NEW JERSEY
DEPARTMENT
OF HUMAN SERVICES

Meeting of the Medical Assistance Advisory Council

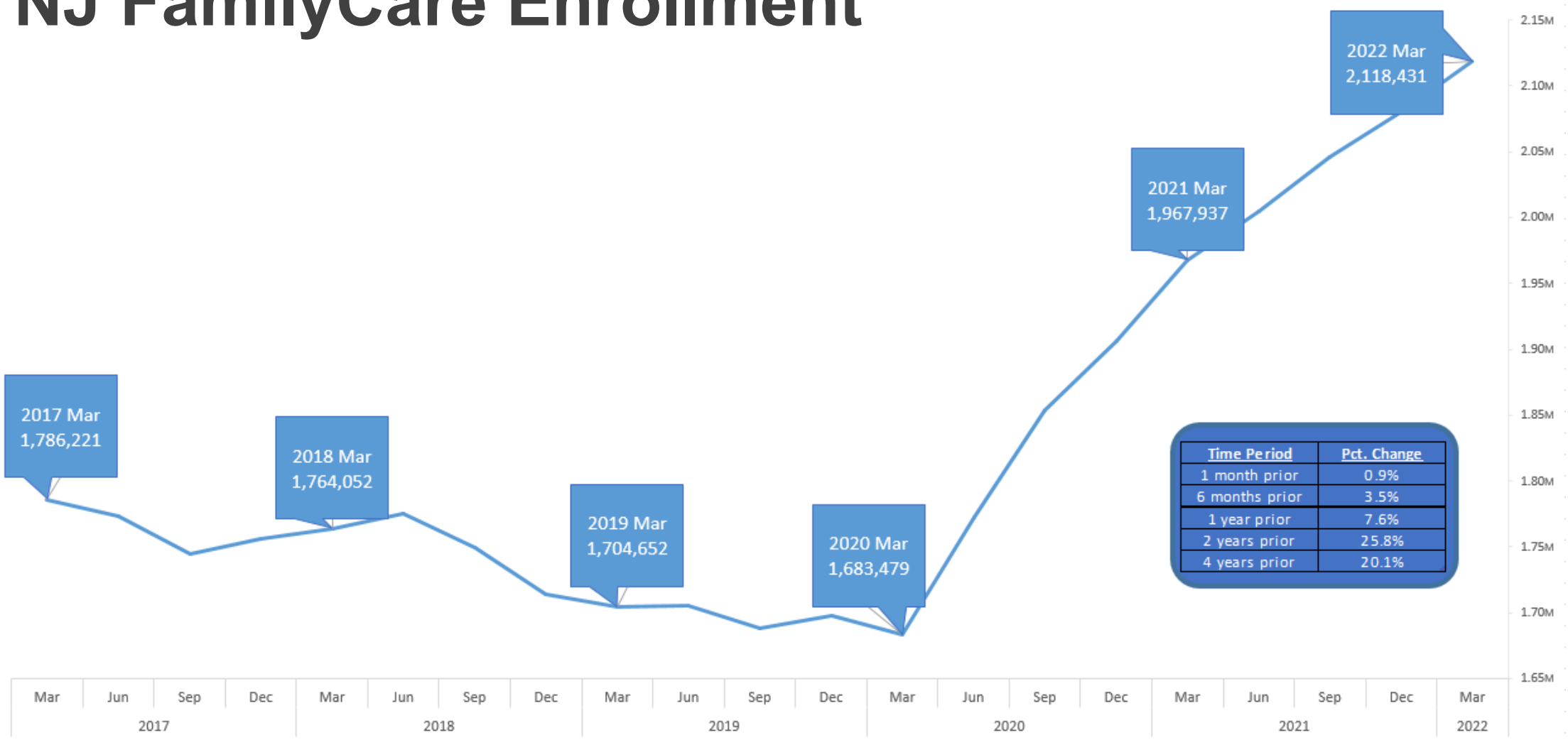
April 28, 2022

Agenda

- **Welcome and Call to Order** – Dr. Deborah Spitalnik
- **Approval of Minutes** – MAAC Members
- **NJ FamilyCare Membership** – Greg Woods
- **Policy Implementation** – Greg Woods
  - 1115 Demonstration Renewal
  - HCBS Spend Plan
  - WorkAbility Implementation
  - Nurture NJ
- **Cover All Kids Updates** – Carol Grant
- **Quality Strategy** – Akanksha Kapoor
- **MCO Quality and Accountability** – Akanksha Kapoor
- **Ending of the Federal Public Health Emergency (PHE)** – Jennifer Langer Jacobs
- **Planning for the Next Meeting** – Dr. Deborah Spitalnik

NJ FamilyCare Membership

NJ FamilyCare Enrollment



Time Period	Pct. Change
1 month prior	0.9%
6 months prior	3.5%
1 year prior	7.6%
2 years prior	25.8%
4 years prior	20.1%

Policy Implementation

1115 Comprehensive Demonstration – Status Update

- New Jersey submitted its final 1115 renewal proposal to the federal government (CMS) in late February.
- Following a federal public comment period, CMS and the state have begun negotiations on substance of 1115.
- Most likely path:
  - Short term extension of existing demonstration (currently scheduled to end June 30th)
  - Final CMS approval later in 2022
- **Note:** DMAHS expects to engage in extensive stakeholder engagement process on major initiatives after the renewal is approved.

Pre-Drafting Stakeholder Input	• Listening Sessions
	  • November 2, 2020
	  • November 12, 2020

Draft Renewal Proposal	• Released September 10, 2021

State Public Comment Period	• September 10 – October 11, 2021
	• Two public hearings:
	  • September 13, 2021 (MAAC)
	  • September 27, 2021

Final Proposal Submitted	• Send to federal partners on February 28, 2022 • Final proposal reflected stakeholder input from State Public Comment Period
Federal Public Comment Period	• March 11 – April 10, 2022

HCBS Spend Plan – Update

- American Rescue Plan made one year of “enhanced match” available to states for reinvestment in Home and Community Based Services (HCBS).
- In January 2022, CMS granted conditional approval to NJ’s HCBS Spend Plan for an estimated $760 million in HCBS investments.
  - Activities representing over $630 million are already operational.
  - We are in the process of implementing remaining approved Spend Plan activities, including seeking additional federal approvals.
  - Baseline spending in the one-year enhanced match period (April 2021–March 2022) was somewhat higher than originally estimated. As a result, some additional reinvestment funds are available.
  - DMAHS expects to update spend plan to match increased amount.
  - Will consider prior stakeholder feedback, and evolving program needs.

NJ WorkAbility Program Changes

- NJ WorkAbility provides Medicaid coverage to people with disabilities who are working, and whose income would otherwise make them ineligible.
- In January 2022, legislation (S. 3455) was enacted that expands eligibility for NJ WorkAbility along several dimensions, including:
  - Removing age restrictions (makes available to individuals 65+)
  - Removing income and resource limits for eligibility
  - Extending eligibility for a year following involuntary job loss

NJ WorkAbility Program Changes (cont.)

- Implementation of S. 3455 is ongoing.
- Next steps based on legislative language:
  - ❑ Develop plan to assess and collect premiums for newly eligible higher income populations.
    - ✓ We are identifying existing State contracts which we may be able to leverage for premium operations.
  - ❑ Receive federal approval for NJ Workability changes, as is required by legislation prior to enactment.
    - ✓ We have begun conversations with CMS.
- DMAHS will provide updates on timing of full implementation asap.

P.L. 2021, CHAPTER 344
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(18) Is a person 16 years of age or older and who is permanently disabled and working, and who pays the premium contribution and other cost sharing as established by the commissioner based solely on the applicant's earned and unearned income, subject to the limits and conditions of federal law.

P.L. 2021, CHAPTER 344
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5. This act shall take effect immediately, but shall remain inoperative until the Commissioner of Human Services receives any federal approvals following the submission of applications for State plan amendments or waivers pursuant to section 3 of this act.

Nurture NJ: Perinatal Episode of Care

- Perinatal episode of care:
  - Three-year voluntary pilot program
  - Tests a new alternative payment model for prenatal, labor, and postpartum services statewide.
  - Clinicians who choose to participate in are financially incentivized to take on comprehensive responsibility for the quality and cost of their patients' care.
  - The episode pilot will tie incentives to improvements in quality and cost of maternity-related care.
  - Key focus on equity in maternal health care and outcomes.

- First Performance Period Launched **April 1**.
- Approximately 15 providers are voluntarily participating in the first performance period.
  - Includes both hospital-based and independent obstetrical practices.
  - Collectively are expected to account for around 4,000 eligible NJ FamilyCare births.

Fee-for-Service Nursing Facility Resident Updates

Fee-for-Service (FFS) Nursing Facility Resident Updates

- New Jersey launched the Managed Long-Term Services and Supports program in 2014 to shift the focus of long-term care in our state to home- and community-based services:
  - In the first five years of the program, we saw an overall reduction of almost 5% in nursing facility census while the elderly population in the state grew by 12%.
  - We now have two-thirds of our MLTSS population receiving home- and community-based services.
  - MLTSS member surveys indicate high levels of satisfaction across most measures, and we are working with MCOs to continuously improve the program.

- In 2014, residents of Nursing Facilities and Special Care Nursing Facilities were not enrolled in Managed Care Organizations (MCOs), and about 3,000 of these individuals remain in FFS today.

- **In order to provide the support of a care manager to these individuals, DMAHS will enroll the remaining FFS NF residents into MCOs on July 1, 2022**
  - Residents will be assigned an MLTSS Care Manager and receive face-to-face care management and person-centered care planning.
  - Residents will receive letters in May and will be asked to choose an MCO. If they do not make a choice, they will be auto-assigned to an MCO.
  - **Residents may change their MCO at <u>any</u> time.**

Cover All Kids Updates

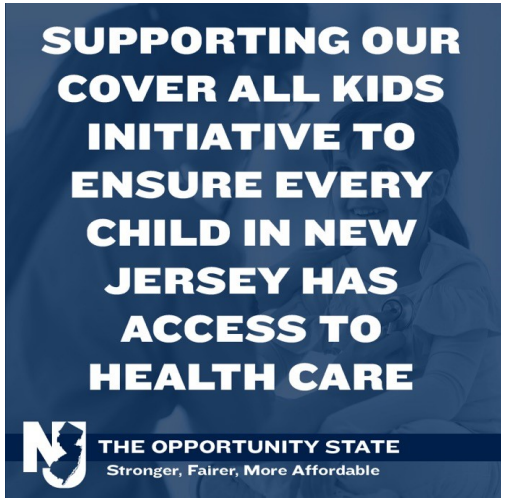
Cover All Kids is part of the Murphy Administration's commitment to the well-being of young New Jerseyans

Initiatives funded by the FY23 budget include:

- Cover All Kids
- Goal of universal pre-K
- Commitment to expanding social service programs
- Statewide universal newborn home nurse visitation
- Heightened Medicaid reimbursement rates for maternity care providers
- Midwifery education
- Central intake hubs
- Childcare revitalization fund

Fiscal Year 2023 Budget in Brief: Cover All Kids

- NJ FamilyCare continues to provide key support to NJ kids:
  - Since June 2021, 32,116 members under 21 years have enrolled in NJ FamilyCare.
- NJ DHS will continue CAK Phase 1 efforts in FY23, including:
  - The elimination of CHIP waiting periods and premiums;
  - Increased community marketing and outreach efforts for NJ FamilyCare; and
  - The convening of the outreach, enrollment, and retention working group.
- $11 million more allocated for the implementation of CAK initiative:
  - Funds to support Phase 2 include expanding NJ FamilyCare coverage to include undocumented children.



State Fiscal Year 2022 Activity to Date

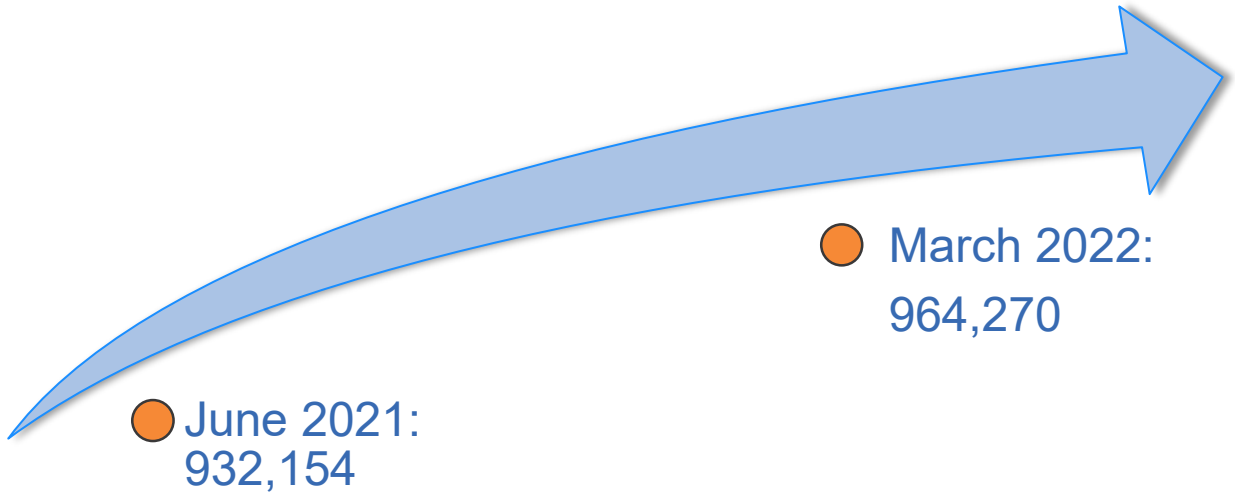
- Eliminated premiums and waiting periods
- Targeted household mailings including cases disenrolled pre-pandemic or application previously denied due to waiting period
- Poster mailings to community partners – completed January 2022
  - Community partners include food pantries, libraries, laundromats, diners, ESL class locations, family planning centers, family success centers, WIC locations, local health departments, childcare centers, child and health advocacy organizations, immigration organizations, faith-based organizations, and other community groups.
- Planning for “unwinding” of the federal Public Health Emergency

State Fiscal Year 2023 Plans

- Continue and enhance outreach collaboration with community partners
- Implement coverage for income-eligible undocumented children
  - We are building a 100% State-funded program for these children that provides the same coverage they would have under Medicaid/CHIP

~48,000 children	Eligible for NJ FamilyCare
~16,000 children	Ineligible due to immigration status

Enrollment Growth of Members under age 21 since Enactment of Cover All Kids Legislation



32,116

members under 21 years old have enrolled in NJ FamilyCare since enactment of Cover All Kids legislation in June 2021

Based on March 2022 Public Stats

Purpose and Charge of the Cover All Kids Working Group

- **Governor Murphy**: “No child in New Jersey should be left without the support and security of health care coverage.”

- **P.L. 2021, c.132** builds on past collaboration:
  - *The Commissioner of Human Services shall establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low- and moderate-income families who may be eligible for Medicaid, NJ FamilyCare, or NJ FamilyCare Advantage; to maximize enrollment in these programs; and to ensure retention of enrollees in these programs.*

Cover All Kids Working Group Overview

- An Outreach, Enrollment, and Retention Working Group, comprised of Cabinet representatives and public members, has been convened as required by P.L. 2021, c.132. The working group has met three times, and additional meetings are scheduled every 4-5 weeks throughout the remainder of the year.
- Initial focus areas for the Working Group:
  - Marketing & Messaging
  - Overcoming Barriers to Access in Specific Communities
  - Enrollment and Retention
  - Data, Research and Effectiveness of NJ FamilyCare (NJFC) Outreach Material
  - Immigrant Eligibility Criteria for Health Coverage
  - Interagency Confidentiality and Collaboration
- Their important work is underway.

Managed Care Quality & Accountability

Quality Strategy

The Quality Strategy is:	A set of guidelines that structure a state's Managed Care accountability
	Designed to assess and improve the quality of services provided by MCOs
	A roadmap for ongoing improvements in care delivery and outcomes
	Compliant with the federal regulations that CMS requires for states with managed care contracts

Key Sections of the Quality Strategy

History of Quality Strategy	1115 demonstration initially approved October 2012
	Renewed August 2017
	Current demonstration combined/expanded upon two 1915(b) Managed Care Waiver programs – Four 1915(c) HCBS waivers, Title XIX Medicaid and Title XXI CHIP Section 1115 demonstrations
Organizational Structure	Operates under Department of Human Services (DHS)
	Administers Medicaid's state and federally-funded NJ FamilyCare program
	Medical Assistance Advisory Council (MAAC) advises DMAHS and fosters communication with the public.
Key Demographics	Serves over 2 million low-to-moderate income adults, nearly 22% of NJ's residents
	Provides health coverage to children, pregnant people, single adults, childless couples, aged, blind, disabled, and individuals qualified for long-term care services
NJ Managed Care Organizations	MCOs coordinate services and health care needs
	~97% of NJ FamilyCare beneficiaries are enrolled in an MCO
	5 MCOS participate in the NJ FamilyCare program

Mission, Values, and Goals

The Department of Human Services (DHS) is dedicated to providing **quality services** that consistently meet expectations with the goal to **protect, assist, and empower** economically disadvantaged individuals, families, and people with disabilities to achieve their maximal potential. We strive to **ensure a seamless array of services** through partnerships and collaborations with communities statewide. We seek to **promote accountability, transparency, and quality** in all that we do.

CMS Aims	NJ DMAHS Goals	NJ DMAHS Objectives
 **Better Care**	Serve people the best way possible through benefits, service delivery, quality, and equity	• Improve maternal/child health outcomes • Help members with physical, cognitive, or behavioral health challenges get better coordinated care • Support independence for all older adults and people with disabilities who need help with daily activities
 **Smarter Spending**	Experiment with new ways to solve problems through innovation, technology, and troubleshooting	• Monitor fiscal accountability and manage risk • Demonstrate new value-based models that drive outcomes • Use new systems to improve program operations
 **Healthier people, healthier communities**	Focus on integrity and real outcomes through accountability, compliance, metrics, and management	• Address racial and ethnic disparities in quality of care and health outcomes • Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers • Ensure program integrity and compliance with State and Federal requirements

Purpose and Scope

Purpose of the Quality Strategy

- Establish a quality improvement plan designed to develop and sustain an effective and efficient healthcare delivery system
- Design a roadmap that continues to expand on assessment, measurement, and improvement opportunities for MCOs
- Achieve program excellence and improve member satisfaction through meaningful quality improvement activities
- Identify new and innovative ways to simplify and make healthcare more affordable
- Promote person-centered healthcare, social services, and supports

Scope of the Quality Strategy

- All NJ FamilyCare beneficiaries in demographic groups and service areas in which the MCOs are contracted
- All services covered by the MCOs
- All aspects of care of services covered by NJ FamilyCare
- All aspects of MCO operations and performance

Development, Review, and Evaluation

Development of the Quality Strategy

- Uses internal and external stakeholder feedback
- Considered a living document reflective of the ongoing improvements in NJ
- Draws upon shared goals and priorities across programs

Review and Update of the Quality Strategy

- Annual review
- Updates every three years at a minimum, or whenever upon significant change (material changes to structure, quality management practices/standards, membership demographics, provider networks, or benefits)

Evaluation of the Quality Strategy

- Review of the Managed Care Contract every six months and alignment to aims/objective of the Quality Strategy
- Annual review of EQRO reports to monitor compliance to the Managed Care Contract
- Ongoing MCO accountability reviews highlighting each MCO's strengths, weaknesses, and concerning findings
- Routine monitoring of lead and lag performance indicators and data collected by DMAHS and/or submitted by the MCOs (i.e. member and provider inquiries, HEDIS, CAHPS, NCI-AD, grievances and appeals)
- Effectiveness evaluation (appendix F) to assess and improve the quality of managed care services

Quality Assessment and Performance Improvement

External Quality Review	Performance Improvement Projects (PIPs)	Quality Metrics & Performance Targets	Disparity Prevention and Reduction	Grievances and Appeals
• NJ contracted with IPRO • Measures MCO quality and monitors compliance standards • Conducts mandatory and optional activities (i.e. MCO annual assessment, validation of performance measures, Care Management audits)	• DMAHS collaborates with MCOs and the EQRO on topics • MCOs required to report twice each year • All NJ MCOs engaged in at least one of each PIP: clinical, non-clinical, and MLTSS-specific	• NJ uses nationally recognized measures wherever appropriate and possible • MCOs that fall below benchmarks must submit a work plan with interventions to improve • Many scores publishes on NJ FamilyCare Analytics Dashboard	• MCOs are required to submit a program that identifies, evaluates, and reduces healthcare disparities • 1115 renewal includes addressing known gaps and improving quality in maternal and child health • DMAHS is looking to expand health equity analyses to support improved access and outcomes	• MCO systems must support monitoring and tracking of all grievances and appeals • MCOs submit standardized reports to DMAHS quarterly • DMAHS shares concerns and trends with MCOs during accountability meetings

State Standards for Access and Operations

Availability of Services

- Establish, maintain, and monitor a network of providers that is sufficient to provide adequate and timely services
- Standards of care are outlined in MCO Contracts by provider type (emergency services, routine care, dental, etc.)

Assurances of Adequate Capacity and Services

- Must comply with certain provider ratios, geographic access, and travel time standards
- Submit quarterly network reports to demonstrate compliance with standards

Coordination and Continuity of Care

- Review other sources of coverage to coordinate services
- MCOs honor and pay for ongoing services for established prior to enrollment for new enrollees grammar clarity needed
- Provide members with the opportunity to select a PCP or assign one if no selection is made

Coverage and Authorization of Services

- Members have access to all covered services in an amount, duration, and scope as established by the Contract
- Cannot arbitrarily deny or reduce services solely because of diagnosis or condition
- Contract specifies timeframes and requirements for specific types of determinations

Enrollees with Special Needs

- Contract sets forth requirements for identification and services delivery for those at risk or for those who have special needs
- Must complete Comprehensive Needs Assessment (CNA), develop care planes, and ensure services are rendered timely and are equal in quality and accessibility

Standards for Structure and Operations

- Contract sets forth requirements for MCO structure and operations
- MCO systems must protect patient confidentiality; providers must protect the rights of enrollees
- Must adopt evidence-based clinical practice guidelines

Improvements and Interventions

Quality Improvement Program (QIP)

- DMAHS partnered with DOH to develop a hospital performance initiative to advance quality in maternal and behavioral health

EPSDT Incentive Payment

- MCOs are required to pay an increased fee to providers for each EPSDT screening, which motivates providers to conduct age-appropriate screenings to support better health outcomes

Performance-Based Contracting

- DMAHS developed performance payment pools to leverage competitive dynamics and to incentivize managed care performance in achieving defined benchmarks

Corrective Action Plan (CAP)

- Required for activities resulting in noncompliance

Notice of Deficiency (NOD)

- Issued for noncompliance with program standards, performance standards, or terms of the Contract
- Accompanied by a CAP

Liquidated Damages

- May be issued as a disciplinary action
- In conjunction with or separate from NODs

Administrative Sanctions

- May be issued if an MCO fails to correct a deficiency in a timely manner
- Type of action is relative to the nature and severity of the deficiency

MCO Accountability

	What have we accomplished?	What are we working on next?
MCO Contract and Reporting	• Modified pay-for-performance incentive structure to include new measures while maintaining performance on historical measures • Developed concise reporting to make data-driven decisions (COVID-19 vaccinations, unstaffed cases)	• Ongoing updates to MCO interventions (pay for performance, value-based programs) and intermediate actions (notices of deficiency, liquidated damages) to drive MCO accountability • Introduce quality withholds
Accountability Performance Reviews	• DMAHS leadership meets with MCO executive teams monthly to review performance and quality trends • Use available data (public and proprietary) to develop agendas including provider/member inquiries, audit findings, network adequacy, clinical and operational trends, etc.	• Further align program operations to MCO performance – e.g. boost auto-assignment to high performing MCOs • Ongoing incorporation of key metrics required by CMS

MCO Accountability

	What have we accomplished?	What are we working on next?
New Jersey's Quality Strategy	• Drafted NJ's Quality Strategy: a roadmap to assess and improve the quality of services provided by Managed Care Organizations • Posted for public comment	• Ongoing updates to NJ's Quality Strategy, aligning MCOs improvements and interventions to State objectives • Advance health equity across NJ FamilyCare through MCO collaboration
NJ FamilyCare Dashboards	• Developed and published NJ's quality dashboard • Compares NJ MCOs to national measures of clinical care and consumer experience	• Enhance quality dashboard to include other public performance metrics such as service delivery, network adequacy, and performance improvement actions

COVID-19 Unwinding

“Unwinding” the federal Public Health Emergency

Since March 2020, NJ FamilyCare members have remained enrolled due to federal “maintenance of effort” requirements during the Public Health Emergency (PHE).

The PHE is expected to end on July 15, 2022, at which time standard redetermination activity is expected to resume.

CMS has given states 12 months after the PHE ends to reprocess eligibility for all Medicaid beneficiaries – this includes 2 million NJ FamilyCare members.

This “unwinding” represents the single largest redetermination exercise in the history of New Jersey’s Medicaid program. Our preparedness for this exercise is a top priority at DMAHS.

What we will talk about today

- ✓ We are collaborating with existing operational and community partners to raise awareness and do this work the best way possible.
- ✓ We will coordinate with partner agencies to connect people who are no longer eligible for Medicaid to other coverage, including subsidized coverage through GetCoveredNJ.
- ✓ We will spread cases evenly over the twelve months and we have upgraded our eligibility systems throughout the PHE, which will help with quality and efficiency.
- ✓ There is always a pathway for eligibility appeals, which includes a Fair Hearing through the administrative courts, but we hope to resolve individual issues without the need for hearings in as many situations as possible.

North Star Principles for Unwinding the PHE

Serve people the best way possible.	We will **resume Medicaid eligibility redeterminations** 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.

Hypothetical Timeline for PHE Unwinding

4/18/22
Ambassador call center goes live

5/15/22
CMS announces that the federal PHE will not be extended

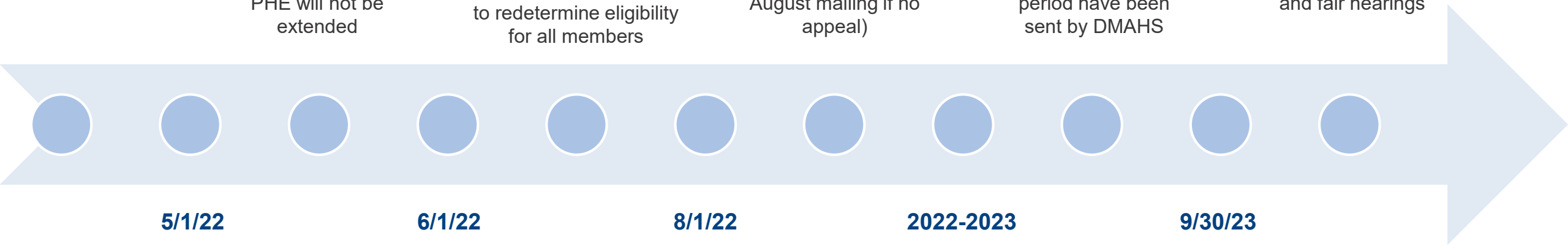
7/15/22
Federal PHE ends

States have 12 months to redetermine eligibility for all members

10/1/22
First disenrollments occur (cases from August mailing if no appeal)

8/1/23
All pending renewals from PHE period have been sent by DMAHS

Post 10/1/23
Likely ongoing "good faith" cases and fair hearings



5/1/22
MCO member outreach kicks off – priority on members who have not responded to recent mailings

6/1/22
Outreach continues

Communications campaign underway

Counties prepare to manage volume

8/1/22
First renewal mailings that may result in disenrollment are sent

2022-2023
Continuing high volume of outreach, redetermination, and fair hearing activity

9/30/23
All determinations from the PHE are complete, per federal requirements

All dates are hypothetical pending federal guidance

Role of Eligibility Determining Agencies

Our Eligibility Determining Agencies (EDAs) will need to redetermine Medicaid eligibility for 2 million beneficiaries in the 12-month period following the end of the PHE. *We will be spreading the activity evenly over those twelve months*.

County Welfare Agencies

21 counties

- Responsible for eligibility for about 1 million members
- System upgrades initiated during PHE will support quality and efficiency
- 2022 MOU added incentives for renewal performance

NJ FamilyCare Health Benefits Coordinator

Conduent

- Responsible for eligibility for about 1 million members
- Ambassador team will support all NJ FamilyCare members with address updates and unwinding questions
- Eligibility processing is within contractual timeframes

Weekly operating reports and monthly regulatory reports will track progress.

Examples of Medicaid Eligibility Determination

Halima	Hector	Samuel	Sofía
• Called the Ambassador line to provide an updated address to NJ FamilyCare (or didn't) • Received and responded to eligibility mailing • Determined eligible • Halima's eligibility continues	• Responded to eligibility mailing (or didn't) • Hector does not want to remain enrolled • Determined ineligible based on the information he provided or his non-response • Hector's eligibility ends	• Responded to eligibility mailing • Determined ineligible due to income/assets • Received disenrollment notice; account transfer to GetCoveredNJ • *Samuel wants to remain enrolled*	• Did not respond to eligibility mailing • Determined ineligible due to non-response • Received disenrollment notice, which includes GetCoveredNJ information • *Sofía wants to remain enrolled*

Rapid response, informal resolution, and Fair Hearings will support these members

MCOs will support member-specific outreach strategy

Starting now:

MCOs will share updated member contact information with DMAHS

- **For the first time**, CMS is permitting states to accept updated member contact information from MCOs with a temporary waiver
- **Next steps**: We received CMS approval of our waiver request last week and testing is complete, so we will be formally operationalizing with MCOs in May

Starting May 1:

MCOs will reach out to members who have not responded to mailings

- **For the first time,** DMAHS is identifying MCO members who have not responded to recent eligibility mailings.
- MCOs will attempt to reach these members and their providers to update contact information and encourage them to respond to mail*
- **Next steps**: We are finalizing outreach plans for consistent messaging across the program

Once the PHE ends:

MCOs will help members avoid disenrollment and/or access other coverage

- Once the PHE ends, members set to disenroll will be identified for MCOs as we have done in the past
- MCOs will attempt to reach members and help them avoid disenrollment
- **For the first time**, CMS is allowing post-disenrollment outreach. We are working on an approach to this.
- **Next steps**: Finalize communication templates and protocols for MCOs

*Federal guidance states that MCO communications cannot be "intended to influence a beneficiary to enroll."

Important Messages to Share with our Communities

- **Key messages to our communities today…**
  - Call 1-800-701-0710 to make sure NJ FamilyCare has your current address
  - Respond to any mail you receive from NJ FamilyCare

- **Message after the PHE ends…**
  - Same as above, and:
    - If you believe you have been incorrectly terminated, you have appeal rights
    - If you are ineligible for NJ FamilyCare, you can apply for coverage through GetCoveredNJ

- **Community partners include…**
  - Health care providers and payers
  - Community leaders and organizations
  - Aging and disability advocates
  - Medical Assistance Advisory Council (MAAC) and Cover All Kids workgroup members
  - Regional Health Hubs
  - Sister agencies, including DOBI navigators

Planning for the Next Meeting – July 12, 2022