MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Videoconference
April 28, 2022
10:00 a.m.

MEETING SUMMARY (FINAL)

MEMBERS PRESENT:
Deborah Spitalnik, Ph.D., Chair
Mary Pat Angelini
Sherl Brand
Chrissy Buteas
Theresa Edelstein
Beverly Roberts

MEMBERS NOT PRESENT:
Mary Coogan
Dorothea 'Dot' Libman
Wayne Vivian

PRESENTERS:
Jennifer Jacobs, Assistant Commissioner,
NJ Division of Medical Assistance & Health Services
Greg Woods, Chief, Policy & Innovation,
NJ Division of Medical Assistance & Health Services
Carol Grant, Deputy Director,
NJ Division of Medical Assistance & Health Services
Akanksha Kapoor, Chief, Managed Care Accountability,
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/

DR. SPITALNIK: Good morning, I'm Deborah Spitalnik chair of the New Jersey Medical Assistance Advisory Council (MAAC), and it's my pleasure to welcome you to this April 28, 2022, meeting of the MAAC being conducted virtually. This meeting has been scheduled and complies with New Jersey Open Public Meetings Act.

Let me welcome almost 200 of our colleagues in the community and the members of the MAAC and let me share with you how we will proceed through this meeting.

I will first review the agenda and then I will ask the members of the MAAC to introduce themselves. As we proceed through the agenda, if members of the MAAC have comments or questions as we did when we were meeting in person, they will then unmute and ask their questions. Our stakeholders, which are essential to our process, are invited to submit questions in the Qustion and Answer box. There's no operative chat feature in our meeting.

So with that, again, welcome. And I will go through the agenda and then ask the members of the MAAC to introduce themselves.

So we will start with an approval of the minutes. Greg Woods, Deputy Director, will talk to us

about the NJ FamilyCare membership. He will also then present a series of policy implementation updates. We'll then turn to Cover All Kids with Carol Grant. Medicaid Quality Strategy with Akanksha Kapoor, the MCO Quality and Accountability Agenda with Akanksha again, Assistant Commissioner Jennifer Langer Jacobs will speak on the end of the Federal Public Health Emergency, and as always, we will then summarize and collect items for our next meeting, which I'll point out is July 12th. That's a change from the original date that was set a year ago.

So with that, may I ask that we go back to the gallery view and then have the members of the MAAC unmute and introduce themselves. So I will call on Mary Pat, Sherl, and Chrissy, in that order, to unmute and introduce themselves.

MS. ANGELINI: Good morning, everybody. Mary Pat Angelini, I'm the CEO Preferred Health Group, and former assemblywoman.

DR. SPITALNIK: Thank you.

MS. BRAND: Good morning, everyone. My name is Sherl Brand. I'm Vice President at CareCentrix. And I also apologize, I am having technical difficulty so will be hearing most of you today unless I can fix things. Thanks.

DR. SPITALNIK: Thank you.

Chrissy.

MS. BUTEAS: Good morning, everyone. I'm the Chief Government Affairs Officer at the New Jersey Business and Industry Association. Great to be here.

DR. SPITALNIK: Chrissy Buteas, thank you.

Now I'm going to turn to Theresa Edelstein and Beverly Roberts.

MS. EDELSTEIN: Good morning, everyone. I'm Theresa Edelstein. I'm one of the senior vice presidents at the New Jersey Hospital Association. Great to be with all of you today.

DR. SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: Good morning, everybody. My name is Bev Roberts, and I'm with the Arc of New Jersey.

DR. SPITALNIK: And I think, unless through the miracle technology I'm missing anyone, that is our full complement of members today. We may have other members joining by phone, and I know there's some technical difficulties.

We'll now turn to the approval of the minutes from our last meeting, which was January 27, 2022. Does anyone have any comments, corrections, or

additions to the minutes?

MS. ANGELINI: Deborah, I move to accept as submitted.

DR. SPITALNIK: Thank you.

Do I have a second?

MS. BRAND: I second.

DR. SPITALNIK: Any objections, abstentions, agreement?

Then the minutes are accepted. And thank you to the members. Thank you, as always, to Phyllis Melendez, and our transcriber, Lsa Bradley.

We'll now turn to Greg Woods to present to us New Jersey FamilyCare membership.

Welcome, Greg. Good morning.

MR. WOODS: Good morning. Thank you, Dr. Spitalnik.

So I'm going to start this morning by just doing a quick update on total enrollment in NJ FamilyCare. This is the slide we presented over the several MAAC meetings. It's updated here. As of March, we were somewhat North of 2.1 million total enrollees in our program. As you can see, this represents a continuation of the trend of increasing enrollment that we have seen for some time now. As a reminder, we are still operating under the requirements

of the Federal Public Health Emergency which means that while new members continue to enroll in our programs, we are, with a few limited exceptions, not disenrolling members. So that's what drives this trend. We have members coming in. By and large, we don't have members exiting the program. So that's where the overall program growth comes from.

When we look back two years to roughly the beginning of the pandemic, our total enrollment is now about 25 percent higher than it was at the start of the pandemic. And I flag that because I think it's helpful context as we think through the end of the Federal Public Health Emergency which we are expecting later this year and which I know Jen is going to discuss at some length later this morning.

Dr. Spitalnik, do you want me to keep going?

DR. SPITALNIK: Yes, please. But what I will suggest is there are a couple of topics under policy implementation. So I think after each one, I would ask that we pause for any comments of the MAAC and then pick up the next one.

MR. WOODS: Okay. Great.

So first topic under policy implementation is our Section 1115 Comprehensive Demonstration. I am just today going to give a quick update on the status

of our renewal of our 1115 Demonstration. For those who may not be familiar, as a reminder, I know we talked to this group before, our 1115 Demonstration is the legal vehicle through which we receive permission from the federal government to waive some of the standard Medicaid rules. It gives us more flexibility in how we offer coverage. It allows us to cover services that might otherwise not be eligible for Medicaid. It allows us to deliver services in new, different, creative ways. And as we discussed before, this demonstration is approved by the federal government for a time-limited period. So we need to update it every five years, and we're coming up to the end of a five-year period this July. And as I said, we've talked extensively to this group before about the substance of what we're proposing for our next five-year renewal. And as is shown on the slide, over the past year and a half, we have had multiple rounds of stakeholder discussions and input. So I'm not going to focus today on the substance of the renewal proposal, although I would encourage anyone who is interested and hasn't done so already to go to our website and read the proposal. There's a link in the slide, and I think we'll put a link in the chat for that. But I did want to just quickly provide a process

update on where things stand with our renewal and our work with our federal partners, so since the last MAAC meeting in January, a few updates.

First, we formally submitted our final renewal proposal to our federal partners at the Centers for Medicare and Medicaid Services in February. The next step in the process after that was our federal partners at CMS reviewed. They confirmed that our application complete, that it complied with all federal requirements. And once they had done that, there was a federal comment period, which is a standard part of the process for all Section 1115 Demonstration approvals and renewals. That ran for 30 days. It ended earlier this month. You can see on the slide. And I would just note on that, those comments are technically not to us, they're to the federal government, but they're publicly available. We have been going through them. Some of them are really very helpful. We appreciate everyone commenting, and it will certainly inform our policy and program design moving forward.

Now that we've reached the end of the federal comment period, we're in a period of negotiations with the federal government to determine what will ultimately be approved as part of our next five-year period. We're still pretty early in that

process, so I don't have a lot of detail or really any detail in substance to share today. However, I did just want to make two quick points.

First, just in terms of timeline, our current demonstration period ends on June 30th. Based on our conversations with the Centers for Medicare & Medicaid Services (CMS) and based on the various delays in the process primarily due to COVID but also to other factors, we are not expecting full approval of our renewal by the end of June. So instead, based on conversations with CMS, we're expecting to receive a temporary extension of our current demonstration from the federal government. I expect that will extend our authority under existing demonstration for several more months while we continue to negotiate with the federal government and finalize our renewal, and I expect that to happen later in 2022. So I just wanted to set expectations about where we are in terms of timeline.

The second point I wanted to emphasize -- and I know I've said this before, but it's relevant and it's related to the timeline point I just made -- is that as we move forward with negotiations with CMS and even after we receive federal approval, we expect to continue to work very closely with stakeholders on implementing key provisions in our proposal. And that

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includes but is certainly not limited to initiatives around behavioral health integration, housing, other key topics. And just to reemphasize what we said before, receiving federal approval is an absolutely critical step, but it doesn't mean that the moment we receive that federal approval that the programs go live. Rather, for many of the areas where we've made proposals, we expect that the implementation will continue and will be ongoing well beyond the federal approval and that we will continue to engage with stakeholders throughout that implementation process. So I just wanted to reemphasize that.

So I think that's all I have on 1115. I'll pause here, Dr. Spitalnik, to see if there are any questions on this topic.

DR. SPITALNIK: Thank you so much.

If anyone on the MAAC has a question or a comment on what was just presented on the comprehensive demonstration, please unmute.

Hearing none, thank you very much. And I've noted things we want to track for our next meeting. Thanks very much, Greg, and you're still on the screen with the HCBS, Home and Community Based Setting services spend plan. Thank you.

MR. WOODS: So next topic, as Dr. Spitalnik

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said, I did just want to very quick update on the status of our implementation of the additional funds that New Jersey has received under the Federal American Rescue Plan legislation for Home and Community Based-Services. Just as a reminder -- it's a little technical, but I'll do my best to just quickly summarize -- these were funds that were made available under a provision of that federal COVID relief legislation. And what that provision did is it temporarily provided an increase in federal contribution to Medicaid-covered home and community-based services. So the federal share of coverage of those services increased, and the state share decreased. But as a condition of receiving that enhanced federal support, New Jersey and all states were required to take those dollars and reinvest them right back into home and community-based services. That was a condition of receiving the dollars. So as we discussed in a previous MAAC meeting, we developed a spend plan which we submitted to the federal government on how we plan to reinvest those funds. We received approval for that spend plan in January. I think the last time the MAAC met, we were maybe receiving that approval sort of in realtime just as we were meeting. So in that plan that has been approved, we described

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investment totaling around $760 million. And this included a number of different activities. I'm not going to go into a ton of detail today, but it included rate increases to support our workforce across several different provider types. It also included a number of new initiatives and restructure to support the delivery of home and community-based services and investments more broadly to support our members who depend upon those services.

So just to give a high-level update on implementation of those $760 million in investments in our spend plan, at this point, we have implemented activities that will account for about $630 million of those dollars, so the lion's share of those investments. So those have gone live. The remaining activities, we're actively in the process of implementing them. For each remaining activity, there's a different set of issues we're working through. But generally, there's some logistical and legal issues, including in some cases we need -- this is a little confusing, but in some cases we need additional federal authority even though they approved it as part of our broader spend plan. In some instances, we do need to go back to them for some further authority. So we are actively working on the

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remaining items and will continue to provide updates on those remaining activities at future MAAC meetings.

The only other thing I wanted to mention on this point. So the way that the additional funds were structured, it was an additional match. The additional match was available for a year from April of 2021 through March of 2022. And so the actual amount of dollars available to us to reinvest depended on our actual spending during that period on home and community-based services. We did our initial spend plan based on a projection, and the update I would give is the actual spend has come in a bit higher than the projection and we're still finalizing that number. But that means we will have some additional dollars to spend. And right now, we're in the process of determining where to reinvest those dollars. I will just say as we make those decisions, first, we received extensive input from stakeholders last year when we built our initial plan. We're going to go back to that and look if there are other opportunities that were suggested then. And then, of course, we'll just be looking at how our programs have evolved since last year. And we expect to submit an updated spend plan that does include that somewhat higher total to the federal government in the coming months.

I will stop there and pause again to see if there are any questions.

DR. SPITALNIK: Thank you so much.

Any questions from members of the MAAC?

I think it was so comprehensive that we're ready to go on, and we'll continue to turn to you, Greg, for the New Jersey WorkAbility implementation.

MR. WOODS: Thanks, Dr. Spitalnik.

So as Dr. Spitalnik said, I'm going to turn now to the NJ WorkAbility Program, and I want to talk today a little bit about some changes that are forthcoming in that program.

So just quickly, for those who may not be familiar, NJ WorkAbility is a longstanding pathway that allows certain New Jersey residents who have a disability who are working and who, as a result, have an income that would otherwise be too high to qualify, it allows individuals in that situation to receive Medicaid benefits. So it's a very specific pathway for that population, which we here at DMAHS administer in partnership with our sister agency, the Division of Disability Services. And we know that it's really a critical pathway for many of our beneficiaries. So that's the background on NJ WorkAbility.

The reason I want to talk about this this

morning is there was new State legislation, S3455, that was enacted earlier this year. And it expands eligibility for NJ WorkAbility across several different dimensions. So what did this legislation do? I'm just going to very quickly at a high level walk through some of the key changes here.

So first, it removed age restriction. So previously, the program was limited to those ages 16 to 64, and so it was not available for individuals age 65-plus. The legislation removes that restriction and extends potential eligibility to those who are over age 65.

Change number two, it removed income and asset restrictions. So as I just said, historically, the purpose of NJ WorkAbility has been to expand access to Medicaid to working disabled individuals whose income would otherwise be too high to qualify. But that said, there has been an upper limit on income and resources even under that pathway. While the program has extended eligibility to relatively higher income working individuals, there has always been some limit on that, an individual whose income and/or assets are too high to qualify. Here, I'm going to simplify a bit and not go all the way deep into the weeds because there is some complexity here around earned versus

unearned income that I'm not going to get into. But I think the key point is that this legislation eliminated those limits and essentially open NJ WorkAbility to all the individuals who qualify based on disability and work statutes without reference to income or assets at all.

The third change I want to highlight from this legislation was that it allowed individuals who are enrolled in NJ WorkAbility to remain eligible for up to a year after an involuntary job loss. So here, for instance, if a working individual who is enrolled in NJ WorkAbility were, for instance, to be laid off through no fault of their own, they could stay enrolled in NJ WorkAbility for up to a year after that.

So those are the changes in the legislation. I will just say we view these as very significant changes. They significantly expand the program. It's not just tweaks around the edges, it really makes major changes to who can qualify through this pathway. So that's what the bill did.

I want to turn now to giving an update on where we are on putting the legislation into action. And before I get into the nitty-gritty here, I just want to underscore that as the State Medicaid agency we absolutely recognize the importance of this legislation

to those affected. We know that this is a critical pathway to eligibility to those who qualify. And we feel a real sense of urgency around getting these program changes stood up as soon as possible. So this has been a focus area for us over the past several months. And we know it's important to many of you. And as we go through this process, it's really important to us to make sure that we remain engaged with all stakeholders. And we are committed as we go through this process to keeping you up to date on our process.

With that said, I did want to talk candidly about some of the things we need to work through as we make this legislation a reality and give an update and be transparent about some of the challenges that we do need to work through as we stand this up.

So there are two things that I wanted to specifically highlight that are key challenges we need to work through as we apply this legislation.

First, we need to develop and implement a new premium structure for the NJ WorkAbility Program. And this comes directly out of the elimination on income restrictions in eligibility for the program. Now that we are making this pathway to coverage available to a much broader range of individuals,

including those who do have higher incomes, we need to develop a premium schedule on a sliding scale for all of those individuals across the distribution who weren't previously eligible.

And there's a state law piece of this in the legislation that is shown on the slide here. There are also relevant federal requirements around premiums. Within of this premium piece, there are a couple of different elements. There's a policy development piece of this. We need to come up with premiums that make fiscal and policy sense and comply with all state and federal requirements which are fairly complex. And then equally important, there's an implementation piece of this. When we're collecting premiums for individuals under this program, we need to make sure that we have a vendor or mechanism where we can accurately and securely collect those premiums. And there's some real occupational complexity there. I will say right now we are looking at existing state contracts that we could leverage to accomplish this quickly so that we wouldn't need to go through an extensive procurement process. So that's something we're working on actively right now. I think the bottom line I would just emphasize here is there is some complexity there and there are some issues to work

through. We're very confident we'll get them figured out, but this is going to take some time. So that's one thing that we're working through right now.

The second thing I wanted to flag is that, again, consistent with the language of the legislation -- we've exerted this here as well -- we do need to have federal approval before we can implement any of these changes. Because we are implementing several different eligibility changes at once, there's some more complexity here than there might otherwise have been in getting this accomplished. I will say we have begun conversations with our federal partners at the Centers for Medicare and Medicaid Services on this. I think the good news from those conversations is that they've been largely very encouraging, and we're very optimistic that we have a pathway to obtain federal approval for most, if not all, of the changes implemented through the legislation. I think the slightly harder part of this is I think that the pathway to approval may be a little bit complicated. It will require us to use multiple sections of federal law, and there are sort of different requirements that we need to fulfill to get that federal approval. So, again, there's just some technical complexity in getting that part set up. So we are also continuing to

actively work on that, to work with our federal partners. So that's another thing that we are actively working through.

So I will just say we know that there's a lot of interest in getting this done as quickly as possible, and we are very eager to get this done as quickly as well. We're sharing a little more detail on implementation than we might ordinarily, just to give some transparency into what we're working through. And as we continue to make progress on implementation, we will continue to share our progress updates with all stakeholders. And as soon as we have a firm implementation date, we will certainly share that.

So I expect there are probably questions about this one, so I will stop there.

DR. SPITALNIK: Thank you so much. And as I turn back to the MAAC for questions or comments, I also want to welcome Mary Coogan for Advocate for Children, a MAAC member, who is with us by phone. So she's not visible, but her voice can be if she has questions.

Any questions or comments from the MAAC about New Jersey WorkAbility policy changes?

MS. ROBERTS: Thank you very much. It's Bev, and I do have a quick question and comment.

First of all, Greg, thank you very much.

I've talked to you in the past about this. I know you understand at least from the IDD perspective for sure how important this is. So thank you. And I know you have no crystal ball, but do you think it could be possible that at the point the PHE ends and the redetermination starts that this might be in place for NJ WorkAbility?

DR. SPITALNIK: Bev, are you saying the Public Health Emergency?

MS. ROBERTS: Yes.

DR. SPITALNIK: I just wanted to clarify the acronym.

MS. ROBERTS: Sure. Yes, the Public Health Emergency. At the point when that ends and all the redeterminations will start, as to whether there's hope that the NJ WorkAbility improvements will be in place?

MR. WOODS: What I would say about that, Bev -- and Jen or others may also want to jump in -- there is a lot of uncertainty here. We don't know for certain exactly when the Public Health Emergency is going to end, as Jen is going to talk about later. I will just say that we are very mindful of that timeline and a potential interaction between these two issues. So I don't have a crystal ball and I can't give a specific date, I think we are very much aware of the

interaction there. As I said, we will do our very best and move this along as quickly as we possibly can.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Thanks, Bev.

Any other questions or comments?

And I will add my thanks for the responsiveness of DMAHS and the complexity of this important new opportunity. So thank you so much for explicating that.

We'll now turn to discussing Nurture NJ, the Perinatal Episode of Care Pilot.

Greg, thanks.

MR. WOODS: Thanks, Dr. Spitalnik.

So lastly and fairly briefly, I did want to give a quick update on an initiative that I and members of my team here have been working on really closely now, and that's our Perinatal Episode of Care Pilot Program. This was a legislative mandate back from a couple of years ago. It's a new alternative payment model pilot that we're testing. And it's really focused on changing payment for obstetrical clinicians who participate in NJ FamilyCare to emphasize quality of care, sustainability of care, outcomes and experience for patients.

We have spent a couple of years consulting

with stakeholders and working intensively to design this model. Some key features that I have highlighted, number one, it really focuses on improving the quality of care, of maternity care in a sustainable and affordable way.

Number two, clinicians who choose to participate in this model are assuming broad responsibility for their patient's care from the prenatal postpartum period and including a broad range of services, including outpatient, inpatient, labs, pharmacy, et cetera.

And the third, I just want to highlight that we really tried, as we designed this model, to build a real focus on equity in terms of experience and outcomes of care into the design of the model.

We have been working on this for a couple of years. And then subsequent to completing the design, working with providers to participate. So we're excited. The model has gone live at the beginning of this month on April 1st, and we're really pleased to have about 15 obstetrical practices participating. I would just note that these practices include both independent and hospital-affiliated providers. Some are relatively large, some are relatively small. And there are providers from all regions of the state. And

in total, we're projecting that the episode will include about 4,000 NJ FamilyCare births in the first year.

So we're going to continue to report back on this. I just wanted to give a high-level update today. As I say, this is a pilot program. Our intention is to work with the participating providers and with other stakeholders to iterate and evolve this and figure it out together as we go along. So as we continue to go through that, we'll continue to update the MAAC on our progress.

DR. SPITALNIK: Thank you so much.

Any questions or comments from the MAAC?

And any of the MAAC members that are on the phone do have the ability to speak. You're unmuted.

Any questions or comments?

Hearing none, Greg, I want to raise a summary question, going back to one of the earlier issues you raised in policy implementation, and this came from a stakeholder. Do you know the timeline that the Home and Community Based Services (HCBS) additional funds, when you'll have to spend these additional funds?

MR. WOODS: Just to be clear, the initial timeline was, as I said, there's one year of enhanced

match from April of 2021 through March of 2022 that sort of generates the funds that are available to reinvest. We then have through March of 2024 to actually complete the reinvestments. And it's possible -- I think based on conversations we've had with the federal government, it's always possible that might be extended, but we're really focusing on getting all of those dollars out by March of 2024.

DR. SPITALNIK: Thank you. And thank you for all of these updates. It's very much appreciated and we appreciate the clarity about all the complexity that's inherent in each of these programs.

We now turn to Cover All Kids -- I'm sorry. Fee-for-Service Nursing Facility Resident updates.

Is that Carol? I know you're up Cover All Kids. Are you also going to do this, present this for us, please?

MS. JACOBS: I can cover this one, Dr. Spitalnik. I think we had an internal disconnect there, and this got missed in the agenda originally. My apologies for that.

This is Jen Jacobs. Good morning, everybody.

We are excited to talk to you today briefly about plans we have for our members who are resident in

a nursing facility and have been there since before the start of our MLTSS Program in 2014. So a little bit of history there. We launched that MLTSS, Managed Long-Term Services and Supports Program, now eight years ago to shift the focus of long-term care in our state from nursing facility to home and community-based services whenever possible and for as long as possible. In the first five years of the program, we saw an overall reduction of almost 5 percent in our nursing facility census which contrasts with the growth of our elderly population in the state at 12 percent during the same period. And so we saw some of that rebalancing to home and community-based services that we were looking for, and we feel good about that. We now have about two-thirds of our MLTSS population receiving services in the community and one-third residing in nursing facilities.

Our MLTSS members surveys indicate high levels of satisfaction with this program across MLTSS and PACE, and we are working with our MCOs to continuously improve the program on the Managed Care side.

So what is important to note here is that in 2014, we had residents of facilities who were not enrolled in MCOs. About 3,000 of those individuals

remain in Fee-for-Service today. In order to provide the support of a care manager to these members, we will be enrolling the remaining Fee-for-Service nursing facility residents into MCOs on July 1st.

This is important to us because we see the benefit of the availability of a care manager. We are continuing to improve the quality of this program as we go, and we know that that is very important to do, but we recognize the value of having a care manager who's boots on the ground face-to-face care management for person-centered care planning and for explaining and understanding the options that are available to someone who is residing in a nursing facility. So we'll be sending out letters to the residents of these facilities in May. We will ask them to choose an MCO. If they don't choose, they'll be auto-assigned to an MCO. But the important thing to note here is our MLTSS members can change their managed care organization (MCO) at any time. So we're asking them to choose. If they don't choose, we have a default, we can pick one for them. If they don't prefer the one that they've been given, they can always make a change to that. So we wanted you to be aware that that is coming. It's still a few months off, but as Dr. Spitalnik mentioned at the top of the meeting, we don't meet again as a

MAAC until after the first of July. So we wanted to share that information with you now, and we will be working very closely with our providers, with our advocacy groups, and with our members to make sure that this is a person-centered transition, that folks understand what is happening in the process of this, and that we are able to answer any questions and resolve any concerns that people have. And like I said, the continuous improvement of our MLTSS program is very important to us. Akanksha is going to be talking in a few minutes about our quality strategy and Managed Care accountability. So you will hear that theme echoed there, and it will be very important to us to be working closely with our stakeholders as we go forward in this process in the same way that we did when the program launched originally.

Dr. Spitalnik, that's it for that slide, and I'm happy to take any questions.

DR. SPITALNIK: Thank you so much.

Any questions or comments from the MAAC about nursing home facility update?

Not seeing or hearing any, we'll now turn to Cover All Kids and welcome Carol Grant to speak with us.

Thanks so much, Jen.

MS. GRANT: Good morning, everyone. I'm really pleased to be here to give you a bit of an update on the Cover All Kids initiative which is part of the Murphy Administration's commitment to the well-being of New Jerseyans. The initiative is proposed to be funded in the FY23 budget, and Cover All Kids is one of those, along with the goal of reversal prepay, commitment to expanding social service programs, statewide universal newborn home nurse visitation, heightened Medicaid reimbursement rates for maternity care providers, midwifery education, central intake hubs, and childcare revitalization fund.

DR. SPITALNIK: Carol, I'll ask that your volume go up a little. I don't know if we can do it centrally or if I need to rely on you to do that.

MS. GRANT: I've actually just increased it to a hundred percent. I don't know if that makes it any better.

DR. SPITALNIK: It's a little better. Thank you.

MS. GRANT: You know what? I'm going to try to put earphones in. Perhaps that will help.

Can you hear me better now, though?

DR. SPITALNIK: Yes, much better. Thank you so much. Forgive the interruption.

MS. GRANT: No problem.

So in the State Fiscal Year 2023 budget regarding Cover All Kids (CAK), NJ FamilyCare continues to provide support the New Jersey kids. We're going to talk a little bit about enrollment numbers. They're mentioned here now. So since June 2021, we've made really good progress in that we have enrolled 32,116 members, children, under 21 years of age into the NJ FamilyCare. You're also going to be seeing later the estimated target population that we're going after. I just wanted to point out that the estimates of those numbers are really done by outside experts, outside researchers, but this is our enrollment data. And our numbers even as of March indicated enrollment of more than 5,000 children. So we are making progress and we do have some momentum.

New Jersey will continue Cover All Kids Phase 1 efforts in State Fiscal Year (SFY) 2023, including the elimination of Children's HealthInsurance Program (CHIP) waiting periods and premiums, increased community marketing and outreach efforts through NJ FamilyCare, and the convening of continued support of the outreach enrollment and retention working group.

The Governor's proposed budget includes $11 million more allocated for the implementation of

the CAK initiative, and they do include the expansion and Phase 2 to include undocumented children.

Next slide. So if we want to talk what have been doing to date in Fiscal Year 2022, we have, in fact, eliminated premiums and waiting periods. We have targeted household mailings, including PACE's disenrolled pre-pandemic or applications previously denied due to waiting periods. And we have done postal mailings to community partners, and we've listed a lot of them here, food pantries, libraries, laundromats, diners, and every place where we can expect families to see them and to move on to seek to apply and get enrolled in NJ FamilyCare. And we really are looking to plan for the unwinding of the Public Health Emergency. Our working group really is designed, not only to do outreach in enrollment, but also retention. So we're going to pay a lot of attention and be very involved to make sure that we don't have kids falling through the cracks and to make sure that continuing care is seamless.

Next slide. In Fiscal Year 2023, again, we're going to continue and enhance outreach collaboration with community partners since there's no other way to do that. We're going to implement coverage for income-eligible undocumented children.

This is a state-funded program that will provide to the extent possible the same coverage they would have under Medicaid or CHIP. There are these expert estimates, 48,000 children eligible but not enrolled in New Jersey FamilyCare and 16,000 children who are ineligible due to immigration status.

Next slide. As I said, we have momentum. As you can see here, we've enrolled 32,116 children since June of 2021. We're proud of it. We're not there yet. We've seen the estimates, but we're going to continue our efforts.

Next slide. Really, there are also the law, Public Law 2021, requires the reconvening of an outreach enrollment and retention working group. This is consistent with Governor Murphy's commitment to no child in New Jersey should be left without the support and security and health care coverage. This group needs to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate-income families that may be eligible for Medicaid NJ FamilyCare or ultimately to some type of NJ FamilyCare advantage model to maximize enrollment in these programs and to ensure retention. This is not a short-term endeavor. It really is putting the kind of fixes, process, outreach, marketing, messaging that

will enable us to keep kids insured in New Jersey for the long term.

Next slide. Again, the outreach enrollment and retention working group, which is composed of cabinet representatives and public members, has been convened, as required by law. They have already met three times. And additional meetings are scheduled every four to five weeks throughout the remainder of the year. The initial focus of this group are things like marketing and messaging, overcoming barriers to accessible in specific communities, enrollment and retention, data research and effectiveness of New Jersey FamilyCare outreach material, immigrant eligibility criteria for health coverage, interagency confidentiality and collaboration. Their important work is underway. And I'm hoping, because we did invite them to listen in to the MAAC, so I'm hoping that a number of members actually with us this morning.

I believe that's it.

DR. SPITALNIK: Carol, thank you so much and thank you for this uplifting report. Deeply appreciated.

Before we turn to the quality strategy, I would ask if any members of the MAAC have any comments or questions?

Hearing or seeing none.

Thank you for this comprehensive overview.

We now turn to Akanksha Kapoor for two different presentations, starting off with Managed Care quality and accountability.

Good morning and welcome, Akanksha.

MS. KAPOOR: Thanks, Dr. Spitalnik. Good morning, everyone. I'm excited to talk to you guys today about Managed Care quality and accountability. We're going to start with Managed Care quality, so we're going to go right into the quality strategy.

We at DMAHS actually posted yesterday on our website the quality strategy, and so I encourage everyone to go out and read it. It is a lengthy document, but it is quite important and we do have a 30-day public comment period open. Before we get into what's on the slide today, I wanted to talk to you guys a little bit about what we think of the quality strategy to mean for us. And so as Jen alluded to earlier in the presentation, it's really important that we continue to do the right thing for the people we serve. And what that really means is that we're continuously working with our managed care organizations in New Jersey to continue to improve our program. And so the quality strategy is just that. It

is our road map for us here at DMAHS and our Managed Care Organizations to ensure we are serving our members the best way possible.

So if I direct your attention back to the screen, there are sort of four definitions of the quality strategy. Really, we think of it as a road map for ongoing improvements in our program, and it is a CMS requirement for any state with Managed Care contracts.

So if we go over to the next slide, there are some key sections of the quality strategy. I'm not going to go through each one in detail, but really we talk at the beginning of the strategy about the history of our program, the organizational structure here at DMAHS, some of the key demographics of our state, and, of course, our New Jersey managed care organizations.

On our next slide, we're going to talk a little bit about the mission, values, and goals. So here you're going to see, most importantly, the mission statement of the Department of Human Services which we obviously operate under. What you'll also see is the Division of Medical Assistance and Health Services (DMAHS) goals and objectives on this screen and how these goals and objectives on the screen and how these goals and objectives relate directly back to the CMS

triple aim, better care, smarter spending, healthier people and healthier communities. So really, this is the structure of what I think of as the trifecta, CMS, New Jersey DMAHS, and then Department of Human Services.

Moving to the next slide, the purpose and scope of the quality strategy is really for us to establish an improvement plan so that we are continuously sustaining and improving an efficient health care delivery system. The quality strategy covers all aspects of the care of services in New Jersey as well as all aspects of the MCO operations and performance.

We go on to the next slide. There are some rules we have to follow with the development, review, and evaluation of the strategy. We do have to receive public comment for the strategy before we can submit it to CMS and post it as final on our website. We here at DMAHS have agreed to undergo an annual review of the quality strategy. So every year we really want to make sure this a living breathing document. And every year we are adding and editing to make sure it is reflective of our goals and priorities at the State. At a minimum, every three years we will go ahead and update the quality strategy or if there is a significant

change.

Then there's evaluation of the quality strategy. So every year as part of the review, we will evaluating what goals we've made and how we are progressing towards where we want to be as a State with our Managed Care Organizations.

So part of the requirements of the quality strategy are to outline the quality assessment and performance improvement requirements of our Managed Care contract. So we here on the screen have some of the activities of our external review organizations. In New Jersey, we are contracted right now with IPRO to conduct those activities, and there are performance improvement projects that are required of the Managed Care Organizations. There are quality metrics and performance targets that are defined in our managed care contracts. Where we can, we try to use nationally-recognized measures so that we are able to benchmark performance across the nation. And there is disparity prevention and reduction. And, of course, there are processes in place for grievances and appeals.

Go to the next slide. Also defined by CMS are some state standards for access in operations. So I want to just underscore that these are not the only

standards that we have. There are far more in our Managed Care Contract, but these are some of the ones that the quality strategy does highlight. There's the availability of services, ensuring adequate capacity of services, coordination and continuity of care, coverage and authorization of services, and requirements for enrollees with special needs, and standards for structure and operations.

If we go to our next slide. One of my favorite parts is the Managed Care Contract has sections where we are creating incentives for Managed Care Organizations to really go above and beyond in certain quality benchmarks. So you can see on the screen payment here the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) incentive payment and some performance-based contracting.

Equally as important, we do have corrective actions, notices of deficiency, liquidated damages, and administrative sanctions outlined in the Managed Care contract should quality and program expectations not be met. Before I go into accountability, we can put the link to the posted quality strategy on our website. There is a general mailbox that we invite all comments. And then there are some methods of mail delivery and fax if you choose to do that. But we really encourage

everybody to go out and read the quality strategy.

Dr. Spitalnik, would you like me to pause before I go into managed care accountability?

DR. SPITALNIK: Yes, please. And I thank you so much for this presentation. I would invite the members of the MAAC to ask questions, make comments.

And, again, hearing none, please continue with MCO accountability.

MS. KAPOOR: Thanks.

So as we just mentioned one slide earlier, there are some accountability requirements we have in our Managed Care contract. I wanted to take a minute to share with the group what Managed Care accountability looks like today. The theme that you're going to see on this slide and the next slide is based on subject for what we've accomplished in recent months what we are looking ahead to in the future. And so starting on this slide around Managed Care contract and reporting, we have taken steps to modify some of those pay-for-performance incentives that I mentioned earlier to make sure that they are aligning with our program's priorities and to make sure we are continuing to improve quality measures that really make sense for the members we serve. Similarly, we've also done a lot of work most recently on some of the COVID vaccine

reporting to really make sure that we are developing reports and collecting data that can inform the decisions we're making about the program today. Similarly, what are we working on next? We are really trying to make sure those value-based programs and those performance incentives as well as the intermediate actions that we put in place with our organizations are driving MCO accountability across the state. So we're excited to start to introduce that in the months to come.

And related to that accountable performance reviews, over the course of about a year and a half, we have introduced a monthly meeting. Our leadership team here at DMAHS meets with MCOs monthly to review performance and quality trends. We're using data that's available both public and proprietary to develop robust agendas to underscore MCO strengths, weaknesses, concerning findings, areas of opportunities, and we're also trying to understand better some of the different operations within the MCOs. What do we expect to look like over next couple months? We really want to align our program operations to MCO performance. So one example that I think have been mentioned in the past is really through the auto-assignment process to align with high-performing MCOs. We're also very, very keyed

into the key metrics that are being required by CMS to make sure that we are looking at our data the same way. Go to the next slide. I just talked a lot about the New Jersey quality strategy. So what we have accomplished? We have drafted that quality strategy, and it is posted for public comment. And what are we going to be working on next over the months there? Like I mentioned earlier, we expect that document to be a living, breathing document so we are going to be meeting regularly with our leadership teams and our internal teams to make sure that we are aligning our MCO improvements and interventions to state objectives. Also very important, we are looking at advancing health equity across New Jersey, and so in future iterations of the quality strategy, you will see, obviously, more details of that.

Then last but not least, New Jersey FamilyCare dashboard. So over the last few months, we have developed and enhanced and published New Jersey's quality dashboard. So you can find those on the DMAHS analytics website. The dashboards compare New Jersey as a whole and also New Jersey MCOs individually to national measures both related to clinical care and to consumer experience.

So now that we've done that, of course, the

work isn't ever done. So we are looking in the next couple months to really enhance those quality dashboards to include more public performance metrics so that our communities are able to make informed decisions.

That's the end of my slides.

DR. SPITALNIK: Thank you so much.

Again, I turn to the MAAC for comments or questions.

MS. ROBERTS: Hi, this is Bev Roberts with the Arc of New Jersey. Thanks, Akanksha. This was really very helpful. I don't know if you can answer the question I have, but what I'm very concerned about in looking at the accountability performance reviews is for people with disabilities who are in ABD Medicaid, if there's going to be a way to -- obviously, you want to look at performance overall which is perfectly fine, but also when there are individuals with developmental disabilities or other special needs who need a lot and may have complex needs, I just want to be sure that there's going to be a recognition and encourage for the MCOs to really be meeting the needs of those members.

MS. KAPOOR: Thanks, Bev. I think what I can share today is we are going to be working with stakeholders. We've already started working with

stakeholders, and you'll see that in integrated as part of our health equity, and we are really already starting to look at specialized populations through things like specific care management audit results. So our MCOs have already started talking to us around performance around care management, for example, in the IDD population and what those results look like across the board.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Thank you.

Other questions or comments from the MAAC?

Akanksha, in addition to, of course, the thanks of the MAAC for your presentation and all that you're doing, I just wanted to reflect the comment about what a wonderful overview of the quality strategy. So thank you so much.

Our next agenda item is listed on our public agenda as ending with the federal public health emergency, but I really appreciate the verb I've been looking for in terms of unwinding as we turn to Assistant Commissioner Jennifer Langer Jacobs to speak with us about COVID-19 unwinding.

Jen.

MS. JACOBS: Thanks, Dr. Spitalnik. And I will just take a moment to thank Carol, Greg, and

Akanksha for their leadership on all of the initiatives that they've described to you today. As you know, we have a lot going on here at Medicaid. Those were just a few pieces, and this one is another. So I'm happy to talk to you, but I wanted to start by thanking my leaders for their great work on the critical initiatives that they described to you a few minutes ago.

So I am here, yes, to talk to you today about the unwinding of the Federal Public Health Emergency, and there is a lot to talk about. And people are following this at different levels of detail. So some people are reading headlines, some people are reading a little bit of an article, and some people are deep in the weeds of this with us; and we want you to meet wherever you are for purposes of this discussion today. So I wanted to just sort of set up initially here's what we are able to talk about today and then what comes in the future.

So for starters, let me give you a little background, which is in the gray box on this slide. I think most of you know and Greg has described in each MAAC meeting that our members have remained continuously eligible for Medicaid. They've all remained enrolled due to the federal maintenance of

effort requirements during the Public Health Emergency, which we've finally called PHE, and that Public Health Emergency is expected to end on July 15th. Now, that has been the case all along. We have had these sort of 90-day extensions of the Public Health Emergency. This was another one. They extended it through July 15th. I think what brings our attention and focus in this moment is there is reason to believe this will be the last extension of the Federal Public Health Emergency. So a lot changes when the Federal Public Health Emergency ends. When we talk about unwinding it, eligibility is one piece. There are other moving parts related to waivers that were provided by the federal government during the PHE. But the part I'm going to focus on today is the eligibility piece because that is the part that most significantly impacts the 2 million people we serve here in New Jersey.

So when the PHE ends, CMS has given states 12 months to reprocess eligibility for all their Medicaid beneficiaries. So for us, that's the 2 million people that we serve. And that, in the context of many other important initiatives, only some of which have been mentioned to you today, that represents the single largest redetermination exercise in the history of our program. And our preparedness for that is

critical. It is top property for us. It is right up there with all of the policy work that you hear us talking about, which is exciting work. The eligibility work is hard behind-the-scenes work but critically important.

And so what we wanted to talk to you about today, shifting to the right-hand side of the slide, we want to talk to you about how we are collaborating with our existing partners, our operational partners and our community partners, to raise awareness of what this eligibility exercise will look like and to make sure that we're doing the work the best way possible. Linking back to the quality strategy that we were just talking about, we are always focused on how we do this work that we need to do the best way we possibly can.

It is going to require partnership with many agencies who are doing related work, including connecting people who may no longer be eligible for Medicaid to other coverage. And I think as most of you know, there is subsidized coverage available through Get Covered NJ which will be available to many of our many members. There are Medicare savings plans. There will be connections that we want to make for folks who are potentially becoming ineligible for Medicaid.

We have a lot of work to do, and our

intention is to spread the cases evenly over the 12 months that the federal government has given us. And thanks to our operations team -- and I need to underscore that. Thanks to our operations team and our IT systems folks, we have upgraded our eligibility systems throughout the PHE. We never stopped working on that, bringing those systems into the future, and that will help us with quality and efficiency. We are not going to be doing this work nearly as much on paper as we were in past years. The team had been bringing systems into a more modernized state when the pandemic began, and they continued that work, to their great credit, and also the credit of our counties who were really frontline in the pandemic and continued to see the value of training up their teams and implementing these new systems so that we would be able to do our work better and smarter in the future. That is going to work for us. That will work to our advantage when this begins.

Then we know that as we do eligibility work, many folks will remain enrolled and some will be found ineligibility. Those who are found ineligible may have other coverage, and we'll talk about that in a minute. They may not want ongoing NJ FamilyCare coverage. And, in fact, that is a group we're hearing from right now.

But there will be folks who do want to continue their coverage and they feel the eligibility determination was in error or that some information was missing, and we will have pathways for working through that.

There's a formal pathway, which includes a fair hearing through the administrative courts, but we hope that we'll be able to resolve individual issues as much as possible without the need for those kinds of hearings. We would like to take care of it quick and clean if there's a way to do that. So I'm going to talk to you a little bit about that today.

Before I get into those operational details, though, we felt it was important to talk to you about our North Star principles. This is an exercise that we do whenever we are going into a big, important project and we want to make sure that we have principles that will guide our decisionmaking, and we keep those principles in front of us through the course of that project. And those of you who are frequent flyers with MAAC, you may remember that when we had this April meeting in 2020, I shared the North Star principles that we had drafted for managing the pandemic because this was not something we had ever had to do before and we knew that we were going to have to work differently and we were going to have keep our values in front of

us.

We're taking that same approach here as we think about unwinding from the pandemic. So we wanted to share with you -- it's not the same words that you saw in April of 2020 because it's not the same work that we were doing in April of 2020, thankfully. This is different work. This is moving into the next chapter of our lives after COVID, and so the words on this page are different than the ones you saw two years ago. But our intention now with respect to the unwinding, we continue to focus on serving people the best way possible. That just looks different now. What it looks like now is we need to resume Medicaid eligibility redeterminations. That's required by federal rules. But we do it with a focus on the quality of our work and support for the people we serve.

We know that we need to communicate with clarity and concern. That is always a focus for us. What does that look like in this case? We need to emphasize shared understanding. Internal to our organization candidly and externally because we will be managing these broad technical systems and also very unique individuals, circumstances that apply to families and to individuals. So where those systems

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and those individuals are interfacing, we need to be very focused on shared understanding, on being clear and simplifying.

We know and we always focus on experimenting with new ways to solve problems. We know that that's important. Here, what does that mean? We have the opportunity to collaborate in new ways with our operational partners. And we can use some of that collaborative learning to improve our program for the long term. Change is opportunity. What are the ways that we can work together now in this context that will make us better, smarter, stronger for the future?

We always want to stay close to our stakeholders. We spend an enormous amount of time in conversations with our stakeholders in problem-solving related to issues they have brought to us. What does that mean in this context? Well, it means that we need to raise awareness ahead of time, and we're going to talk about that here today, raise awareness of what is happening and provide support to the community. And we must have a shared commitment to equity, inclusion, and that synergy that makes the collaboration work.

Finally, we always talk about making sure that we are showing people we care, that we are leading our program with our hearts. And what does that mean

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in this context? It means a lot like what it means in general, which is empathy, positive energy, and collaborative focus have got to be what we're bringing into the room, whether it's an internal discussion here at Medicaid or an external discussion with individual stakeholders, members or, frankly, the MAAC. So this is important to us. This is keeping our values in front of us. It's not a mission statement on the wall. It's how will we function every day as we are being asked to take action, make decisions, and serve our community.

We wanted to share a timeline with you because we think that the details here are -- many of the question marks over people's heads right now are about these details. So I'm going to use this horrifically ugly laser pointer to help you follow along what we see as the hypothetical timeline. I do want to point out that we use the word hypothetical in 36 point font for a reason. All the dates here are what we are working with for operational planning, but they are not official dates. And you will see why in a moment. So just pointing out to you "hypothetical" is there really big for a reason.

This is the timeline that we are working on. I'm going to bounce around a little bit. We currently

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are expecting the Federal Public Health Emergency will end July 15th. That is when it is scheduled to end. As I said earlier, we've had extensions since 2020, and it is entirely possible that there would be another. But that is the date we are working with now because we need to be planning now for the possibility that this will end. And so here is where we are today. We have an ambassador call center that has been set up. It is at our health benefits coordinator which some of you know as Conduent, and some of you just know as our NJ FamilyCare hotline, 1-800-701-0710. That call center is available to take address changes for any and all of our Medicaid members. That was not the case in the past. In the past, if a member was assigned to a county for their eligibility redetermination, they would have to call the county to make that address change. We felt that under these circumstances, the best way to serve people, going back to those values and making sure that we're applying those values in our operations, the best way to serve people is to give them one option where everybody could call. So they can call that ambassador line, and we'll share that with you again. They can call that ambassador line, they can call their county. And in a minute, I'm going to tell you they can call their MCO to change their

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address. But we wanted to make sure we had one phone number that we could use for anybody and everybody, and that call center is live. So that's already in motion. And what will be in motion next is member outreach through our Managed Care Organizations. I'm going to talk to you a little bit more about this in a minute, but we will be focusing, top priority, on members who have not responded to recent mailings. Those are the members we're worried may not be receiving our mail. And if you are a community organization or an advocate in the community, you have probably heard in the past that this is an issue. We're aware of it, and this is how we're going to try to tackle it, between that ambassador call center and MCO outreach. I'm going to talk to you a little bit more about that in a minute.

In the middle of May, we are expecting the possible announcement from CMS that the Federal Public Health Emergency will not be extended beyond July 15th. They have told us repeatedly that we will have 60 days notice if that is the case. So May 15th is the magic day when we expect we will know whether or not the PHE is being extended. If CMS does not make an announcement on that day, then we would expect that this July 15th date pushes forward into the future. But for now, we are expecting that CMS will make the

announcement on May 15th that the PHE will end, and that will be the 60 days notice before the July 15th end.

So let's continue with that assumption. We will continue our outreach through May, June, and into July. That outreach will really be focused on making sure members are aware this is coming and that there's something they can do to make sure that their coverage continues. And we're going to talk about that in a little bit of detail.

We will have a communications campaign that will be broad media communications. We will be partnering with providers and community organizations and advocates all over the state. We will be participating in events to make sure that as much as possible we're bringing awareness as we're moving into this process. And while we're doing that, behind the scenes we will be working with our 21 counties to prepare to manage the redeterminations for the people that they serve.

So in our hypothetical scenario, then, the Federal PHE ends July 15. As I said, there's a lot more around that than just eligibility; but here today, we're focused on eligibility. At that point, the 12-month timer begins, and the federal government

expects that we will initiate redetermination for all of our 2 million members over those 12 months. What that means for New Jersey is we will start mailings in August. That will be the first renewal mailings that may result in disenrollment. That's when the mailings will begin. Now, there's an important nuance here which is we have been doing these mailings all along; we just haven't been disenrolling anybody. And that's important because if you come back to here, the priority on members who have not responded, we know who hasn't responded to these mailings. It just hasn't had any consequences. We've set them aside because everyone is going to get a fresh eligibility determination after July 15th or whenever the PHE ends. So we did those mailings and we now know who didn't respond. We're going to outreach to those folks so that they are our top priority. These are the ones where we don't know if you got our mail. We're going to have to get creative about this. And we will be spreading all that eligibility activity over 12 months.

So for the individuals who receive a mailing in August, the first risk of disenrollment is in October. But that would really be a case from the August mailing where there's no appeal, there's no back-and-forth with the county, it's a simple case,

it's open and closed, and it's possible that that person would disenroll in October. But remember, this is going to be rolling over those 12 months. So this is only August mailings that might see disenrollment for October; and most of them, we believe, will still be in process. So all of that process actually continues through 2022 and 2023.

The next date that you see here is August 1 of 2023, which is 12 months after that August 1 of 2022 start. And that is when the federal government expects that we would have initiated redeterminations for everybody, but they know that some of those will not have been initiated until month 12 because we're spreading it evenly. So they say, "There's another couple months here where we know you're going to be finishing off that last group." They recognize that. And we recognize that there may be good faith cases and fair hearings that are still going on at that point. So we're just pointing that out to you as part of our hypothetical timeline.

As we are looking at how to approach this work, we have to be thoughtful and strategic, and this timeline is part of that. But I do want to emphasize that these dates are all subject to change, and I think fair to say every one of will have changed in some way

before this is over, with the possible exception of these federal announcements. So we will stay close to you on this but wanted to just share that so that you had a sense of the timeline that we're working with just for operational planning purposes.

Then I wanted to share with you because this is something that sometimes we think everybody knows this, and everybody does know this. So it's important in this moment even though it's really kind of behind-the-scenes work for most of you, not something that you will interact with, but it feels important in this moment to just give you a sense of how we do this work.

So we have eligibility determining agencies. We really have 22 of them. There are 21 counties who do this work, and we have our NJ FamilyCare health benefits coordinator, Conduent, who is doing this work. And they each serve, between the 21 counties, about half the program; Conduent has about half the program. They will need to do the redetermination work for their assigned beneficiaries over that 12-month period. I keep emphasizing we're going to spread it evenly over the 12 months. We're not trying to create bumps, if you can imagine where we have a lot of people in August and very few in September. We want to make it nice and

smooth. And we're talking with CMS about the strategy for doing that, our options for how we smooth out the volume over those 12 months.

I wanted to point out, as I mentioned before, with the counties, we've done these system upgrades that are helping the counties do the work with more accuracy and efficiency and visibility. And we have included in their memorandum of understanding, which all 21 have signed, incentives related to their renewal performance. There are other incentives built into that agreement as well, but the renewal performance obviously is relevant to this exercise.

Before I move on, I should mention, we do have reports that we are seeing on a weekly basis and on a monthly basis that give us a sense of the work that's going on in each of these 21 counties and Conduent so that we're able to kind of keep our eye on it and make sure that we're addressing any flags that come up.

And then I want to talk to you about the people we serve. These are four examples. There are many dozens of examples because each case is going to be unique, and some of them are very complex. But we've given you four simple examples here because we think these are ones everybody can relate to and we

don't get too far into the weeds of things, but I think it will help you frame out how this is going to work. So let's walk through all four.

I want to talk about Halima first. In Halima's case, we imagined that she called the ambassador line and she gave us her updated address. Or maybe she didn't. Maybe we just had an address that worked for her. Either way, she received her redetermination mailing, she responded to the mailing, she was determined eligible, and her eligibility continues. Halima is our simplest, happiest case.

Another simple case is Hector. Hector responded to the eligibility mailing. Or maybe he didn't. But he doesn't want to remain enrolled either way. Maybe he threw the envelope away or maybe he responded and said, "I do not wish to remain enrolled. I have other coverage." Either way, he's determined ineligibility based on the information he provided, and his eligibility ends. But that's what he wanted to happen. So Hector is fine, too.

It's Samuel and Sofia who we worry about. We want to make that we are that we are as supportive as we can be to Samuel and Sofia because they are really looking for that support from us.

In Samuel's case, he responded to the

eligibility mailing, but he was determined ineligible due to income or assets. Now, there's a whole process that occurs there. And then he receives a disenrollment notice, and his account is transferred to GetCoveredNJ, which is our state-based exchange, because we're trying to connect him to that over coverage. But Samuel does not want that other coverage. Samuel wants to continue his NJ FamilyCare, and he believes that in an eligibility determination was an error.

In Samuel's case, our intention is to have a rapid response team and informal resolution at our counties and at Conduent where we are working together to address the issue that Samuel raises and to make sure that we get him into the right coverage. Samuel will have the fair hearing option, but if we can solve this problem before it goes to fair hearing, I think we can all agree that is ideal for Samuel. So Samuel is an example of a member we want to make sure we have a solution path for, and that is something we're working through right now with our operational partners.

Likewise, Sofia. But the difference between Samuel and Sofia is Samuel responded to our mailing, and Sofia called what I called the "Jen Jacobs." She got the envelope in the mail. She put it on the

kitchen table. She did not open it. It ended up in the recycling. We never got a response from her. I am guilty of that and I feel a connection to Sofia because of that. So Sofia didn't respond. Now she's ineligibility due to nonresponse. She gets the disenrollment notice, which includes information for GetCoveredNJ. But, again, Sofia just lost track of the mail or maybe Sofia never got the mail, and she wants to remain enrolled. So, again, we want to support her in the same way that we did Samuel. To the extent that we can work through some of the troubleshooting informally with rapid response team, we will be doing that. But Sofia also still has that fair hearing path if that is what is needed, and we will work through that as we always do.

So these are four simple examples. And if you work closely with Medicaid eligibility -- like I said at the top, people are at very different levels of detail on this thing. If you work closely with Medicaid eligibility, you have 25 other examples in your mind, and we understand that. But when we frame it out in the simplest way, we recognize there are people who are going to get an outcome they're comfortable with; that's Halima and Hector. There are people who are going to get an outcome they're

uncomfortable with; that's Samuel and Sofia. We need to be there for them and work through it.

Our MCOs will be important to us whenever we are talking about things that are happening programmatically or operationally. Folks are asking us, "What are the MCOs doing to support that?" They know, everybody knows MCOs are an important partner to us. They are boots on the ground. So we wanted to answer that question for you proactively and explain some of the initial steps we are taking with our MCOs to support outreach that's really specific to individual members.

As I mentioned earlier, we will be working closely with providers and community organizations and media on awareness generally, but what the MCOs can do that those organizations can not is really outreach for us very specifically the individual members that they serve. So that's what we're starting now, and we'll be continuing throughout this process.

I wanted to walk you through that a little bit. What can we be doing right now with our MCOs? Well, this is exciting news. For the first time, CMS is allowing us to accept updated member contact information from the MCOs. They're allowing that with a temporary waiver, and that will give us the

information the MCOs have when a member has called in, verified their identify, provided a new address. The MCO typically says, "Make sure you call the state and share that new address with them." That call doesn't always happen for various reasons. So sometimes they have more current information than we do. This is the first time we will be able to simply accept that updated information. So we submitted the waiver request to CMS. We received approval of that last week. Our testing is complete with the MCOs. So we are ready to formally operationalize this with them in May. That is very exciting to those of us who have been following this issue for many years. It's challenging that the MCOs have sometimes more current information than we do, and they can use it but we haven't been able to accept it at scale. And now we will be able to do that. So what will we do then?

Starting in May, the MCOs are going to be reaching out to those members I described to you who have not responded to mailings. And I just want to point again to our operations team and our county teams, our systems teams who made sure that we used technology here during the pandemic in creative ways. One of the ways we did that was as the counties continued sending redetermination, re-det packets, and

Conduent was sending re-det packets and members were responding to those re-det packets. We were taking those who did not respond and putting a little flag on them, this person did not respond. Now we know who they are. And even though we'll be sending a whole new round of redetermination packets, we know who's at risk there because they didn't respond to us the last time, and we're going to use those flags.

So we are identifying for the MCOs who didn't respond. The MCOs will attempt to outreach those members and their providers to update contact information. And as I said before, maybe they have updated contact information for those members already. We're going to be reaching out to those members and encouraging them to respond to the mail they received from NJ FamilyCare. So we're finalizing the outreach plans for that with the MCOs right now, and we'll ensure that we'll have consistent messaging across the program. We will share that messaging with you.

Once the PHE ends, we shift a little bit because at that point we will see folks starting to be at risk of disenrollment. We want to help them avoid disenrollment and/or access other coverage. So when the PHE ends, we will identify members who are set to disenroll for the MCOs. We've done that in the past.

The MCOs will attempt to outreach those disenrolling members and help them avoid disenrollment or connect to other coverage. And what is interesting here, another first, for the first time, CMS is allowing post-disenrollment outreach for the MCOs in creative ways. So we're working on an approach to that. Obviously, we have a little bit of time, and we're focused on the first two boxes that you see here on this page, but intending to leverage that flexibility that CMS is providing for post-disenrollment outreach which is new and different and changes opportunity. So next steps on that would be finalizing the communication templates and the protocols that we expect the MCOs to follow.

I think something that's important to point out to you, which we've included here in a little footnote at the bottom, this is not particularly new but MCO communications cannot be intended to influence a beneficiary to enroll. And CMS has been underscoring that in their messaging, and so we will be doing the same. So what the MCO is really doing is providing information. They are not saying, "We are the best MCO, you should come to us." They're saying, "Here is information on NJ FamilyCare, on the state-based exchange, et cetera," and all of that compliant with

federal rules.

I think I have one more. So this is our key message for you. And the most important thing I will say to you today is inside the blue box. Please help us transmit these key messages to our communities. The ambassador line I described to you a few minutes ago, 1-800-701-0710, I am repeating that at 2 o'clock in the morning when I wake up, and I hope that you will, too. It is important that folks call that number to make sure we have their current address. Many people have moved during the Public Health Emergency, and they have a new address. And it doesn't feel new anymore because they moved two years ago. But you know what? It might be new to us. So it would just be helpful to say, either way, whether you moved or not, call NJ FamilyCare, make sure they have your current address. It's really important because you're going to be getting a redetermination mailing, a renewal mailing, an eligibility mailing, and it will be critical that you respond to that mail to keep your coverage.

So we've spent a lot of time on this with CMS and with other states. And in all of those conversations, we've talked about a billion things, but those billion things boil down to these two key messages. Please have folks share their current

address with us, and please emphasize responding to any mail they receive from NJ FamilyCare.

After the PHE ends, that message is still the same. We still need them to keep a current address with us and respond to our mail, but we will shift to some additional messaging, including if you believe you've been incorrectly terminated, you have appeal rights. You can shift over to GetCoveredNJ or other options. So there will be some additional messaging once the PHE ends. But for now, the really critical stuff is in that blue box. And we look forward to working with our community partners, many of whom, 234 of whom can hear my voice right now but others who are not on with us today to spread this message, to troubleshoot as we work through the process. We do intend to do this the best way possible, and we believe that partners like our providers and payers, community leaders and organizations, the advocates who you are talking to every day, our MAAC and our Cover All Kids workgroup that Carol mentions, the regional health hubs we work so closely with, and all of our sister agencies will be critical to helping us achieve that goal.

So, Dr. Spitalnik, I know that was a lot, but we really felt it was important to be very transparent and share as much as we could at this point

in time. I have not had a chance to look at the Q and A.

DR. SPITALNIK: I'll raise any questions in Q and A after the MAAC, but I did want to start off with thanking you, both for the level of detail which is essential with all these moving pieces, and for starting off with the guiding North Star principles. I think it's real what quality and caring is about. So thank you for that.

And I will turn to members of the MAAC and ask you to unmute if you have comments or questions at this juncture.

MS. ROBERTS: Hi, this is Bev. I do have a comment and a question. Thank you so much, Jen. This was an excellent, excellent presentation. I like the examples that you gave.

What I wanted to do is just make a comment. And I know you couldn't go into the weeds about a whole lot of stuff that you could still be talking for a long time if you went into a lot of detail. But I know there were people at this meeting who are involved with people with IDD, so the comment that I just wanted make is that -- of course, I've been in touch with you and people on your team specifically about people who are served through the Division of Developmental Disabilities because, as you know, they must have their

Medicaid intact in order to keep their DDD services. And there's also the DDD waiver unit which is a way for some people, hopefully a number of people if they're not eligible for another Medicaid category, to still keep their Medicaid eligibility through that route. So I just sort of to other people that are listening to this to know that there is something that's in place and we're continuing to work on it for folks who receive DDD services.

MS. JACOBS: Thank you, Bev. That is a perfect example of the community partnership that's so critical. We do appreciate that you brought that to our attention very early so that we could put good planning around it.

DR. SPITALNIK: Thank you, both.

Other comments or questions from the MAAC.

Then I will raise for consideration some of the questions in the question box.

One of the questions was: Given the extent of or the historic extent of the redetermination process, do you anticipate that having impact on new applications for eligibility?

MS. JACOBS: That's a really good question. We have guided our operational partners along this path. We're working together on this to determine how

we will manage volume. We expect that everyone will remain on performance metrics, consistent with existing performance metrics around both removals and new applications. We've been very pleased with the progress we've seen, again, from those systems upgrades and a lot of work at the counties, in particular; the progress that we've seen with turn-around times for new applications. And because of those system upgrades, we have visibility there that we never had before. So as I said, we will be monitoring those reports and looking for any flags or changes in activity levels. But we're feeling pretty optimistic because our partnerships have been really going very well, and I think folks are pretty well prepared here.

DR. SPITALNIK: Thank you.

And in terms of enlisting community partners, there's a comment about a request for the image, distributing the images of what the envelope and the determination letters will look like. I'm also of the school of the Jen Jacobs coffee table or kitchen table. So can you speak to that, please?

MS. JACOBS: Sure I can, but I will have to come back to you on it because there has been sort of a traditional way that this was handled which was each of the 21 counties are doing their own mailings, Conduent,

our health benefits coordinator doing the mailings for the members they are assigned to. As you can imagine, there were some sort of variations there. So we're just locking down on what this will look like and really what we can do with those envelopes to draw attention to them.

I did see, as I was just quickly scanning the Q and A, I saw a question about the color of the envelopes, I think. And that would be somebody who has been following this very closely because one of the strategies folks have talked about is, can we identify a particular colored envelope that we can say folks, "Look for the yellow, purple, orange, green envelope," and a couple of states have gotten out of the gate with that. I will be very candid with you and say there is a national paper shortage. And so part of our planning in this process includes planning around a national paper shortage, so we're currently identifying what are the options available to us, given what is out there in supply. And then we will identify for you what that's going to look like. So bear with us a couple more minutes as we figure out those final details.

DR. SPITALNIK: Thank you for that.

Similarly, something I know that the Division and the Department are very sensitive to, but

I think it's a good point to explicate. What strategies are in place for outreach to members with limited English proficiency?

MS. JACOBS: So that is where community partners become very important. Anybody who works with our community and particularly with folks who don't speak English as their first language knows that Medicaid includes Spanish translation with materials and then also a notice that includes a couple dozen languages and says, "If you need additional help, you can call this translation line for support." But out there in the community, raising awareness, we need to be doing more than that. It's not just in the mailing, it's also in the awareness piece. And so we will be working closely with community organizations in all the ways that I've described through our existing MAAC and the Cover All Kids workgroup and other advocates we work with. And as we proceed, we also want to make sure, as Akanksha mentioned, that we're always keeping an eye on equity and monitoring so that we know if there are specific communities that we can jump in and provide some additional intervention. So staying close to our stakeholders on that feels really important.

DR. SPITALNIK: Thank you.

Additionally, there's a specific question

about the fair hearing timing. Is it still a 20-day window to request a fair hearing, or is it longer in the circumstances?

MS. JACOBS: A good question, and thank you for that. So that is part of the operational discussion that we are having here internally with our partners on the administrative court side and with CMS. So we're working on the block and tackle around the plan for how we manage those fair hearings and what flexibilities may be available to us in this process. So that's another piece that we'll be getting back to you on, and we look forward to it.

DR. SPITALNIK: Thank you.

There's also a question about the issue of overpayments and whether somebody became ineligible July 15th because of the end of the emergency but was not disenrolled until 12 months later. So maybe a clarification between when the hammer hits for the end of the emergency and how beneficiaries are managed through the disenrollment process.

MS. JACOBS: We are going to put out clear communication on this. It is important for folks to understand. And we've had a few questions about this, so I'm glad somebody asked it and I should have mentioned it earlier.

Their eligibility was continued through this process because of the Public Health Emergency. And that is recognized by CMS, that is recognized in our eligibility determination process, so there will not be recoveries related to the Public Health Emergency period at all, regardless of when that redetermination occurs, when that person is determined eligibility or ineligibility. This Public Health Emergency period, they were eligibility and there would be no recovery.

DR. SPITALNIK: And that includes the protracted timeline?

MS. JACOBS: Yes.

DR. SPITALNIK: Thank you very much for that.

I think that addresses the questions that we've received from our public stakeholders.

Before we move to the planning for our July 12th next meeting, are there any comments or questions from the MAAC about any of our topics that we've covered to date?

MS. GRANT: Thank you, Jen. That was a very good and simple boiled-down explanation. I really appreciate it. Thank you.

DR. SPITALNIK: Thank you so much for that comment.

What we have traditionally done, and I will do my best to do, is to go back through things that were raised for follow-up or addressing at our next meeting. And I'll say now, but I certainly will say in closing, our admiration for the tremendous amount of work that has been going on in so many fronts as well as the clarity and transparency in presentation.

So on my list, and I please encourage MAAC members to add to this, that at our next meeting to have an update on the continued negotiations on the 1115 Waiver and whether we have more sense of timing; continued information on the home and community-based services spending on the increased federal funding on WorkAbility; the continued update on where implementation stands, where the negotiation with CMS stands because of the need for state plan amendment and also what has been learned or determined about the mechanism for payment.

I think people would appreciate an update on the very exciting perinatal episodes of care, as well as the transition for nursing facility residents to have the benefit of a care management.

Now we deal in the relationship between the hypothetical and the actual. I don't know if it's propitious or otherwise that we will be meeting three

days before what at least now is the projected ending of the Public Health Emergency and what federal guidance is revealed.

And then concretely, and I think this will be an interim measure for communication for community partners, any clarification on the literal physical description of the envelopes, we speak of drivers of health. We usually mean social determinants of health. Who knew that it would be paper that would be a driver in our ability to do outreach.

That's what's on my list for now.

May we go back to a gallery view of the members and speakers?

Is there anything that anyone would like to add to our agenda for our next meeting?

MS. ROBERTS: You've captured it very well.

DR. SPITALNIK: Thank you.

Well then, I will end with appreciation and gratitude for the stakeholders who stick together despite some of the limitations that we have by not being able to be in person, to the members of the MAAC, to Carol Grant, to Ankansha Kapoor, Greg Woods, and always Assistant Commissioner Jennifer Langer Jacobs. I want to reflect not only on the work that we have heard about today, but the effort that goes into

planning our meetings of the Medical Assistance Advisory Committee to assure stakeholder input and transparency. Thank you all very much. Thanks to everyone for attending. Wishes for good health, warmer spring weather, and we will convene again. At this point, we will still project that we will convene virtually on July 12th and hopefully back together at some time during the unwinding that we can meet face-to-face.

Thank you all. Thank you to Phyllis Melendez for bringing us together and Karen and Sam. And with that, we will end and we will end six minutes early, so I think that's the height of a good meeting. Thank you all. Be well.

(Meeting adjourned at 11:54 a.m.)

CERTIFICATION

I, Lisa C. Bradley, the assigned transcriber, do hereby certify the foregoing transcript of the proceedings is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate transcript of the proceedings as recorded.

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Lisa C. Bradley, CCR

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