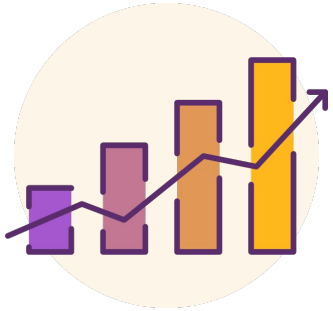
The budget helps deliver on our shared goal to make NJ the best place to raise a family. It includes new and ongoing investments in the services and supports that are important to those served by the Department of Human Services.

- Maintains expansions of **Earned Income Tax Credit**, **Child and Dependent Care Tax Credit**, and **Child Tax Credit**.
- Provides funding for **RetireReady NJ**, a new option for retirement savings for private sector employees.
- Includes an additional **$200 million** for **Stay NJ**, which is designed to cut property tax bills in half for many New Jersey older adults beginning in 2026.
- **58,000 new households** will benefit from recent expansion of the **Senior Freeze** program.



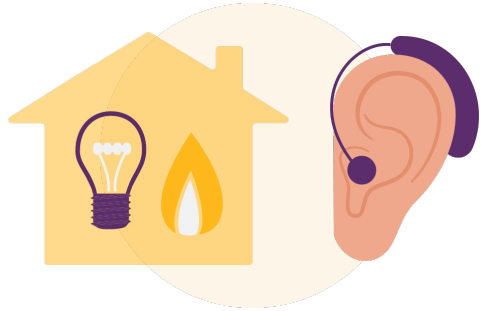
Prescription Drug Savings

Maintains commitment to making life more affordable for older adults by maintaining expanded eligibility for the **Pharmaceutical Assistance for the Aged and Disabled (PAAD)** and **Senior Gold** programs to further cut costs for prescription drugs.



Income limits for the assistance programs increased by **$10,000** as of January.

Includes added funding to support continued enrollment growth due to new promotional initiatives and outreach grants.



Income limits for the **Lifeline Utility Assistance** program and the **Hearing Aid Assistance to the Aged and Disabled (HAAAD)** program, both tied to PAAD, also increased by **$10,000**.

Connecting Older Adults to Services

- The **Division of Aging Services** receives an additional **$1 million** for county Area Agencies on Aging.
- Will help manage increased volume and referrals to ensure that individuals are first screened so they can be connected to appropriate services sooner, reduce admission to facility-based care, and support people to age-in-place.

Cover All Kids

- The FY25 budget provides more than $6 billion in state funding for **NJ FamilyCare**.
- This includes about **$100 million** in new funding to continue our Cover All Kids initiative.
- Over 41,000 children already enrolled through Phase II of the **Cover All Kids** initiative, launched in January 2023.
- Phase II enables children to enroll regardless of immigration status.

NJFAMILYCARE | Cover All Kids

Serving Individuals With Intellectual and/or Developmental Disabilities

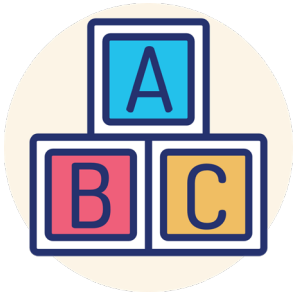
- The budget provides **$5.25 million** to increase mandatory training hours for Direct Support Professionals to improve readiness and quality of services.
- New training requirements include:
  - Additional health and safety areas
  - Effective communication
  - Cultural competency
  - Trauma-informed care
  - DSP professionalism
  - Individual rights

Critical Wage Enhancements

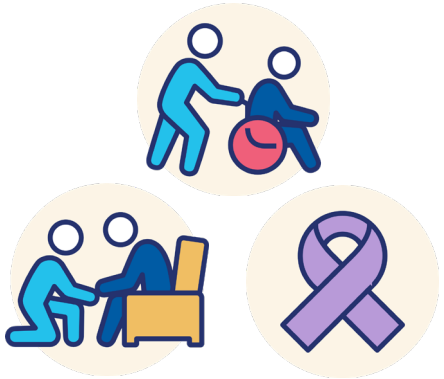
The budget builds upon more than $1 billion of investments for the care sector workforce with over $30 million in new state and federal funding for wage increases.

$18.7 million for wage increases under **Personal Preference Program**.

$14.4 million for nursing facility wage increases for certified nurse aides.



$3.6 million for wage increases for **child care** workers.



Wage increases in the **Jersey Assistance for Community Caregiving** program, **Alzheimer's Adult Day Program**, and **Statewide Respite Care Program**.

Rate Increases

The budget includes Medicaid rate increases for:

Nursing home resident care

$60M

Personal care assistant services

$50M

Private duty nurse

$50M

Division of Developmental Disabilities Rate Increase

$15M

Adult medical day care

$10M

Federally Qualified Health Centers

$2M

New Benefit Programs

- Governor Murphy also signed into law the **Menstrual Hygiene Benefit** and the **State Work First New Jersey (WFNJ) Diaper Benefit programs**.
- Under the **Menstrual Hygiene Benefit Program**, eligible adults ages 18 through 50 participating in WFNJ may purchase menstrual hygiene products using a dedicated **$14 monthly state benefit** through their electronic benefits card.
- Under the **Diaper Benefit Program**, individuals with a dependent under 36 months of age and who participate in WFNJ will receive a **$30 monthly state benefit** through their electronic benefits card for the purchase of diaper products.

Food Assistance

- Includes **$3.2 million** to provide households new cards with embedded microchips, enhancing security.
- Participating households will also continue to receive a **minimum of $95 per month**, continuing New Jersey's status as the only state to extend pandemic-era benefits after federal funding expired.
- **$3.73 million** to help implement summer food assistance for children through the **Summer Electronic Benefit Transfer Program**.
- An estimated 550,000 children will be eligible to receive a **one-time $120 benefit** through this program.

NJ WorkAbility Expansion

- The budget includes $49 million in additional funding for the NJ **WorkAbility** program expansion.
- Allows people with disabilities to continue their Medicaid benefits as their income rises, knocking down barriers to employment and full participation in society.
- NJ WorkAbility eliminated asset limits in April 2023.
- Will soon begin to enroll people with incomes over 250 percent of the Federal Poverty Level.

Policy Updates

Recent Federal Policy Changes

- CMS recently finalized several Medicaid rules, which have now gone into effect:
  1. Medicaid Access Final Rule: Effective July 9, 2024
  2. Medicaid Managed Care Final Rule: Effective July 9, 2024
  3. Medicaid and CHIP Eligibility and Enrollment Final Rule: Effective June 3, 2024
- While effective dates for each rule are in 2024, specific *provisions* within each rule have significantly later effective dates.

1. Access Final Rule

- Titled “Medicaid Program: Ensuring Access to Medical Services,” the Access Final Rule went into effect on July 9, 2024. Dates for specific provisions to apply are up to **six years** out.
- The Access Final Rule includes these core topics:
  - Composition and responsibilities of **Medicaid Advisory Committees** (MACs) and **Beneficiary Advisory Councils** (BACs)
  - Requirements for **home and community-based services** (e.g., incident management and grievance systems, payment adequacy, HCBS Measure Set)
  - **Access to care** and **payment rates**, which replaces Access Monitoring Review requirements

Access Final Rule: MAC

- The Access Final Rule establishes new compositional, recordkeeping, and activity requirements for the **Medicaid Advisory Committee** (MAC), including:
  - Expanding **topics** for the MAC to advise, including eligibility, enrollment and renewal processes, beneficiary and provider communications, etc.
  - Requiring MACs to post their **governing bylaws, meeting minutes**, and **membership lists**
  - Meeting quarterly, with at least **two meetings** having a **public comment period**
  - Modifying membership requirements to capture specific stakeholder groups and **prohibit consecutive terms**
- The effective date for these provisions is **July 2025**.

Access Final Rule: BAC

- The Access Final Rule requires states to establish a **Beneficiary Advisory Council** (BAC), including:
  - Establishing membership requirements, including a **portion of MAC members that must also be part of the BAC**
  - Requiring BACs to post their **governing bylaws, meeting minutes**, and **membership lists** (though members can opt out)
  - Meeting **quarterly**
- The effective date for these provisions is **July 2025**, except for the proportion of MAC members that must be BAC members, which increases over multiple years
- The Rule requires states to publish an **annual report** for the MAC and BAC that includes the Medicaid agency's response to the recommendations of each group. Effective date: **July 2026**.

Access Final Rule: HCBS Requirements

- The Access Final Rule establishes new operational, reporting, and payment requirements for home and community-based services. This excludes services delivered through PACE, the Program of All-Inclusive Care for the Elderly.
- According to the Rule, states must:
  - Report on and ensure payment adequacy for categories of **direct care services** (effective dates: **July 2028 for reporting**; **July 2030 for minimum threshold**)
  - Establish an **HCBS Quality Measure Set** (effective date: generally, **July 2028**)
  - Establish an **electronic incident management system** (effective date: generally, **July 2027**)
  - Establish a **grievance system** for services delivered as fee-for-service (effective date: **July 2026**)
  - Report on **annual person-centered service planning activities** (effective date: **July 2027**)
  - Report on HCBS service **access** and **waiting lists** (effective date: **July 2027**)

Access Final Rule: Payment Rate Provisions

- The Access Final Rule requires reporting related to fee-for-service (FFS) rates, analysis for changes to FFS rates, and establishing an advisory group on direct care payment rates.
- According to the Rule, states must:
  - Publish Medicaid FFS **payment rates** (effective date: **July 2026**)
  - Compare Medicaid FFS payment rates to ***Medicare* FFS** payment rates for **primary care, OB-GYN**, and **outpatient mental health and substance use disorder services** (effective date: **July 2026**)
  - Publish average Medicaid FFS **hourly rates** for certain **direct care services** (effective date: **July 2026**)
  - Establish an **advisory group** to advise and consult on FFS rates paid to **direct care workers** (effective date: **July 2026**)
  - Require specific new analyses when states submit a state plan amendment with a rate change that could result in diminished access (effective immediately)

2. Managed Care Final Rule

- Titled “Medicaid Program: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality,” the Managed Care Final Rule went into effect on July 9, 2024. Dates for specific provisions to apply are up to **six (or more) years** out.
- The Managed Care Final Rule includes these core topics:
  - Access to, payment for, and information transparency related to services
  - State-directed payments
  - Medical-loss ratio
  - In-lieu-of services
  - Quality assessment and improvement

Managed Care Final Rule: Access and Transparency

- The Managed Care Final Rule establishes requirements focused on measuring and improving network access, including through rates of payment.
- According to the Rule, states must establish:
  - Standards for **appointment wait times** (effective date: **July 2027**)
  - Annual **payment analysis** of select **managed care payments** to Medicare or Medicaid FFS (effective date: **July 2026**)
  - Annual independent **secret shopper survey** (effective date: **July 2028**)
  - Annual **member experience survey** (effective date: generally, **July 2027**)
  - **Remedy plans** when there is an identified network access issue (effective date: **July 2028**)

Managed Care Final Rule: State-Directed Payment Requirements

- The Managed Care Final Rule establishes new requirements for **state-directed payments (SDPs)**, which are payments for which a Medicaid program requires managed care organizations (MCOs) to pay providers specific rates or using specific methods.
- There are many state-directed payment provisions; some of the most relevant provisions for New Jersey include:
  - Increased **evaluation requirements** (effective date: **July 2027**)
  - **Prohibited** state-directed payments **based on historical utilization** (i.e., using a post-payment reconciliation; effective date: **July 2028**)
  - **Prohibited** use of **separate payment terms**, where MCOs pay providers outside of the capitation rates (effective date: **July 2027**)
  - Required attestation by providers that they **do not participate in hold harmless** arrangements (effective date: **January 2028**)
  - Establishment of requirements for SDPs that are pay-for-performance, population-based, or condition-based (effective immediately)
  - Required inclusion of SDPs in medical-loss ratio reports (effective immediately)

Managed Care Final Rule: Quality Rating Systems Requirements

- The Managed Care Final Rule establishes a **Medicaid and CHIP Quality Rating System**, to be known as MAC QRS. It is intended to facilitate easily understandable quality ratings that members can compare across health plans.
- Most provisions are **effective December 2028**, with website interactive capacity increasing afterward.
- According to the Rule, states must:
  - Establish **18 mandatory quality measures**
  - Require the **collection, validation, and calculation of MCO performance** ratings for all measures
  - Create a **website to display QRS results**, with a required increase in interactive capacity over time (e.g., viewing plans for which members may be eligible)

3. Eligibility and Enrollment Final Rule

- Titled “Medicaid Program: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” the Eligibility and Enrollment Final Rule went into effect on **June 3, 2024**. Dates for specific provisions to apply are up to **three years** out.
- Many of these provisions are consistent with the guidance and flexibilities CMS offered to states as part of unwinding.

Eligibility and Enrollment Final Rule – Key Provisions

- The Eligibility and Enrollment Final Rule includes these core topics:
  - **Enrollment and renewal processes** (effective dates: **immediate through June 2027**)
    - Requirements include aligning MAGI and non-MAGI enrollment requirements, removing requirement to apply for other benefits, and removing the option to limit Reasonable Opportunity Periods
  - **Timeliness for determinations and redeterminations** (effective date: **June 2027**)
  - **Returned mail / change of address** policies (effective date: **December 2025**)
    - Requirements include establishing a process to regularly obtain updated address information for members, designating multiple sources of information as always reliable for address information, and establishing provisions for dealing with changes of address (including "good-faith efforts" at outreach)
  - **Recordkeeping requirements** (effective date: **June 2026**)
  - CHIP enrollment and services (effective immediately)

MCO Contract Changes

Effective July 1, 2024

July 2024 MCO Contract Amendment Highlights

- Expanded Diversity, Equity, and Inclusion (DEI) requirements to include collection of Sexual Orientation and Gender Identity (SOGI) data for the purpose of health screening and intervention and to improve health outcomes. MCOs shall implement appropriate security from unauthorized access, disclosure or loss, and prohibit discrimination based on SOGI data in provision of services and treatment.
- Expanded Behavioral Health MCO requirements to reduce perceived barriers to care and to improve member and provider experience; Phase I implementation currently scheduled for January 2025.
- Increased minimum performance standard for EPSDT preventive dental services. Extended coverage for completion of medically necessary endodontic treatment started before loss of eligibility to 90 days after loss of eligibility.
- Added SFY2026 requirement for NCQA LTSS Distinction for MCOs.
- Expanded care management and screening requirements for pregnancy-related health risks during pregnancy through 12 months postpartum.

The July 2024 contract will be posted to “Hot Topics” on the DMAHS website when it has been approved by CMS. The February 2023 contract, as approved by CMS, is posted here.

Preventive Dental Visits for Children: Updated Contract Requirements and Penalties

- NJ FamilyCare continues to challenge our MCOs and dental providers to continue improving preventive dental utilization in their members, increasing the target each year.
- In the FFY 2023 MCO contract, we set the target for pediatric preventive dental utilization at **50%**. In the FFY 2024 contract, we have set **52%** as an ambitious and achievable target.
- The managed care contract includes new sanctions to address substandard utilization of preventive dental services for children. MCOs that fail to meet the preventive pediatric dental target are now sanctioned according to the following guidelines:

FFY 2023 MCO Contract	FFY 2024 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

Behavioral Health Requirements

- In anticipation of **integration** of some behavioral health services into the **managed care benefit** for all populations in January 2025, DMAHS has significantly strengthened behavioral health requirements for MCOs.
- Goals:
  - Improve **access to services**
  - Focus on **whole person care**; ensuring physical, behavioral and social needs are met
  - Increase use of MCO **integrated care management** to help members get services in the right setting, at the right time
- Policy Priorities:
  - Ensure access to a **robust provider network**
  - Ensure **continuity of care** for members actively involved in treatment
  - Improve **provider experience**
  - Enable **streamlined, integrated care delivery**

Amendments to Ensure Access and Continuity of Care for Members

Court Ordered Services	Continuity of Care	Network Adequacy and Access
• Specified that MCOs are required to cover court ordered behavioral health services	• Required MCOs to contract with **all** FFS providers who will be providing services to members at the time of transition	• Required MCOs to maintain a robust network of providers who are actively providing Medicaid covered services

Amendments to Promote a Positive Provider Experience

Credentialing

- Required MCOs to accept a **standardized** credentialing tool (CAQH) to reduce requests for duplicative information
- Reduced the required timeline for processing properly completed applications **from 90 to 60 days**

Claims

- **Shortened processing timelines** for properly submitted behavioral health claims
- Increased **minimum payment cadence** for claims from once every two weeks, to **weekly**

Amendments to Enable Streamlined, Coordinated Care Delivery

Prior Authorizations

- Required MCOs to **automatically approve all SUD detoxification** services
- Established minimum approval **durations** for initial authorizations
- Set **rapid** timelines for processing **prior authorization** requests

MCO BH Staffing

- Required MCOs to have a full time **Behavioral Health Medical Director** to oversee medical necessity determinations, integration of care, and ensure appropriate discharge planning

Quality Monitoring

- Identified BH **quality and outcome measures** to be monitored annually

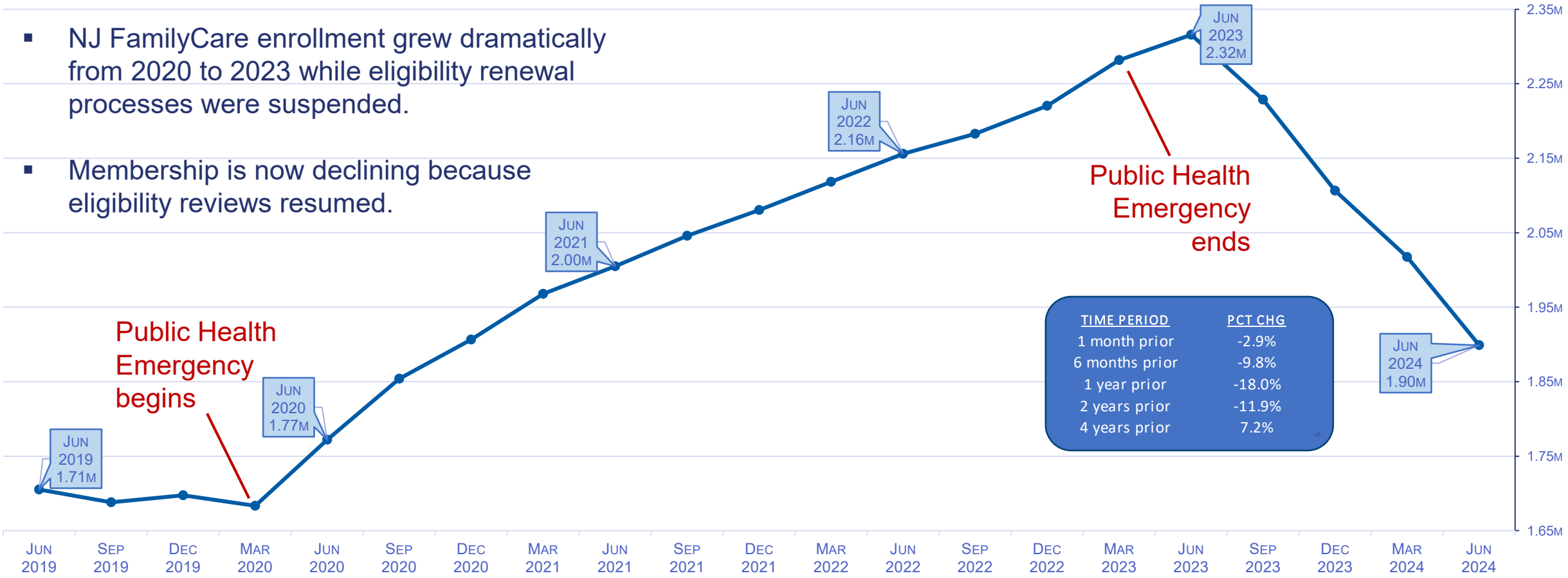
Unwinding the Public Health Emergency

North Star Principles for Returning to Regular Renewals

Serve people the best way possible.	We will **resume Medicaid eligibility renewals** as required by federal rules, with a focus on the quality of our work and support for our members.
Communicate with clarity and concern.	We will emphasize **shared understanding** as we manage broad technical systems and very unique individual circumstances.
Experiment with new ways to solve problems.	We will collaborate in new ways with our **operational partners** – and we will consider how we can use those new approaches to improve our program for the long-term.
Work closely with our stakeholders.	We will collaborate with our **community stakeholders** to raise awareness and provide support, with a shared commitment to equity, inclusion, and synergy.
Show people we care.	We will make **empathy, positive energy, and collaborative focus** our hallmark, internally and externally.

NJ FamilyCare Enrollment

- NJ FamilyCare enrollment grew dramatically from 2020 to 2023 while eligibility renewal processes were suspended.
- Membership is now declining because eligibility reviews resumed.



Is Unwinding Over?

Complete	Ongoing
• All 12 monthly cohorts (representing more than **2 million members**) have gone through the unwinding renewal process. • The last monthly group of **"procedural"** disenrollments (i.e. disenrollment of members who failed to respond to a renewal request) took place on June 30th. • Members who successfully renewed during the first months of unwinding in mid-2023, are now beginning their next, **regular annual renewal cycle**. • This represents a return to **ordinary** (post-unwinding) operations.	• Due to **high volumes**, a significant number of renewal applications that were returned during the unwinding period still need to be processed. Members retain coverage during this period. • A significant number of **fair hearing** requests from members appealing loss of eligibility remain pending. Members retain coverage during this period. • Members disenrolled in April, May, or June for non-response remain within the **90-day window** when they can return their application and be reinstated without a gap in coverage. • Various **federal flexibilities** to ease renewal processes remain in place until (at least) June 2025. • **Enhanced outreach** efforts to encourage members to return renewal applications continue.

Unwinding Flexibilities Granted by CMS

Strategies to increase ex parte renewals	• **SNAP strategy (MAGI)** - Renew individuals based on SNAP eligibility (MAGI). • **$0 income strategy –** Automatically renew Medicaid eligibility for certain individuals with no previously reported income. • **Stable income strategy** – Automatically renew Medicaid eligibility for certain individuals whose sources of income are Social Security and/or pension payments that do not typically change.
Update contact information	• **MCO Beneficiary Contact Update Strategy** – Partner with MCOs to update in-state beneficiary contact information. • **NCOA and/or USPS Contact Update Strategy** - Partner with National Change of Address (NCOA) Database and/or United States Postal Service forwarding address to update in-state beneficiary contact info.
Other strategies	• **Fair hearings timeframe extension strategy –** Extend timeframe to take final administrative action on fair hearing requests.

CMS has provided guidance that these flexibilities may remain in effect through June 2025.

Retrospective View: Unwinding Outcomes

- **Retrospective Analysis:** Unwinding outcomes from members up for renewal in **first quarter of unwinding** (renewal packages that were due between June 2023 and August 2023)
- Benefits of this snapshot:
  - Reviewing this subgroup with recent data allows more **complete picture** of ultimate unwinding outcomes
  - Few cases (**<2%**) are still pending
  - Shows members who have **"churned"** off and back on to coverage

Initial Outcomes: Unwinding Q1

- When members from the first quarter of unwinding **initially** completed the renewal process:
  - Slightly **more than half** had maintained coverage;
  - Roughly **1/3** had lost coverage due to **non-response**.

Category	Number	Percentage
Determined Ineligible	63,600	13%
Procedural Termination Due to Non-Response	165,030	33%
Renewed (Ex Parte)	81,423	17%
Renewed (Not Ex Parte)	172,299	35%
Guaranteed Eligibility (SSI, Pregnancy, Etc.)	10,556	2%
Total*	**492,908**	

*Excludes a very small number of pending cases

Updated Outcomes: Unwinding Q1

- Among the 13% of members initially found **ineligible** for NJ FamilyCare:
  - Roughly 1.5% have since **re-enrolled**
  - Roughly 4% have an alternative (known) source of coverage (Medicare, private insurance, exchange plan)
    - This is an **undercount**, as we lack data on many forms of private coverage
  - Roughly 7.5% **do not have a known source of coverage**
- Among the 33% of members initially terminated for **non-response**:
  - More than 9% were **reinstated** with no gap in coverage (within 90-day window)
  - Around 1% were re-enrolled after a gap in coverage
  - Roughly 6% have an alternative (known) source of coverage (Medicare, private insurance, exchange plan)
    - This is an **undercount**, as we lack data on many forms of private coverage
  - This leaves around 17% **without a known source of coverage**

Updated Outcomes: Unwinding Q1

- Among the roughly **500,000** members who attempted to renew during the first quarter of unwinding, based on May 31 data:
  - Around **323,000 (~66%)** are **actively enrolled** in NJ FamilyCare;
  - Around **48,000 (~10%)** have an identified alternative source of coverage;
    - Likely a significant undercount
  - Around **121,000 (~24%)** are **not enrolled in NJ FamilyCare** and do not have a known alternative source of coverage.

Unwinding: Lessons Learned

Partnership is critical	Close coordination with both **operational partners** (MCOs, County Social Service Agencies, Health Benefits Coordinator vendor, Regional Health Hubs, etc.) and **outside partners** (advocacy and community-based organizations, local governments, etc.) is critical.
Experiment with new ways to reach members	Phone / text / postcards Direct outreach / through MCOs / through Regional Health Hubs Centralized member hotline
Importance of strong **data analytics infrastructure**	Supports real-time **policy** and **operational** improvements
"Ex parte" (automatic) eligibility renewals remain an area of opportunity	Continue to build technical capacity, to improve rates of automatic renewals

Unwinding: Where Do We Go From Here?

- Work to clear existing **backlogs**:
  - Renewals awaiting processing;
  - Cases awaiting fair hearing.
- Continue to **enhance and upgrade** eligibility systems to support key goals:
  - Increase **ex parte** rate;
  - Come into full **compliance** with new and existing federal eligibility rules;
  - Streamline processes, allow eligibility workers to work more **efficiently**.
- Build upon enhanced member **outreach** efforts during unwinding
  - **Short term**: Continue most enhanced outreach efforts into post-unwinding period.
  - **Medium-to-long term**: Rigorously assess impact of specific outreach efforts and continue to iterate / improve.
- Maintain special federal **eligibility-related waivers** through **June 2025**
  - Continue to discuss with CMS whether some flexibilities can be made permanent.

Planning for the Next Meeting

October 23, 2024

NEW JERSEY HUMAN SERVICES

1115 Comprehensive Demonstration Post-Award Forum

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."

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.

North Star Principles for the 1115 Renewal

Maintain momentum on existing demonstration elements.	We will **continue improvements in quality of care and efficiency** associated with managed care; improve access to critical services in the community through Managed Long Term Services and Supports (MLTSS) and other home and community based services programs; and create innovative service delivery models to address substance use disorders.
	We will **update existing demonstration terms and conditions** to address implementation challenges, and accurately capture how the delivery system has evolved in New Jersey over the past several years.
Expand our ability to better serve the whole person.	We will **test new approaches** to addressing the social determinants of health, with a particular emphasis on housing-related issues.
	We will **encourage greater integration** of behavioral and physical health, and continued availability of appropriate behavioral health services for all Medicaid beneficiaries.
Serve our communities the best way possible.	We will **address known gaps** and improve quality of care in maternal and child health.
	We will **expand health equity analyses** to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. LGBTQ identity).

Implementation Progress to Date:

- **Deliverables Submitted and Approved:**
  - Health-Related Social Needs (HRSN) Infrastructure Protocol
  - Behavioral Health Promoting Interoperability Protocol
  - Postpartum Proxy Methodology

- **Deliverables Submitted or In Progress:**
  - HRSN Services Protocol
  - HRSN New Initiatives Implementation Plan
  - Provider Rate Ratio Attestation
  - New Monitoring Reporting protocols

  - **Ongoing Operational Planning**
  - IT Systems changes, including:
    - Provider Enrollment
    - Eligibility

Initiative Implementation Updates

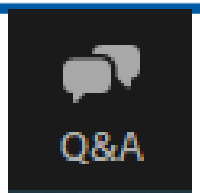
	Recent Progress	Next Steps
Demonstration-Wide Efforts	• Demonstration Evaluation drafted. • Quality Improvement Strategy (QIS) for HCBS elements of the Demonstration is drafted with CMS technical assistance. • Developing new monitoring reporting templates.	• Finalize and submit CMS deliverables.
Housing Support Services	• Continued extensive stakeholder outreach. • Working with the Department of Community Affairs (DCA) and the Regional Health Hubs to support provider participation.	• Finalize program design components such as service definitions, rate structure, assessment and authorization processes. • Draft program guidance and MCO contract language.
Behavioral Health Integration	• Continued stakeholder engagement. • Incorporated initial requirements into the MCO contract.	• Expand stakeholder engagement with a focus on feedback from NJ FamilyCare members and provider readiness. • Finalize program guidance for MCOs.
Community Health Worker (CHW) Pilot	• Received five proposals from the MCOs. • DMAHS reviewed submissions and provided feedback.	• Review resubmissions and notify MCOs of preliminary approval, if appropriate. • Prepare CHW Protocol for CMS.

Initiative Implementation Updates

	Recent Progress	Next Steps
Medically Indicated Meals Pilot	• Held MCO and vendor information sessions to support pilot design. • Drafted Pilot MCO Guidance Document.	• Finalize and release MCO Guidance Document allowing the pilot to begin.
Nutrition Supports	• Developed detailed program guidance and shared with MCOs for feedback.	• Finalize program design and support MCOs in implementing the new benefit.
Caregiver Support Services	• Assessed similar programs in other states. • Developed detailed service definitions, eligibility criteria, provider qualifications and shared with MCOs for feedback.	• Determine billing codes and units of service. • Coordinate with MCOs to establish and onboard provider networks. • Support MCOs in developing marketing materials and implementing outreach plans.
Behavioral Health PIP	• Program design finalized and approved by CMS.	• Program was launched on July 1 in collaboration with DMHAS, DOH and NJII.

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 19, 2024.



Comments and Questions

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We want to hear from you!