MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Videoconference
April 22, 2021
10:00 a.m.

FINAL
MEETING SUMMARY

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

MEMBERS NOT PRESENT:
Dorothea Libman
Sherl Brand
Chrissy Buteas

ALSO PRESENT:
Jennifer Langer Jacobs, Assistant Commissioner,
Division of Medical Assistance and Health Services
Carol Grant, Deputy Director,
Division of Medical Assistance & Health Services
Heidi Smith, Chief of Operations,
Division of Medical Assistance & Health Services
Greg Woods, Chief Innovation Officer,
Division of Medical Assistance & Health Services

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

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1 DR. SPITALNIK: Good morning. I'm Deborah
2 Spitalnik, Chair of the New Jersey Medical Assistance
3 Advisory Council (MAAC), and it's my pleasure to welcome you to
4 this April 22nd meeting, which is being conducted
5 remotely. Notice of this meeting and all required
6 conditions of the New Jersey Open Public Meetings Act
7 have been met.
8 Before we move to the agenda, let me explain a
9 little bit about our format. The members of the of the
10 Medical Assistance Advisory Council have the capacity
11 to unmute and ask questions or speak. The good news is
12 the size of our meeting; the bad news is that that
13 creates technical challenges. So if you have questions
14 or comments that you wish to make, please put that in the
15 Question and Answer box and we will try to address that in the course
16 of the meeting. Thank you for being with us today.
17 And let me ask the members of the Medical
18 Assistance Advisory Council who are present to please
19 unmute. And I'll just do it visually. If all the
20 members would unmute, and I will call on Wayne Vivian.
21 Please introduce yourself by name and then I'll call on
22 the next person. Thank you.
23 MR. VIVIAN: Wayne Vivian, President of the
24 Coalition of Mental Health Consumers Organization.
25 DR. SPITALNIK: Thank you.

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1 Theresa.
2 MS. EDELSTEIN: Good morning. Theresa
3 Edelstein, New Jersey Hospital Association.
4 DR. SPITALNIK: Thank you.
5 Mary.
6 MS. COOGAN: Good morning. Mary Coogan,
7 Advocates for Children of New Jersey.
8 DR. SPITALNIK: And Mary Pat.
9 MS. ANGELINI: Good morning, everybody. Mary
10 Pat Angelini, CEO of Preferred Behavioral Health Group.
11 DR. SPITALNIK: Thank you.
12 Beverly.
13 MS. ROBERTS: Good morning. Bev Roberts, The
14 Arc of New Jersey.
15 DR. SPITALNIK: I think that's the members
16 that we have with us today. While I'm going through the
17 agenda on the next slide, would someone from the Division
18 let me know whether we have a quorum to approve the
19 minutes?
20 So our agenda for today is to address our
21 minutes from our last meeting. We have the report on
22 COVID-19 vaccine distribution with Assistant Commissioner
23 Jennifer Langer Jacobs. We'll have a series of policy
24 implementation presentations, Managed Care updates, other
25 New Jersey FamilyCare updates, and as always, then we'll

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1 plan for our next meeting.
2 So we do have a quorum to approve the minutes.
3 So I would entertain a motion from someone on the MAAC
4 for approval.
5 MS. COOGAN: I'll make a motion to approve the
6 minutes.
7 MS. ANGELINI: Second.
8 DR. SPITALNIK: Are there any comments,
9 corrections?
10 Hearing none, by signifying aye, would the
11 members who approve the minutes unmute and say aye.
12 MAAC MEMBERS: Aye.
13 DR. SPITALNIK: Thank you.
14 Anyone opposed?
15 Any abstentions?
16 Hearing none, the minutes are approved, again,
17 with our thanks, as always, to Phyllis Melendez and Lisa
18 Bradley who keep our record.
19 We'll now turn to Jennifer Langer Jacobs who
20 will speak about COVID-19 vaccine distribution.
21 As we turn to you, Jen, I just really want to
22 publicly acknowledge how much effort you and Carol Grant
23 and Phyllis Melendez and Karen Enock put into the
24 planning of the meetings. And certainly, that effort
25 ripples throughout the Department in what everyone

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1 contributes. So thank you and good morning.
2 MS. JACOBS: Thank you. Good morning,
3 everyone.
4 You know, it did not escape my attention as we
5 were preparing for this meeting that this meeting marks
6 one full year that we have been meeting remotely as MAAC.
7 And, obviously, a lot has gone on in that time. We've
8 been down along road together. And it feels good that
9 we're talking today about vaccine distribution. It feels
10 like progress. And also, of course, we know that we're
11 not out of the woods yet with this.
12 The one thing I wanted to mention to you all
13 before I go into the vaccine discussion is I think we had
14 indicated to you our intention to spend some deep-dive
15 time on the 1115 Waiver Renewal in this discussion today.
16 And it turns out that we have a new presidential
17 administration. We are still working through some
18 questions ourselves internally on the 1115, and we're
19 still managing, obviously, a lot of COVID-related work.
20 So we won't be able to deep dive with you today on the
21 1115, but we've had a discussion with Dr. Spitalnik about
22 scheduling a special MAAC session really dedicated to
23 that topic where we can give you all of our thinking, as
24 this renewal really represents some strategic planning
25 for the period that comes up ahead of us over the next

1 five years. So we want to make sure that we're having a
2 very thoughtful discussion about that with you and a
3 detailed one. So Greg's going to talk a little bit about
4 the 1115. You see that on the agenda here for today.
5 But we wanted to be specific with you that the true
6 deep-dive discussion that we plan on having with you is
7 going to be coming up over the next couple of months. So
8 we're still just working through those details. And I
9 wanted to be clear about that upfront before I got into
10 other topics.
11 So let's go ahead and talk a little bit about
12 vaccine distribution. It is really exciting to be having
13 this conversation. It was literally and figuratively a
14 shot in the arm for us when we were able to start doing
15 this work. And so I hope that many or most of you have
16 been out for at least your first shot and hopefully your
17 second, and we're all collectively moving in the right
18 direction here in New Jersey.
19 We want to talk to you about how we have
20 approached this really specifically with an eye to equity
21 and outcomes for our Medicaid community. And so we're
22 going to go deep today on the strategic plan that we have
23 put in place that is currently in motion to ensure that
24 our members have access to the vaccine and understand the
25 benefits of getting the vaccine, and then we'll talk to

1 you a little bit about what the future looks like.
2 So the first thing I wanted to explain is the
3 way that we have partnered with our Managed Care
4 Organizations to prioritize outreach to our Medicaid
5 community. As you know, or I hope you know, the
6 Department of Health has really led the way in
7 determining which populations in New Jersey are eligible
8 at any given time since the vaccine rolled out in January
9 or late December, I guess, and we have obviously followed
10 that guidance. So Department of Health is making the
11 call directly on who is eligible for the vaccine when.
12 And as I hope you know, we're all eligible now as of this
13 week.
14 So what you're looking at here is our
15 prioritization, not of who was eligible because that was
16 already determined, but of who we wanted to be reaching
17 out to first and fastest. So we're not talking here
18 about the Department of Health's eligibility timeline.
19 We're talking here about in our partnership with the
20 Managed Care Organizations, who were we asking them to
21 reach out to first and fastest. So if look at the red,
22 orange, and yellow triangle, just to the left of it, you
23 see a bracket which shows you that most of the people in
24 the categories we saw as highest priority, the red and
25 the orange categories, most of those people were eligible

1 for the vaccine as of January 14th, which is about when
2 our progressive outreach started.
3 So in the red group, we have our members who
4 are 75 years old or older, any member with two or more of
5 the priority conditions you see underneath the triangle,
6 and all of our MLTSS members living alone. The concern
7 there for MLTSS members living alone, there are some
8 MLTSS members who may actually not have been eligible
9 immediately based on age or conditions, but we were
10 concerned to make sure that those MLTSS members who live
11 alone had a plan for when they did become eligible. So
12 that's one group that we were reaching out to right away
13 even though they might not have been immediately
14 eligible. They might have been 65 and not have any of
15 the conditions that are in that box under the triangle.
16 So we were just really there thinking about making sure
17 that people had a plan if they didn't necessarily have
18 community informal supports of family and friends. Then
19 the orange group was the group we saw as being sort of
20 the next most urgent group to reach out. And the yellow
21 group included all of our members above age 16 who we
22 believed would be eligible for vaccination in due course,
23 as in today.
24 So we asked the MCOs to work with us to both
25 establish this prioritization -- and we really

1 appreciated the medical directors who worked closely with
2 us to do this -- and then also to get their care managers
3 mobilized around this outreach. And the one thing I
4 really need to point out to you here as we talk about
5 this work that we've been doing, at the bottom of the
6 slide you see a green arrow where we're telling you that
7 the prioritized outreach work we've been doing with the
8 Managed Care Organizations has really specifically
9 focused on the community population, because there is a
10 federal and state partnership that provides the
11 vaccination program for nursing facility residents.
12 We're not going to be talking about that today because it
13 has not been operated by DMAHS or even by Department of
14 Human Services. Department of Health was really the
15 partner to the federal program, and they have managed the
16 nursing facility vaccinations. So our work has really
17 been focused on the community.
18 And what you see here is the community member
19 count for each of our five MCOs based on the red, orange,
20 and yellow prioritization. So you can see these are the
21 numbers of individuals that they were reaching out to
22 within each priority level, and you can see all of the
23 16-plus community here in the last column.
24 So the first thing we wanted to do in our
25 outreach was make sure that all of our members received

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1 information on the vaccine and that the information they
2 had gave them both the Internet path to vaccination and
3 the non-Internet path to vaccination because we
4 recognized that some of our members do not have an e-mail
5 address, does not have a computer, English may not be
6 their first language, and so we really wanted to address
7 that reality immediately in the first mailing that went
8 out.
9 The other thing we tried to address is
10 concern, the vaccine hesitancy that we heard people
11 talking about from the very beginning but that certainly
12 that we still hear day. So there's both access and
13 education in this mailing. And we asked each of the MCOs
14 to work with us to send one standardized mailing out to
15 our entire Medicaid community. So that mailing went out
16 both in English and in Spanish. I gave you the
17 megacenters piece here in Spanish just so you can see
18 that the translation did occur for each of the documents
19 in the mailing, in the envelope.
20 This is CDC educational material that went
21 out. They did a really nice one-pager in English and
22 Spanish. We sent out the megacenters. And then we sent
23 out this letter that would help people access both online
24 and by phone.
25 And with each of those mailings goes the

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1 notice we call the babble notice which includes
2 information in many languages to help folks understand
3 that they can get the materials translated if they need
4 it. And you can see here in the letter we referenced the
5 many languages that are available through the call
6 center.
7 So this mailing went out to all of our members
8 through their health plan and included the contact
9 information both for state resources and to contact their
10 health plan if they had any questions the health plan
11 could help with.
12 Then we asked the MCOs to start reaching out
13 to their members, and they did that in a lot of creative
14 ways. So I asked them to share with us some slides that
15 would give you a sense of what was going on at each of
16 the Managed Care Organizations. I'm not going to spend a
17 long time on these slides. They'll be available online
18 if anybody wants to take a close look after the meeting,
19 but I wanted to share some of the different ways that
20 they have been doing outreach.
21 So here on the AETNA slide, you'll see
22 reference to the storefront that AETNA has in Newark, the
23 team that they have on the ground, and then also the care
24 managers who have been dialing out to reach people
25 telephonically, including a special task force they hired

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1 to help us with vaccine scheduling specifically when the
2 Newark popup site occurred, which FEMA is operating right
3 now.
4 On the Amerigroup slide, you'll see
5 partnership with provider practices because we understood
6 that our members are community. They really in many
7 cases appreciate and trust the opinion of their PCP,
8 their primary care provider, or other health care
9 providers that they're seeing. So the health plan
10 understood the value of partnering with providers,
11 whether they're physicians, hospitals, FQHCs, et cetera.
12 And you'll also see in a few of these slides
13 references to MCO staff who are volunteering at
14 vaccination sites and out in the community.
15 Horizon's slide talks about some of the
16 creative approaches that they've taken, including
17 extending to evening and weekend hours to help reach
18 their members by phone. Not everybody is available to
19 pick up their phone during the day. I'm certainly not.
20 And so they went ahead and extended hours and
21 collaborated across departments in order to be able to
22 reach people when they were available. And you see
23 additional references to work that they're doing with the
24 community directly, community partners.
25 Similarly for United, a lot of focus on the

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1 outreach by phone, reminder calls. After you've had your
2 first shot, you want to make sure you don't forget to get
3 that second shot. And then volunteering and sponsorship
4 of different community events, so they're really trying
5 to stay involved in that way.
6 And then on the WellCare side, we often see
7 partnerships with community organizations and
8 particularly with faith-based organizations.
9 So you'll see across the different plans,
10 there has been a lot of different geographic focus as
11 well. We see diversity north-south and also lots of
12 different kinds of communities. Being from central
13 Jersey, I feel like I need to say north, central, south.
14 And across lots of different types of organizations.
15 So our goal here was, look, people are going
16 to be going out and getting vaccinated. The Department
17 of Health has an immunization registry. We want to know
18 that our members are getting vaccinated, and we need you
19 to track that for us. So we set up a biweekly report
20 that the MCOs are submitting to us, and it details their
21 progress on reaching out and getting members vaccinated,
22 helping people both understand the value of the vaccine,
23 and also getting appointments to get their vaccine.
24 And we do hear that appointment availability
25 has improved somewhat over the last few weeks as supply

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1 is beginning to come in. But, obviously, it has been a
2 struggle for a lot of folks, present company included, to
3 try to get an appointment. So our Managed Care
4 Organizations are expected to be reaching out to their
5 members, giving them the educational information they
6 might need to help them decide that they want to get the
7 vaccine, and then get the appointment.
8 So when they're reporting to us biweekly, they
9 are giving us information they have from the immunization
10 registry from any claims they may have received from
11 providers. So the federal government is paying for the
12 vaccine, but providers can bill managed care for the
13 administration of the vaccine so they may see a claim.
14 And then members are telling us that they got the
15 vaccine. So if we don't have immunization registry data
16 and we don't have claims, we may still have the member
17 telling us that "I got vaccinated."
18 So they're giving us all that data biweekly
19 and that includes the red, orange, and yellow priority
20 levels I talked to you about a few minutes ago, but also
21 race and ethnicity and geography. So it's a pretty
22 robust look, with some challenges. And so I wanted to
23 talk to you about the challenges that we've experienced
24 with this, because that's just real. So rolling in, we
25 were like we're going to have a great data set, we're

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1 going to know everything in real time. We do not know
2 everything in real time. And so here's what we're up
3 against.
4 For one thing, the immunization registry data,
5 which is fantastic, is constrained by the match
6 limitations. In the register, they are not able to pull
7 unique ID that would allow us to directly one-to-one
8 match a Medicaid member to an ID number. So, for
9 example, in the old days before identity theft, people
10 would use the Social Security number as an ID. That's
11 certainly what they did when I was in college. Nobody
12 does that anymore. So now you have a Medicaid ID, you
13 have a health plan ID. Not all of that ID information is
14 coming through to us in the data sharing from the
15 immunization registry. So some of that is because they
16 don't have it. The provider may not have entered that
17 information or may not have entered it accurately. It's
18 possible also that there are some fields we're just not
19 able to see yet. But the long and the short of it is, we
20 are not getting perfect information yet coming through
21 the immunization registry, so we're a little bit
22 constrained that way.
23 We also know that not all the vaccine sites
24 are collecting health insurance information. And so you
25 may yourself have gone in to get a vaccine and they asked

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1 you for a photo ID probably, but they may not have asked
2 you for your health insurance card. And if they didn't
3 ask you for your health insurance card, then we're not
4 going to have that number. So we're not always getting
5 that kind of information coming through, again, to be
6 able to connect the member to the vaccination. We always
7 expect that we will have delay in claims. So there's
8 some claims data that's not coming through in real time,
9 and it will come through eventually.
10 The next bullet, though, will not always come
11 through. We have many members of our Medicaid community
12 who are also covered by Medicare. And so if there was a
13 claim submitted by their primary care provider, it was
14 probably submitted to the Medicare. And without going
15 into a lot of weeds you don't want me to go into, there's
16 some Medicare data that does come through to us. And if
17 that data flows through, the health plans are
18 incorporating it into their reporting, but there's a lot
19 of Medicare data that does not flow through to us, really
20 specifically, Medicare Advantage plans. And so there's
21 data we will receive over time as providers submit claims
22 to Medicare, and there's data we will never see.
23 And then finally, we are hearing, as I
24 mentioned to you, members are telling us they have
25 received the vaccine. We don't have any way to validate

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1 that information, obviously. So we accept it and we note
2 it, but from a scientific research point of view, we
3 don't have the validation on that without going into
4 their doctor's records one by one.
5 So that's obviously a list of limitations in
6 the data that have become part of our reality over the
7 last few months. And we wanted to share it with you
8 because we really imagined that we would have clearer
9 data at this point in time to be able to report to you on
10 the vaccination rates in our Medicaid community. We're
11 not quite there yet. But we are encouraged that even for
12 the members who we believe to be unvaccinated, which is
13 obviously where health plans are focusing their outreach
14 right now, as they're out reaching those members, they're
15 often hearing, "I have received the vaccine."
16 And so what that means to us is there's a gap
17 in the data that we're seeing, but folks are out there
18 and they're getting the vaccine. And so more and more
19 we're narrowing our focus and trying to make sure that
20 we're reaching out to the folks who truly have not yet
21 had the vaccine and letting everybody else go on with
22 their lives.
23 So that's where we are with what I think of as
24 the quantity tive aspect of the vaccination initiative,
25 and I wanted to you talk to you just a little bit before

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1 we move on to other things about access and hesitancy,
2 which were the two issues we anticipated all along.
3 So let's start here with vaccine access. In
4 our biweekly reports, we've asked the health plans to
5 talk to us about the barriers that they're hearing. So
6 we've definitely heard about limited availability of
7 appointments. We're really just starting to see more
8 appointment volume opening up in recent days. So that's
9 been a barrier. Certainly, members who are homebound,
10 this is discussion that we've been having with Department
11 of Health and local public health officials. Some
12 members who have no computer or e-mail access, which
13 we've talked about a little bit. And then "I'm not sure
14 how I would get there and back." So these are the things
15 that we're hearing in telephonic outreach and from work
16 being done in the community.
17 And then on the right-hand side of this table,
18 we tried to give you the responses that we've already
19 deployed and we continue, obviously, to focus here. For
20 one thing, we have been partnering very closely with the
21 Department of Health's call center. We really set up a
22 nice partnership there so that they're focused on making
23 sure that our Medicaid community has access to the
24 vaccine. And we have really appreciated the shared
25 passion on that. So the most recent example where we

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1 really kind of built our muscle on this as a team was
2 around the FEMA site, the pop-up site in Newark which you
3 may have heard about. We went to the Department of
4 Health really on the suggestion of one of our Managed
5 Care Organizations and we said, "Hey, we have a large
6 segment of the Newark community that's covered by
7 Medicaid. Can you hold an appointment block specifically
8 for people with Medicaid coverage?"
9 And Department of Health worked with us on
10 that. So what we did was we had the Managed Care
11 Organizations reaching out to their members who live in
12 the Newark area, and we had Department of Health reaching
13 out to members as well. And between the two of them, we
14 filled out that Medicaid appointment block of about
15 2,000. So that was a really good partnership. We can
16 talk more about Newark if folks are interested, but it's
17 not the only example we have.
18 And where we are right now with Department of
19 Health is really partnering with them to broaden out the
20 connection of our Medicaid members to appointments all
21 over the state. And so that's been a really nice bridge
22 that we've built, and I think we will be spending some
23 time on that bridge for the foreseeable future because,
24 obviously, this is not something that's going away.
25 We've also had partnership with various

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1 provider groups and our MCOs on scheduling of vaccine
2 appointments to make sure that our members would have
3 access. And then as we have heard about sites, an
4 example that we noted on the page here as Gloucester. As
5 we've heard about sites where there was sudden
6 appointment availability. And the example of Gloucester
7 was early on they had a 75-years-plus distribution
8 opportunity. And it really wasn't widely publicized and
9 it was very specifically for members who were 75 or
10 older. Our health plans can easily pull that information
11 and begin outreaching the right people. So we asked them
12 to do that in a couple of these cases.
13 And then we've also been partnering with
14 ModivCare, formerly known as LogistiCare, and other
15 partners on making sure that people have transportation.
16 And so our members and a caregiver are able to travel to
17 whatever site they're able to get an appointment at
18 regardless of mileage.
19 So that's where we are and where we've been on
20 vaccine access issues. As these issues pop up, we're
21 really just trying to make sure that we're very
22 responsive to what's actually going on on the ground.
23 And that, I think, really has been a larger factor in
24 some ways than hesitancy. Although at some point there's
25 an inflexion point where the access issues start to fall

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1 away because supply and demand have leveled out a little
2 bit. And now you can get the appointment, but we've
3 still got this hesitant population. So access definitely
4 was the bigger challenge in the early days here. But
5 hesitancy remains a challenge. So there, what we've
6 heard is general fear of the vaccine or mistrust of the
7 way the vaccines were developed, "I'm waiting to see if
8 there are long-term side effects for people who got the
9 vaccine." And particularly in the early days, some
10 people saying, "I am waiting for a single dose option."
11 And now, as you probably know, we are paused on the J & J
12 distribution so that single dose option again becomes a
13 factor for some folks.
14 And so we really tried to deploy the right
15 strategies around those specific things. As I mentioned
16 before, we sent out this letter through our health plans
17 to all of our members. And we really tried to use the
18 solid materials that have been provided by the CDC and
19 the Department of Health, and we tried to write that
20 letter. I was really close to that. We tried to write
21 that letter in a way that said, "This matters for you and
22 for your family," because some of the research, the focus
23 groups that were done early on, folks were less concerned
24 about themselves, particularly younger adults, but would
25 become concerned about transmitting the virus to a family

1 member who was older or medically frail. And so the
2 wording of that letter felt important to us.
3 And then we also have made sure that the
4 Managed Care Organizations have talking points around
5 vaccine safety. They worked closely with us to let us
6 know the information that they have felt that people
7 needed as they've been talking with them on the phone.
8 And then also we've made sure that we and the
9 plans are working directly with the community, with
10 public health departments so that as local strategies are
11 deployed, we're not doing our work separately from
12 whatever is happening in the community right there.
13 Dr. Spitalnik, that's where we have been with
14 the vaccine roll-out. It's been just a few months, but
15 it feels like a long road. And we're learning each step
16 of the way. I think we've taken a leadership position
17 among Medicaid programs nationally. That's where we
18 wanted to be. Although the dataset is not yet where we
19 would like, it's not complete, it's not clear, we're
20 building it and we will be building it over time. So
21 we're excited about the work that's been going on here.
22 And I feel like I want to pause for just a minute and see
23 if folks want to talk or ask questions.
24 DR. SPITALNIK: Thank you so much. And I
25 should have pointed out at the beginning that the slides

1 will be posted after the meeting on the DMAHS website
2 under the tab for the medical assistance public council
3 and committees, Medical Assistance Advisory Committee.
4 There's a question in the chat about outreach,
5 but I want to hold that until I poll the MAAC members, if
6 anyone has any questions.
7 Beverly, you look like you've unmuted. Would
8 you like to ask a question?
9 MS. ROBERTS: Deborah, I had not unmuted, and
10 I don't have a question.
11 DR. SPITALNIK: Okay.
12 Anyone else? Please speak out, or speak up, I
13 should say.
14 MS. ANGELINI: I just would like to add a
15 comment, Jennifer, the thoroughness of this plan. It's
16 clear. I know we've got a long way to go, but I'm
17 impressed with the thoroughness of it. Thank you.
18 MS. JACOBS: Thanks, Mary Pat. The teams
19 worked really hard on this.
20 DR. SPITALNIK: Thank you. Any other
21 questions from the MAAC?
22 There was a few questions about outreach. I
23 think you've spoken to a lot of it, but there was concern
24 that there's not sufficient outreach, it may be variable
25 by county, and is the Division relying exclusively on the

1 MCOs for outreach? I think you've addressed some of
2 that, but I didn't know if you wanted to expand on that.
3 MS. JACOBS: Sure. I see a reference to Ocean
4 County specifically, and that's really helpful to us. A
5 couple of things. We asked the plans to send the mailing
6 out to all their members who are eligible. So if anybody
7 didn't receive the mailing, it might be good to
8 double-check your address on record with your health
9 plan. But certainly, if you call your plan, they can get
10 that mailing out to you.
11 And then I would say for the question about
12 are we relying on the plans, the answer there is no. A
13 lot of our partnership is with the plans because we have
14 a contract with them to outreach to our members and
15 provide care management and access to services, so much
16 of what we're doing is through that avenue, but we also
17 have built this bridge with Department of Health. So one
18 of the things that we did in this project was we shared
19 through a data sharing agreement that we have with the
20 Department of Health that is specifically related to
21 public health emergency, we were able to share Medicaid
22 members contact information so that they could reach out
23 directly and help to schedule appointments for our
24 Medicaid community. So we were able to leverage
25 additional resources specifically because of the public

1 health emergency. We wouldn't normally be able to go to
2 Department of Health for that, but those emergency
3 provisions were available to us. And that's why we were
4 so successful with managed care reaching out on this side
5 and Department of Health calling out on their side
6 directly from their appointment call center. That's why
7 we've been so successful in scheduling around that Newark
8 pop-up site, and we're looking to expand that partnership
9 around the State.
10 DR. SPITALNIK: Thank you so much. I think I
11 need to move us to our next segment, which is a series of
12 updates on policy implementation. And we welcome Greg
13 Woods, Chief Innovation Officer for DMAHS; and Carol
14 Grant, the Deputy Director of DMAHS. And I'll leave it
15 to them to figure out the rhythm of who's speaking when.
16 Welcome, Greg and Carol. Thank you for being
17 with us.
18 MS. GRANT: I think Greg is kicking us off.
19 MR. WOODS: Thanks, Dr. Spitalnik.
20 First, I did want to do an update on the
21 status of our 1115 Comprehensive Demonstration renewal.
22 As Jen alluded to at the top, we had previously hoped
23 during this meeting to do a deep dive on the substance of
24 the 1115 renewal. Unfortunately, we're not quite there
25 yet. As Jen alluded to, we're working through a number

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1 of things. We're working through many of the very useful
2 stakeholder comments that we've received and early input
3 on things we should be thinking about as we move through
4 the renewal process. We are working some policy details.
5 And critically, we are working with our federal partners
6 to make sure that when we come out with our proposal,
7 that it's something that we feel comfortable, has a good
8 chance of being at least largely workable and something
9 that our federal partners at the Centers for Medicare and
10 Medicaid Services would approve. So apologies that we're
11 not ready to give a deep dive today. We are working --
12 this is a focus area for us. We continue to work.
13 As Jen mentioned at the beginning, we expect
14 to come back to the MAAC. So the process has not
15 changed, it's just a little bit later than we had hoped.
16 We expect to come back to do two public hearings,
17 including at least one with this body, during our public
18 comment period. There will also, as part of that public
19 comment period, be the opportunity for all stakeholders
20 to submit formal written comments which we'll take into
21 consideration.
22 I also would expect that we will probably do
23 some targeted outreach sessions with specific stakeholder
24 groups on specific issues based on the specific content
25 of our 1115 renewal application. So that will also be

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1 part of the strategy.
2 I have learned my lesson. I'm not going to
3 identify a specific date for when that's going to happen.
4 Our expectation is that will be sometime during the next
5 few months. And so we appreciate your patience on that.
6 We appreciate all the feedback that we've gotten to date.
7 And so please stay tuned, and we expect to be having a
8 more detailed conversation about this soon.
9 DR. SPITALNIK: Greg, thank you very much for
10 this. We're also very appreciative that it's a new
11 administration in Washington and there's a lot of
12 personnel shifting that goes on at this time and that
13 that often creates more protracted periods. So none of
14 us interpret this as the Division being behind, but
15 rather moving to a new frontier.
16 Are there any comments or questions at this
17 point? I'd ask that they just be about the process, not
18 the content of the waiver. If so, please unmute.
19 Theresa Edelstein, please.
20 MS. EDELSTEIN: Just a quick question.
21 Because of the new administration, have any of
22 the submission timetables moved forward? Are there
23 extensions available to you? Anything along those lines
24 that you know?
25 MR. WOODS: So we have had some conversations

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1 with our partners at CMS around time line. The short
2 answer is there is some flexibility there. I think the
3 target is -- our current demonstration runs through the
4 middle of next year. In general, the CMS policy is to
5 request the states submit their renewal application a
6 year in advance, so that would be the middle of this
7 year. We've had some initial conversations with CMS, and
8 I think we're comfortable that there is a little bit of
9 give in that. If it slips for a month or two, I don't
10 think that's going to necessarily have any long-term
11 negative implication for the demonstration. So I don't
12 have a specific updated timeline, but we've been having
13 that conversation with them.
14 DR. SPITALNIK: Thank you. Any other
15 questions just about the process, not the content?
16 MS. ROBERTS: Hi, Deborah. I just have a very
17 quick question.
18 DR. SPITALNIK: Beverly, please say your name.
19 MS. ROBERTS: Sure. It's Bev Roberts with the
20 Arc of New Jersey.
21 Quick question for Greg. And I fully
22 understand that you're not ready at this point to even
23 give us a date as to when this is going to be moving
24 forward. But when you do have that information, what is
25 the way for everybody to know? Will it, in essence, be

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1 the information will be distributed to everybody who
2 typically a tends the MAAC meetings? That's my question.
3 MR. WOODS: Good question. So when we have
4 public notice, when we have a date for the public
5 hearings, we will certainly send a blast e-mail to
6 everyone who is on the MAAC distribution list. We will
7 also post it on our website. And afterwards, I'm happy
8 to put in the chat where specifically I would expect that
9 to be. I think we'll also do targeted outreach to
10 specific communities and specific stakeholders. And we
11 welcome support from all of the MAAC members in spreading
12 the word. Our goal here is to maximize participation in
13 all of those processes.
14 DR. SPITALNIK: Thank you. And I know that
15 we'll rely on members of the MAAC to fan out information
16 to their constituencies.
17 Anything else?
18 Greg, thank you. Thank you for all the
19 ongoing work on the renewal.
20 We'll now move to an overview of the proposed
21 State Fiscal Year '22 Maternal and Child Health Budget
22 Initiatives.
23 MS. JACOBS: Dr. Spitalnik, just real quick
24 before we go on. There was one question in the Q & A
25 that I wanted to make sure to address. And that was

about when people can send comments about the 1115. And the answer is that people can send comments to us anytime.

Greg, we had initially opened up a mailbox, I believe, in order to accept public feedback when we started this discussion. And so I don't know that mailbox off the top of my head, but I imagine that we can pull it before the end of the meeting and make that available to folks.

MR. WOODS: Yes. And that mailbox is still open. And we'll be sure to put it in the chat. We're continuing to monitor that, and we have gotten comments from stakeholders over the last couple of weeks that's been very helpful.

You don't have to choose. You can send us comments now. You can send us comments after we've put out a proposal for public notice. We really welcome stakeholder feedback across the process.

DR. SPITALNIK: Thank you.

MS. JACOBS: Thanks, Greg.

DR. SPITALNIK: So we'll move on to maternal and child health budget initiatives.

MR. WOODS: I think I'm going to start this discussion and then hand it off to Carol in a few minutes.

I wanted to high light a few specific initiatives both from the Governor's proposed budget and also some other things where work has been ongoing in the space of maternal and child health. So I'm going to run through these one by one and give us updates.

The first one we wanted to talk about is the Cover All Kids Initiative, which is part of the Governor's budget proposal. The initiative, as the name suggests, is really focused on covering all children in New Jersey who are currently uninsured. And I do want to emphasize that all of the numbers on this slide and when we talk about this initiative are estimates because these are children who are not enrolled in our programs who we don't necessarily have contact with. But we estimate there are about 90,000 uninsured children total across the State. That's based on census data. And so what we're proposing here is there's a proposal for a $20 million initial investment in this project in the Governor's budget, and we're conceiving of this in two phases. So the first phase, which would take place in the upcoming fiscal year, is focused on targeting the estimated 53,000. So it's more than half of the uninsured children, we think, who are actually currently eligible for either Medicaid or CHIP. And so they're currently eligible, but for one reason or another, they

have not been enrolled in our programs. AND there are a few pieces to this.

One is we're proposing to eliminate the premiums for CHIP. As many of you will remember, those premiums are currently suspended due to the public health emergency. The proposal here is to eliminate those on a permanent basis. I think different states have different policies, but that's a state decision. And our view here is that to extent that that's a potentially barrier for children becoming enrolled, we want to eliminate that barrier.

Similarly, we also want to eliminate the CHIP 90-day waiting period. For those who may not be familiar, this is awaiting period that can apply if a family drops from other coverage and prevents them from immediately enrolling in CHIP. I think it was initially created because of concerns about you didn't want to discourage families from making use of the coverage that was available to them. Again, I think our view is that this may be a barrier, and we want to make sure there are no barriers in place to prevent eligible families from enrolling their children in CHIP.

And then I think the critical piece here is targeted outreach to encourage enrollment among this population of children who shall currently eligible but

uninsured. This builds on the work we have been doing, but the goal is to really enhance that work and ramp it up. I think we're still working through and developing the different strategies we would do around targeted outreach. But I think some of the things that we would be looking at, targeted outreach through trusted community-based organizations, working with partners and particularly schools and other organizations that are touching children where they live in the community, making sure that we are sharing information and using them as a vector to communicate the message that affordable coverage is available through Medicaid and CHIP, and then making sure that we are making the best possible use of the data that we have in-house or within the State to identify children who may be uninsured, who may be eligible for coverage and doing targeted outreach to those children. So all of those are going to be part of the mix. I think we'll have more information moving forward about some of our specific outreach efforts. That's the first phase of this Cover All Kids Initiative.

The second phase are for children who are currently ineligible for NJ FamilyCare and who are currently uninsured. And there are two discrete populations here. One is the group of children who are income ineligible, so the family income is just too high

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1 to qualify for NJ FamilyCare. The second group is those
2 who are immigration ineligible, so who would otherwise be
3 eligible, but because of their immigration status and
4 because of the federal rules that we have to adhere to
5 that govern which children are eligible are ineligible
6 for NJ FamilyCare.
7 I think this upcoming fiscal year we will be
8 working on developing coverage options for those
9 children. And I think it's a little bit premature to
10 speak to exactly the details. I think in general the
11 principles that we want to follow here are we want to
12 make sure there are options for everyone and that there's
13 affordable option for all children and for all families
14 of children. I think we want to make sure that everyone
15 feels comfortable that they can sign up for those options
16 and that it's not going to have adverse consequences in
17 terms of for families that because of their immigration
18 status are ineligible or mixed immigration status
19 families that they feel comfortable that by signing up
20 for coverage that's not going to have any other adverse
21 impact on their family and that data is not going to be
22 shared in some way that they wouldn't want to share it.
23 We are also going to look at opportunities to
24 use federal dollars. I think it depends. We're sort of
25 doing the deep dive on what the possibilities are there,

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1 but we're going to be looking at opportunities and
2 thinking about how to structure this.
3 And the last thing I will note here is for
4 here and for the first phase, we will be working closely
5 with our partners at Department of Banking and Insurance
6 who administer our state-based exchange and who we work
7 with closely, because we want to make sure there's a
8 no-wrong-door approach where any family coming in seeking
9 coverage for that your children, they're connected to the
10 coverage that makes most sense for that family and that's
11 affordable for them.
12 So more work is ongoing on that. And I think
13 that's something that we will over the course of the
14 coming year work on flushing out options for those
15 populations of children.
16 Let me move on to the next slide. The second
17 topic that we want to talk about in the maternal and
18 child health space is the postpartum coverage expansion.
19 I wanted to give an update on the status of this. I will
20 say up front, this has been a somewhat twisting road on
21 this particular issue, but I think we're really happy
22 about where we're landing and the prospects for moving
23 this forward. So I'll dive a little bit into the weeds
24 because I know there have been a number of developments
25 over the last couple of years, and we want to make sure

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1 about where we are and where we're going.
2 So just as a reminder, currently, under
3 federal law, Medicaid coverage of pregnant women only
4 extends to the end of the month 60 days postpartum.
5 Many, but not all mothers, currently do maintain Medicaid
6 coverage under a different eligibility category after
7 that 60-day postpartum period ends. But again, not all.
8 We have seen that there are significant number of mothers
9 who postpartum do lose Medicaid coverage.
10 So about a year ago, based on previously even
11 acted budget language, we had submitted a waiver request
12 to our federal partners at CMS to extend that eligibility
13 to six months postpartum. That was in early 2020 that we
14 submitted that request. We had a number of conversations
15 with our federal partners around that. Long story short,
16 last fall we were told that the previous federal
17 administration was in a place where they could approve
18 that request. Conversations continued, but I think we
19 were at a little bit of a dead end at that point.
20 Once it became clear that we were going to
21 have a new administration, we circled back on this issue.
22 I think at that point the decision was made that we
23 actually think that six months, obviously preferable to
24 60 days, is less optimal and that actually we should be
25 looking towards 12 months of postpartum coverage to make

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1 sure that mothers maintain access to care for an extended
2 period and through the postpartum period.
3 When we restarted the conversation once the
4 Biden administration took office, we got a very favorable
5 reception and have gotten clear signals from our federal
6 partners that this is something they are comfortable
7 moving forward with.
8 I will note that one complication, that while
9 we were having these conversation first with Trump and
10 then Biden administration, is because of the public
11 health emergency, as we have discussed multiple times
12 previously with this group, we are not currently
13 disenrolling Medicaid members except in very limited
14 circumstances. So mothers, actually, in the situation
15 who hit the end of their postpartum period coverage are
16 maintaining coverage and will continue to maintain
17 coverage as long as the public health emergency
18 continues, which the Biden administration has said will
19 be at least through the end of this calendar year.
20 So currently, this is not an issue, but we
21 want to make sure moving forward whenever we do come out
22 of the public health emergency that we're in a position
23 to extend that coverage. So there is a proposal in the
24 Governor's budget proposal to fund and extend this to
25 12 months.

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1 Then, and I apologize. Like I said, this is a
2 bit of a twisting road. But as part of the American
3 Rescue Plan Act that was enacted earlier this year, that
4 included a provision that allowed states just as an
5 option without requiring any special waiver to, in fact,
6 extend coverage to 12 months postpartum. And that's
7 effective next April, a year from now.
8 So I think where we are is we feel very
9 comfortable between the Biden administration eagerness to
10 get a yes on this and between the legislation that was
11 enacted that we will receive federal approval for this.
12 We're working with CMS and what's the best pathway is
13 since now there are a couple of different options. But
14 our expectation is that by the time that the public
15 health emergency ends, when this becomes alive issue
16 again, we will have federal approvals in place to allow
17 mothers to continue to have coverage for up to 12 months
18 after giving birth. So we're excited about that, and
19 we'll give more details as we move forward and figure out
20 with our federal partners exactly what that pathway is.
21 So if we can go to the next slide. So I
22 wanted to give an update on a project that we've been
23 working on for a couple of years now, which is the
24 Perinatal Episode of Care. This is a pilot program.
25 Legislation was enacted back in 2019, mandating that we

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1 test this pilot program within Medicaid. For those of
2 you who may not be as familiar, an episode is a type of
3 alternative payment model that's designed to encourage
4 providers to improve the quality and efficiency of care
5 that they provide. In general, without getting too deep
6 into the details, episodes typically make providers
7 accountable for a set of related services and make them
8 accountable with financial incentives before the cost of
9 those services and also importantly for the quality of
10 those services. In this instance, the bundle of services
11 is across the perinatal period, so from prenatal care
12 through labor and delivery through the postpartum period.
13 So as I said, there was legislation enacted
14 back in 2019 that instructed us to develop and test a
15 pilot program within Medicaid around perinatal episode
16 care. As part of that legislation, a stakeholder
17 steering committee was required to help guide the design
18 of that model. So we split up that stakeholder steering
19 committee. We worked in close partnership with the New
20 Jersey Health Care Quality Institute to help administer
21 that steering committee and was a very valued partner as
22 we worked through that process. And that committee
23 worked from September of 2019 through the end of last
24 year, with a brief interruption last spring when the
25 public health emergency began.

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1 We worked through with that committee which
2 included, I should say, representatives of a range of
3 stakeholders, including our Managed Care Organizations,
4 providers, various community-based organizations, and
5 representatives from a diverse perspective.
6 We worked through a series of questions around
7 episodes and how we should structure this pilot and came
8 up with a set of recommendations that we felt really
9 happy with and that we felt really represented,
10 thoughtful engagement from a range of stakeholders on how
11 to move forward.
12 And so where we are right now is we've taken
13 those recommendations and we are working quite actively
14 right now to translate those into a detailed program
15 specification, the IT things we need to do, the legal
16 things we need to do to put that all in place, and we're
17 working towards a target launch date of next year. So
18 that's where we are in the process.
19 I did want to just give this group some
20 high-level points about what kind of program design we're
21 thinking about here. So first of all, we're thinking
22 that this will be a voluntarily model for physicians
23 and/or midwives providing obstetrical care. I will
24 particularly just emphasize this is focused on the
25 clinician, not on the hospital. Though, obviously, we

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1 would expect as part of an episode that all providers
2 would be working closely together and growing together
3 towards the desired outcomes for mothers. Again, and it
4 will be a voluntary model so this is not something that
5 we are mandating that providers participate in, but we
6 will encouraging providers to participate in and driving
7 incentives for participation.
8 A key goal of the episode is to really focus
9 and center improving quality and, in particular,
10 addressing disparities, racial and ethnic disparities in
11 maternal care, while preserving sustainability. And I
12 say this because episodes are a tool that have been used
13 by different payers and by different state Medicaid
14 programs in different contexts. I think in some of the
15 other states that have introduced episodes, the focus has
16 been really on improving efficiency and reducing costs
17 while maintaining quality. I think we think about it the
18 other way around, that the goal here is really to improve
19 quality and address the disparities while doing that in a
20 financially sustainable way. So we really have designed
21 our episode with the thought that our focus is on how we
22 can improve the care that our providers provide to
23 mothers.
24 Another key element is that providers will be
25 held to consistent statewide standard independent of

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1 their specific MCO. So one thing that we certainly heard
2 from providers during our stakeholder process is that
3 it's really important for incentives to be aligned across
4 our MCOs. So the way we are envisioning this program is
5 that the incentives will be structured the same across.
6 And we will standardize those incentives across our MCOs
7 so that providers don't need to try and adjust based on
8 what MCO their members are enrolled.
9 And then we're envisioning an iterative
10 program design. This is a pilot program. We're going to
11 begin in year one with bonuses and incentives, so an
12 opportunity for providers participating in the model to
13 earn additional payments based on strong outcomes.
14 Over the course of the pilot, our intention is
15 to slowly introduce some level of financial risk so that
16 there is both incentives and potential penalties. But we
17 recognize that that's challenging for providers, so it's
18 not something we expect to be part of the program right
19 away. We want to first allow providers to participate,
20 to get comfortable, to feel confident that they can
21 perform well within this model before we introduce
22 financial risks. And, again, the target launch date for
23 this program is next year. We are working very
24 diligently toward hitting that. I would expect later to
25 hear we will be releasing really detailed information

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1 about how the program will be structured and what
2 providers who are interested in participating will need
3 to do.
4 If we can go to the next slide. The last
5 maternal and child health initiative that we wanted to
6 give a quick update on is the Integrated Care For Kids
7 model. This is a federal demonstration program run by
8 the Center for Medicare and Medicaid Innovation within
9 CMS. This was a competitive grant program that CMS put
10 out back in 2019. And a consortium of New Jersey
11 providers and organizations applied for a grant. I want
12 to be clear that Medicaid, we are not the lead here, but
13 we are very in a supporting role. It's these grantees
14 who you'll see listed on the slide who applied for that
15 grant, were successful and received that grant with
16 Medicaid support. And we have been working very closely
17 with those grantees over the past couple of years to move
18 forward collaboratively.
19 The basic purpose of this program is to
20 enhance prevention, early identification, and treatment
21 of treatment of children who are enrolled in Medicaid and
22 CHIP, their health, behavioral, and social needs, and
23 their particular focus on children who are at high risk.
24 As I said, this is a federal program. Per the
25 terms of that federal program, this is a pilot program or

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1 a demonstration that's being tested in a couple of
2 counties at first. So this is limited, at least
3 initially, to Ocean and Monmouth County. That was what
4 was approved as part of the grant award. And the model
5 includes a couple of different pieces. One is enhanced
6 assessment and screening for children connected to their
7 well child visit with their pediatrician. And then from
8 that screening, the availability on a voluntary basis for
9 the member of advanced case management for children who
10 are identified through that screening as having high
11 needs.
12 And Medicaid's role here is to work with the
13 grantees who are setting up this program and make sure
14 that we have a Medicaid payment structure that supports
15 both of these elements of the program and make sure that
16 we have a pathway to sustainability there.
17 So as I said, we have been working very
18 closely with Hackensack Meridian, DNA of Central Jersey,
19 and the New Jersey Health Care Quality Institute on this
20 program. The start date for actually providing screening
21 and then services under the program is January of 2022,
22 and we're working with those partners to make sure we
23 have the payment pieces in place in order to support that
24 launch.
25 I will stop there. It might be a good moment

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1 to pause for questions before I hand off to Carol.
2 DR. SPITALNIK: Yes, please. I was going to
3 suggest that. That you so much, Greg, for the
4 presentation and all the work that's being done both
5 programmatically and in the spirit of health equity.
6 Are there questions from members of the MAAC?
7 MS. COOGAN: I was going to say not a question
8 but more a compliment. I think it's terrific to cover
9 all the kids. I'm looking at Carol and Heidi for years
10 trying to figure out ways to do the outreach and getting
11 rid of the premiums permanently. And the 90-day, I know
12 is really going to help with the last turn issues. So,
13 please let us know at Advocates for Children of New
14 Jersey how we can help with that continued outreach and
15 that effort.
16 And I think all this other initiatives with
17 reference to the care for pregnant women and expanding
18 that coverage, I applaud you all, given all the other
19 work you've been doing since the shutdown. So let us any
20 how we can all help.
21 DR. SPITALNIK: That you, Mary.
22 Beverly.
23 MS. ROBERTS: Again, I also want to echo what
24 Mary just said. That you, Greg. This is wonderful
25 information. And I have a very quick question on the

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1 Integrated Care For Kids part of it.
2 I'm hopeful that part of what they will be
3 doing is trying to do assessments for autism in young
4 children. There was something that was released recently
5 from the American Academy of Pediatrics that a lot of
6 pediatricians who in busy practices may not necessarily
7 be looking at a very early age for signs of autism.
8 Because, obviously, the earlier that it's recognized and
9 identified, the earlier that early intervention would
10 start. So I'm hopeful that part of what they're going to
11 be looking at would be the earliest ways to identify
12 children who may have autism.
13 DR. SPITALNIK: I would answer
14 programmatically yes, because we've been in conversation
15 with them.
16 Any other specifics from the MAAC?
17 A question came in, Greg, about the pilot
18 around maternal child health, the payment pilot, will
19 that include doulas in the pilot project?
20 MR. WOODS: That's a good question. I think
21 the answer is we have given some thought to that
22 question. We want to make sure in rolling out the
23 episode pilot we will be encouraging the use of doulas
24 and making sure that those two projects are aligned. And
25 so as we've been thinking through, we have been

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1 structuring that episode design to ensure that it doesn't
2 unintentionally or in some way dis-incentivize the use of
3 doulas and, in fact, that doulas could be a critical
4 support in pursuing better outcomes for mothers. So,
5 yes, that is very much a part of our thinking.
6 DR. SPITALNIK: Thank you.
7 There was also a question which may need to be
8 followed up post meeting about how the extension of care,
9 the emergency extension of postpartum care is being
10 communicated to mothers who may be affected by that.
11 MS. JACOBS: We can follow-up on that, Dr.
12 Spitalnik, because these members will continue to receive
13 communications from us, from their health plans, and
14 we've been very public about the continuity during the
15 public health emergency. But we'll be happy to follow-up
16 in a little more detail.
17 DR. SPITALNIK: Thank you. I think that for
18 now satisfies the question. As always, Greg, thank you
19 so much both for what you're doing and also your ability
20 to make this accessible to all of us. So thank you.
21 We'll now move on to the implementation issues
22 around autism spectrum disorder. And it looks like Carol
23 Grant will be the presenter.
24 MS. GRANT: Yes. I want to remind people that
25 this benefit actually was technically initiated in

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1 January of last year with PT, OT, speech, and sensory
2 integration, and then more robustly added ABA and DIR in
3 April. So we wanted to give you a bit of update about
4 where we are today. This is an evolving and growing
5 program, not without some kinks, but we are working
6 through them.
7 So on the ABA side, on the expansion of
8 services, 945 children have received services as of
9 12/31. You recognize that claims really have a lag
10 period. So we've given you the best statistics we have
11 at this point. And ABA services are being provided in
12 all 21 counties, so we're very pleased to know that.
13 On the DIR side -- and I'm cheering while I'm
14 sitting here even though you can't hear me -- we have 11
15 providers enrolled in managed care. And, again, this is
16 a growing pool of providers who can provide this service.
17 And we want to make sure that everybody understands all
18 of the alternatives and the options under the autism
19 spectrum disorder benefit. So DIR applications for Fee
20 For Service are now available online. And we've given
21 you the address at https://urldefense.com/v3/__http://www.njmmis.com__;!!J3
22 These are nontraditional providers, not all of
23 whom are familiar with Medicaid. So, obviously, rolling
24 this out, you peel the onion and you address the issue as
25 they occur. And really taking provider feedback and what

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1 kinds of experiences providers are having as they are
2 attempting to get enrolled and be credentialed by managed
3 care, we've tried to take a look at those and figure out
4 who do we do this better. So we are exploring
5 opportunities to improve the provider enrollment
6 experience, improving the clarity on the application
7 process.
8 As you know, MCOs really need different
9 methods for credentialing and contracting, and we need to
10 make sure that providers know what they are and get
11 comfortable with using them; and providing oversight for
12 the fingerprinting process so it actually integrate
13 smoothly with the entire enrollment experience.
14 The other thing we're doing is working with
15 providers and MCOs to improve the billing experience.
16 Always important. Attending meetings with providers,
17 MCOs, and advocates to really isolate specific problems
18 and address them. We've encouraged and we are having
19 Webex presentations by MCOs. Not dissimilar to the kinds
20 of things when we rolled out MLTSS. People had to learn
21 the process and they had to learn managed care 101.
22 We've all had to do that.
23 The MCOs are alerted to and working on issues
24 that might be related to the ambiguity of denial coding.
25 And really, obviously, we look at issues of rates. We

1 don't particularly get involved in them. But the rates
2 that we set as we designed this program really do compare
3 favorably to the pilot and to other states. So while we
4 recognize that that's an issue, we're trying to work
5 through the entire experience so that we can have a
6 robust network that provides access and availability to
7 children for whom this is necessary.
8 We have set up, and it is operational, ASD
9 phone line and dedicated mailbox. And we are
10 individually tracking and following up on all inquiries.
11 And you can see that there's the link there that once
12 people get slides and the number, obviously, we're
13 encouraging you to use it so we can keep track of issues
14 and address them as we go along. My peeling the onion
15 analogy is something that's really important in new
16 programming.
17 So some of the specific identified provider
18 concerns are really credentialing and contracting. Not
19 surprising. But our MCOs are working and contracting
20 staff are working with providers, and we believe the
21 process will become routine, as it did with the MLTSS
22 nontraditional provider and others with increased
23 experience. Again, we've identified lack of parity with
24 denial notifications. We're sharing those examples with
25 the MCOs, and they are working on identifying denial

1 codes that have ambiguous definitions and trying to
2 clarify so that they're really pretty crystal clear about
3 what has to be done.
4 And, again, with relation to rates, because
5 it's always an issue that are raised by providers, we did
6 take the time to -- and we did this as we were developing
7 this program -- compare rights between states with
8 similar Medicaid populations and commercial coverage in
9 New Jersey. And what we have found is current rates do
10 compare favorably, again, to the previous pilot in other
11 states. It doesn't mean everybody is happy with it, but
12 we want to make sure we at least have some measure of
13 comparability here so that we're not -- we can't have
14 people have unrealistic expectations, but we monitor
15 these things at all times because access and availability
16 is what we really need to assure.
17 We can move on. And I'm hoping, Deb, if you
18 feel the impetus to do so that you will also weigh in on
19 some of these next two kinds of issues.
20 We had a stakeholder meeting in March. We
21 have a regular cadence of these meetings. And we had
22 invited the New Jersey Department of Health Early
23 Intervention Services. A representative came to that
24 meeting. Stakeholders want to focus on initiating
25 services at a younger age and eliminating ethnic

1 disparities. I think we often forget about age. We talk
2 about racial and ethnic disparities, but age is also
3 important because, as Bev points out, early intervention
4 has been found to be most effective. So we want to make
5 sure we're considering all of that.
6 A work group formed to finalize educational
7 resources for families. They're utilizing the Bogg
8 Center. So I'm giving a shout-out to Deb for that for
9 agreeing to assist. To design FAQs, to define the autism
10 spectrum disorder benefit, the description of covered
11 services under New Jersey Medicaid so that families know
12 what's available to them; and working on additional
13 resources, perhaps a directory with Internet addresses
14 for non-Medicaid covered resources so that we can have a
15 full 360 approach to this. And we're working with the
16 stakeholder group on establishing quality metrics.
17 Metrics related so far, I think the ideas that have been
18 put on the table are network capacity, wait times,
19 health-related outcomes, and a family experience member
20 survey. So that group is really a wonderful group. I've
21 participated in two meetings, and the discussions are
22 really robust and really right on the money and I think
23 are going to make this benefit far better than we might
24 have envisioned.
25 I don't know, Deb, if you want to add anything

1 at all?
2 DR. SPITALNIK: I'll pick up the thread of the
3 early intervention in younger ages, which is the average
4 age of diagnosis of autism is about 4 years, 2 months,
5 which means that children don't have the benefit of what
6 is 0 to 3 early intervention program could provide. And
7 it relates to Beverly's question about the integrated
8 care for kids, trying to show a model for screening. So
9 that's what I would add at this point.
10 MS. GRANT: I appreciate that very much.
11 We can go to the next slide. This is a little
12 bit good news because over the period that the program
13 has been operational, obviously, we've seen an increase
14 of total ABA claims. We are not as far along on DIR
15 because it is a benefit that is lesser known and we're
16 still building. And we're also seeing a decrease in
17 denied claims. And this is exactly the trajectory that
18 we would want to see. Claims up, denials down, and
19 that's what we're working on.
20 DR. SPITALNIK: Carol, in terms of claims and
21 denials, there was a question raised about network
22 adequacy in terms of providers, and maybe this would be a
23 good time to speak to that in terms of network advocacy.
24 MS. GRANT: It is a primary focus for us as
25 well. We're spending lots of time trying to understand

1 how to grow this network at every level, the enrollment
2 issues, the billing issues, even the rate issues, as you
3 can see, we're paying attention. We've worked with
4 stakeholders, we've met with them. We are really trying
5 to encourage enrollment in the program and we will
6 continue to do that. I don't know that there's a magic
7 wand except people need to continue to let us know where
8 they're seeing issues so that we can address them.
9 DR. SPITALNIK: And I think one of the
10 comments is also that there's concern that provider
11 either not enrolling or disenrolling have to do with our
12 rates and the perception that our rates are not
13 comparable, that they're less than other states. So that
14 may be a follow-up issue for the autism stakeholder
15 executive group and then bringing that back to the MAAC
16 at some point.
17 MS. JACOBS: I think that would be really
18 helpful Dr. Spitalnik. I saw the analysis that was done
19 before Carol and the team launched this benefit, and
20 there really was an effort to make sure that our rates
21 would be comparable both to other states and to what
22 providers were being paid by New Jersey payers. So if
23 there's specific examples we need to work through, maybe
24 there's an individual code or something where folks feel
25 like we didn't hit the mark, we're, obviously, very happy

1 to have that conversation. Carol and the team have been
2 very close to the providers on this.
3 MS. GRANT: Absolutely.
4 Anything else? Otherwise, I think we can move
5 on to the next slide.
6 This is an early look at the distribution of
7 autism services by age, race, and ethnicity, and it gives
8 us some research questions to consider. It is evident
9 that we have identified a disparity here by race and
10 ethnicity, but we don't know exactly what that means. We
11 really do need to do a deeper dive here to see what the
12 percentage of distribution of race and ethnicity actually
13 defines the population of children in the autism spectrum
14 disorder. We're committed to doing that deeper dive
15 going forward and to looking not only by race and
16 ethnicity, but also how that is stratified by age.
17 Again, we've had a little bit of that conversation at the
18 beginning of this discussion on the benefit. But it is
19 clear that we are incorporating that into our health
20 equity opportunity here. I think this gives us a chance
21 to understand it, to understand whether this is simply
22 something proportional to how things occur within the
23 population, or if there is some way that we move the
24 needle on this. And if there is, we will. We will do
25 everything we can to do it.

1 So I think that's about it for this slide. I
2 think that may be the last one.
3 DR. SPITALNIK: It is, Carol. Thank you. And
4 before we leave the topic, the disparity in terms of
5 access to ABA mirrors the national data as does our age
6 data in terms of who's receiving services. And if we go
7 back to that slide, what we see is this big bump at 4, 5,
8 and 6, when toddlers are no longer eligible for early
9 intervention coinciding with the, unfortunately, more
10 typical age of diagnosis. So it's both a national
11 problem, but that doesn't mean it's acceptable. So I'm
12 very appreciative of the way that this issue of disparity
13 and equity are being addressed full-on in the workgroup
14 and in the commitment to data.
15 With that, questions or comments from the
16 MAAC?
17 Not seeing any or hearing any, I thank you.
18 And we move on to managed care updates. So, Carol,
19 another deep breath and maybe a sip of coffee and we'll
20 call on you again.
21 MS. GRANT: Very good. Happy to do it. I
22 think I'm going to kick this off and it could be that Jen
23 is going to have some follow-up questions on this.
24 One of the things I want to talk about is
25 really the care management ratio compliance provision, so

1 the contract is really discussed in January. We actually
2 provided a commitment in that contract to ensuring that
3 managed care maintained a hundred percent compliance with
4 ratios that are, in fact, in the contract. And that when
5 that does not happen, to apply liquidated damages, and we
6 used an algorithm and a formula in order to do that. Our
7 goal, of course, is to encourage that full compliance is
8 maintained, not that we impose penalties or require a
9 hundred corrective action plans. But this is really to
10 ensure, because we recognize the criticality of care
11 management within our system, and this is really to
12 ensure that all MLTSS members have a trained professional
13 to assist them in the coordination and delivery of needed
14 services. It's an essential service to ensure
15 person-centered care and to assist members to receive
16 quality services appropriately.
17 Just to remind people what the requirements
18 are, is that the MCO is responsible for identifying and
19 analyzing data related to enrollment trends and staffing
20 trends in order to maintain compliance with MLTSS care
21 management ratios. We have to submit a monthly report
22 tracking care management ratios. If, in fact, issues are
23 found, they have 10 days to submit a corrective action
24 plan. Once noncompliance has been identified, and then
25 beyond that, they have 60 days from the submission of the

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1 cap to in 100 percent of compliance. If the MCO fails to
2 reach that 100 percent compliance rate within 60 days,
3 liquidated damages are automatically imposed in the
4 amount of $100 for every weighted member, because
5 caseloads are determined based on certain weight, that
6 exceeds the mandated ratio applied retroactively to the
7 date of noncompliance. The State always reserves the
8 right to apply additional sanctions that could include
9 things like enrollment freezes when noncompliance is
10 identified to be chronic or at a frequency that is deemed
11 unacceptable.
12 I want to say that currently all plans are
13 reporting compliance with contractually-required ratios.
14 One plan's compliance reporting merits a deeper dive
15 review and dialog regarding actions we will want them to
16 take to actually avoid having to get to the point of
17 penalties. In this endeavor, we work closely with the
18 Division of Aging Services to monitor compliance and to
19 oversee any corrective action plans. This is a serious
20 issue for us, and we believe that our health plans are
21 also taking it seriously because we want to top of mind,
22 and the penalty is really just a reminder when it may
23 fall out of top of mind.
24 So I think that's where we are at this point.
25 We'll keep you posted. We made it a focus to improve

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1 accountability across the board in all things we do,
2 whether it's managed care or vendor management or
3 whatever. And this was sort of the first step, really,
4 of being much more crystal clear about expectations. Jen
5 always says energy follows focus, and this definitely
6 provides some focus in this area. So that's the update
7 up to now.
8 MS. JACOBS: Thanks, Carol.
9 I would like to add just one more point.
10 We've spent a lot time on managed care just in context of
11 the vaccine outreach. But I did want to share with you
12 that Carol and I have taken steps forward on a vision
13 that we had that we really wanted to do a couple of
14 things. One was to enable Carol to focus on strategic
15 priorities of the Murphy administration. Like the Cover
16 All Kids policy that Greg is talking about sort of
17 working its way through the development process, we need
18 a leader to make that real. We talk a lot about the true
19 and the true-true. True is we've got a policy.
20 True-true is what we did to make the real. And we had
21 this vision where Carol would be able to focus more on
22 the strategic priorities of the administration and move
23 these things forward in a very true-true way.
24 The second part of the vision that we had some
25 months ago was really bringing our Medicaid managed care

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1 program into a sweet spot. If you look at Medicaid
2 managed care programs around the nation, you see programs
3 that are very focused on synergy and innovation between
4 the State and the Managed Care Organizations; and
5 certainly our program is an example of that. We work
6 closely with our managed care partners. We both have a
7 1,000 page contract and have ad hoc discussions about
8 what is needed right now, and the plans are innovating
9 with us. Examples of that, obviously, come out of the
10 pandemic.
11 Then on the other end of the spectrum from
12 synergy and innovation, you have states that really focus
13 on compliance and accountability. These are strictly
14 vendors. They have a contract that sits somewhere in a
15 state contracting division, and they're executing on that
16 contract in black and white all day, every day, and you
17 don't have the kind of focus on synergy and innovation
18 and partnership that we have. So there is the spectrum
19 where we knew that we wanted to bring this program to a
20 sweet spot that really maximizes the benefits of both
21 sides of that.
22 New Jersey has been very collaborative with
23 our plans all along. They're operational partners to us.
24 We're actually a pretty small agency if you think about
25 the size of the program we're running. We need those

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1 operational partners to make things like vaccine access
2 and availability real, and we need to hold those partners
3 accountable to the requirements of the contract.
4 So one of the things that we envisioned in
5 order to get into the sweet spot was really to think
6 about our organization as both managed care operations
7 and managed care accountability and to be very deliberate
8 about that operational day-to-day partnership that we
9 have and the accountability and compliance that we expect
10 from those operational partners. And so in order to
11 enable Carol's focus on the strategic priorities of the
12 administration like Cover All Kids, we have actually had
13 the opportunity to welcome two new members of our senior
14 leadership team to support that managed care vision. And
15 so we're welcoming now Chief of Managed Care Operations
16 Lynda Grajeda. Lynda will lead the teams that oversee
17 member and provider relations on a day-to-day basis,
18 contract management, self-directed services, and our
19 duals integration, all of that day-to-day operational
20 partnership that we have with the health plans. And then
21 we've also brought on board our chief of managed care
22 accountability who is Akanksha Kapoor. Akanksha will
23 lead the teams that oversee network access, quality
24 assurance, managed care performance measures, and
25 accountability actions. And by having these two leaders

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1 over the managed care program, we will ensure that we
2 have that balanced focus so that we are able to be in the
3 sweet spot that maximizes the benefits both of innovation
4 and synergy and also compliance and accountability, so
5 making sure that we have that balance. And, of course,
6 Carol will continue to be a strategic leader in our
7 organization with respect to both managed care and these
8 other initiatives that really needed her focus.
9 So I just wanted to share that with you
10 because it's a little bit of a change for us
11 organizationally, and I'm happy to answer any questions
12 you have there.
13 MS. ROBERTS: Thanks very much, Jen and Carol.
14 So I have two comments that I wanted to make. The first
15 is with regard to the care management that Carol
16 discussed for MLTSS, which is obviously very important.
17 I also have a concern about care management for folks
18 with intellectual and developmental disabilities in
19 regular Medicaid managed care, not MLTSS, some of whom
20 have conditions that are really equally significant to
21 those that would be in MLTSS. So I don't know if there
22 could be a future discussion on the access that people
23 with disabilities need to have within regular Medicaid
24 managed care. I think that would be really good
25 information for people to know about. So there's that

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1 comment.
2 And then with regard to Cover All Kids which,
3 of course, is absolutely wonderful, there is a concern
4 about kids with special needs and access to CHOP. And we
5 know about that used to be part of UnitedHealthcare
6 Community Plan network. It's not anymore. There were
7 some people who were grandfathered, people who are
8 weren't. So there are concerns about that. And so I
9 don't know what the best way is to sort of make sure that
10 I'm able to communicate and families are able to
11 community the concerns that they're having for children
12 with special needs.
13 MS. JACOBS: Thanks, Bev. Carol and I both
14 have been very close to the situation with CHOP. The
15 first thing I want to make sure folks are aware of --
16 because I know you know this, but I don't know that
17 everyone who's hearing me knows this -- is all five of
18 our Medicaid managed care do work with CHOP. And so the
19 question of whether or not children who need CHOP have
20 access to CHOP, the question there is really about the
21 nature of the need. So, for example, if there are
22 services available through CHOP that are not available
23 anywhere else, the health plans are arranging those
24 services through CHOP, all five of them are. And we see
25 that happening every day. The challenge is when CHOP is

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1 not in their network. Not every service is going to be
2 available because it can be provided through other
3 network providers. So then our monitoring is very
4 focused on making sure that members do, in fact, have
5 access to the services they need. And if those services
6 are only available through CHOP, making sure that, in
7 fact, is making them available.
8 So a couple of things. We have asked united,
9 in particular -- remember, all five plans, right? But
10 we've asked United in particular to really stay close to
11 us on any member issues that they're hearing, and they're
12 giving us a report on a biweekly basis which Carol and I
13 both review. So we know the exact status of concerns
14 that have been raised by members directly to United. And
15 then we also have received some escalations through
16 channels, Bev, like through your organization, through
17 sister agencies, and we have explored the individual
18 circumstances of those recommendations as well. And in
19 some cases, those are children who need services at CHOP.
20 And in other cases, there are children whose services
21 could be provided through other network providers. So
22 what's really important is as we're talking about this
23 that we focus on the specific details and needs of each
24 child and really specific circumstances. In one case, we
25 had twins, both of them medically complex. We were

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1 looking at the specific needs of the twins and also of
2 the mom who's dealing with two children with medical
3 complexities. So the details of each case really, really
4 matter. But our clinical team has been working through
5 them all very closely with all of the plans as we
6 navigate the situation that you described.
7 MS. ROBERTS: Thanks, Jen.
8 DR. SPITALNIK: Other questions or comments
9 from members of the MAAC?
10 There's a request that I'd asked of the DMAHS
11 staff to please put in, as you welcome these two new
12 Managed Care Organization workers, we congratulate on
13 getting two positions and we'd ask that you put your
14 names and contact information in the chat box.
15 Other things that are coming the question and
16 answer, I'll deal with the end as we generate our agenda
17 for our next meeting.
18 Hearing no other or seeing no other questions,
19 thank you, Carol and Jen, for the update on managed care.
20 We're going to turn to other FamilyCare
21 updates with Heidi Smith who's Chief of Operations at the
22 Division.
23 MS. SMITH: Thank you, everybody. It's nice
24 to see some faces and it's always good to get back
25 together again for these meetings.

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1 So my first set of slides are about processing
2 times, application processing times. At this point, we
3 do have our IES system. It's Integrated Eligibility
4 System. It's our worker portal that they use to process
5 applications. So we're able to pull data and at this
6 point we're sharing the processing times. And we're
7 sharing the same data that we share with CMS quarterly
8 because they also ask about our processing times of our
9 applications. It's something they monitor us for and
10 have certain conversations if we're not on point.
11 So here we are of what the ABD and the MAGI.
12 CMS will looks at ABD applications. That's the Aged
13 Blind and Disabled applications for that program. They
14 look at them as a whole. So here is the average
15 processing time in January of '20, July '20, and March of
16 '21. So you can see their average processing time is
17 going down, as with MAGI. January 20th, 31 days;
18 July 20, 21 days; and then March 21st, the average
19 process time of a MAGI application is 16 days.
20 DR. SPITALNIK: Heidi, help us with the
21 acronym for MAGI, as you did with the ABD population.
22 MS. SMITH: Sure. So MAGI, it's Modified
23 Adjusted Gross Income, but when we talk about MAGI,
24 that's the expansion population. That's basically
25 Medicaid for children and parents and individuals. It's

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1 not the disabled population or the aged population. This
2 is our children and families group. And we're use
3 modified adjusted gross income to determine their
4 eligibility, which is different than how we determine
5 eligibility for the Aged Blind Disabled program.
6 DR. SPITALNIK: Thank you.
7 MS. SMITH: Again, for the ABD electronic
8 processing, we call it the ABD online processing because
9 that's done at the County Boards of Social Services. ABD
10 is processed with those agencies. So if what we want to
11 show here is that as the volume for the ABD application
12 increased, the processing time decreased. So the blue
13 bars show the amount of applications that they were
14 processing in our IDS or in our worker portal in our
15 online system. You can see from January of 2020, there
16 were 750 in there. And then that online use the
17 utilization of that tool. The applications that were in
18 that tool grew. We kept an eye. It's more transparent
19 when you have the online system going on, and we're
20 watching the processing times get better. So this is the
21 previous graph presented in another way.
22 So this is about MAGI processing, the
23 electronic processing or online processing. As the MAGI
24 applications decreased, so did the processing time.
25 You're looking at what was received and then the

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1 processing time.
2 So I was asked to do an update on the ABD
3 assistor portal. This is the assistor portal that was
4 developed for our Medicaid long-term care providers.
5 Previously we spoke about this. Just a little bit of a
6 reminder, when someone applies as an individual for the
7 online application, they create a registered user
8 account, so it's their account. They monitor their
9 application and their processings, and they can upload
10 documents. We heard from the long-term care community
11 that they wanted to be more helpful to the patients that
12 that are residing with them, so they'd asked for a
13 particular way that they could apply with the family,
14 with the patient, for there patients, so we came up with
15 this ABD assistor portal which allows the Medicaid
16 long-term care facilities to apply for multiple people.
17 And how this is done is that they have to create a user
18 ID as a facility. And this will allow them to track the
19 online applications that they submit. So anybody that
20 they submit an application for, they can track its
21 progress.
22 Next slide. So we did a pilot during the PHE.
23 And this was not to pat ourselves on our back, but we
24 worked with Genesis long-term care facility. They had
25 asked to pilot with their agencies. This involved

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1 Bergen, Burlington, Camden, and Cape May County Boards of
2 Social Services, because once the long-term care facility
3 submits the application, they have to be processed by
4 those County Boards of Social Services.
5 The application volume was low due to the PHE,
6 but we were able to get feedback, work out some issues,
7 and then the plan is to enroll other facilities. And we
8 will have more information on that when we issue our
9 provider newsletter with how to go about that and opening
10 this up to more people and more agencies.
11 So it's important with the ABD provider
12 assistor portal as an assistor that the family, the
13 patient, is aware of their rights and responsibilities.
14 That is a requirement. The Medicaid long-term care
15 facility has to attest that those communications were
16 provided to the applicant and they are able to print off
17 a hard copy so they can have them and they can understand
18 them because the rules of Aged Blind Disabled Program
19 program have not changed, people are applying, they are
20 attesting for what resources they have, what income they
21 have. Same thing, we validate online if we're missing
22 anything. The family has that ability to upload or the
23 provider can upload for them if they have any documents
24 that they need and add their attachments right into their
25 application where they can be visible online by the CWA.

1 Now, an ISR, this is the Information Security
2 Representative. All agencies have to have an ISR at this
3 point. It's about privacy. It's about protecting online
4 applications, online processing systems. So in order for
5 it to get access -- and this will all be explained in the
6 provider Medicaid communications that we'd like to do --
7 the ISR for the agency sort of verifies that these
8 employees work for them and they help sign off on the
9 forms that they need because those forms are going to
10 need to get processed by our Division security team to
11 get them access.
12 These are called the access request forms. So
13 the forms come into our Division. They're filled out by
14 the agency. The ISR validates and verifies everything
15 and sends them in. And all it's doing is asking for
16 permission to use the system and that they will be secure
17 with the system that we're giving them access to.
18 This is a look of the dashboard. You've seen
19 this before. This shows the ABD assistor, the
20 applications that they processed or that they put
21 through, let's say, and it will talk about which county
22 that that application went to and the status. And they
23 can always view the application that they submitted.
24 It's a section to view the PDF there. But again, they're
25 only going to see the applications that they submitted.

1 Once the individuals are an authorized user,
2 these are the employees of that facility, they're going
3 to given a link, it will be mailed to them, and then they
4 will have access to the ABD assistor portal.
5 The online application is for them to use to
6 monitor. This will help cut down any phone calls to the
7 CWA, "How is this application doing?" Calling the
8 Division, "How is this application doing?" They can go
9 into the portal and they can see for themselves. They
10 can see what's missing or the status of it.
11 DR. SPITALNIK: Thank you very much, Heidi.
12 We're very close to the end of time, because
13 we've had such a full agenda. But are there any very
14 brief comments or questions for Heidi from the members of
15 the MAAC?
16 MS. EDELSTEIN: Just congratulations. That's
17 great progress. Thank you very much.
18 DR. SPITALNIK: Thank very much, Theresa.
19 And there's a question that I'll raise from
20 the public. Will attorneys have access to the assistor
21 portal in addition to individuals or facilities?
22 MS. SMITH: No. This is the ABD long-term
23 care assistor portal. So that's different than if an
24 attorney were the DAR or the representative for the
25 family and they helped them to apply, they usually help

1 the individual apply. But this assistor portal are for
2 Medicaid providers. That has to be the first
3 passthrough. And once it's affirmed that they are truly
4 a Medicaid provider, then the employees of that Medicaid
5 provider would have access to this portal.
6 DR. SPITALNIK: Thank you.
7 As is our custom, I try to summarize from our
8 meeting the items that have come up in the course of the
9 presentations. And so bear with me as I look at paper.
10 We had established that either at the next regularly
11 scheduled MAAC, meeting which is July 22nd, or a special
12 meeting to be called before that, that the MAAC will
13 serve as one of the stakeholder forum for public input to
14 the 1115 Comprehensive Waiver review.
15 We would ask that there been updates on
16 Cover All Kids. We realize that these are proposed
17 initiatives under the budge. So what the budget looks
18 like may certainly influence the update.
19 Continued information is requested about the
20 services under the autism benefit.
21 We have two requests around mental health
22 care, one of which is related to the mental health
23 benefit for people who are served by DDD and how that's
24 being implemented by the Managed Care Organizations;
25 that's one. And the second mental health issue is given

1 the widely understood increase in mental health
2 challenges for all of us during the pandemic, how is
3 access being maintained or enhanced? And how are our
4 waiting lists for mental health services, which are
5 signature in the community, being addressed?
6 Those are the items that I've been able to
7 keep track of. Anything else from any of the members of
8 the MAAC to add to our list?
9 Beverly.
10 MS. ROBERTS: It would be really good if we
11 could get more information on how care managers are
12 serving people with disabilities in regular Medicaid
13 Managed Care Organizations.
14 DR. SPITALNIK: Thank you. And I apologize.
15 I had that.
16 Anything else?
17 Jen, in closing, anything you would like to
18 add?
19 MS. JACOBS: No. I would just want to say
20 thank you to everybody who joined us today and stuck with
21 us for a couple of hours. I really want to show my
22 appreciation for the broad team that has managed to carry
23 this program forward and make a lot of progress on policy
24 and programs that are completely unrelated to the public
25 health emergency at the same time that we have continued

1 to manage the public health emergency. So just a big
2 thank you for my team and our community for work together
3 on that.
4 DR. SPITALNIK: Thank you. And on behalf of
5 the MAAC, I would like to echo that both in terms of the
6 public health emergency, but also getting closer to the
7 vision that everyone has.
8 So, again, we will meet on July 22nd. I guess
9 I could say same place same time same box pictures of
10 ourselves.
11 If there is another stakeholder meeting
12 scheduled, it will comply with the requirements for
13 notice under the Open Public Meetings Act, and we will
14 disseminate that through the mailing list or e-mailing
15 list that we have MAAC attendees as well as posting.
16 I want to thank Jen, Carol, Phyllis, Greg and
17 Heidi. There's a tremendous amount of effort that goes
18 into planning MAAC meetings, in addition to the service
19 and policy responsibilities that everyone at the Division
20 is bearing. And appreciate both the focus on that
21 planning. And a strand I want to close with a note on is
22 the raising of health equity through vaccines, through
23 maternal and postpartum health, through autism, and all
24 the other programs of the Division of Medical Assistance
25 and Health Services.

1 So we close at this point with heartfelt
2 wishes to those who have lost loved ones, who are ill
3 themselves, who are recovering, and to everyone for
4 persevering through these difficult times.
5 Thank you so much everyone for participating
6 in the MAAC, the members and the public. And we look
7 forward to being together in July.
8 Thank you very much. Stay well. Take care.
9 (Proceeding adjourned at 11:56 a.m.)
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1 CERTIFICATION
2
3 I, Lisa C. Bradley, the assigned transcriber,
4 do hereby certify the foregoing transcript of the
5 proceedings is prepared in full compliance with the
6 current Transcript Format for Judicial Proceedings and
7 is a true and accurate non-compressed transcript of the
8 proceedings as recorded.
9
10 ____________________________
11 Lisa C. Bradley, CCR
12 The Scribe
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