MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
Via Zoom

July 22, 2020
10:00 a.m.

FINAL
MEETING SUMMARY

Members Present:
Deborah Spitalnik, PhD, Chair
Theresa Edelstein
Beverly Roberts
Mary Pat Angelini
Sherl Brand
Wayne Vivian

State Representatives:
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CHAIRWOMAN SPITALNIK: Good morning. I'm Deborah Spitalnik, Chair of the Medical Assistance Advisory Committee, and it's my pleasure to welcome everyone to our July 22, 2020 meeting. We are meeting yet again virtually, but we are delighted that Commissioner Johnson, Commissioner Adelman, Assistant Commissioner Jennifer Jacobs, members of the MAAC, and many of the stakeholders are with us today.

We have evolved some in our technology since our last meeting, which I'll explain in a moment. Let me reiterate, as always, that our meeting has been advertised per the Open Public Meetings Act, and we are delighted that everyone is here and very appreciative of all the efforts of the Department of Human Services, of course, in this time of pandemic, but particularly the Division of Medical Assistance and Health Services in bring us together.

The way that our technology is working today is you can now see the panelists, the members of the MAAC, and the Department that are present today. We know that the stakeholders are with us. You will not be visible to each other. The panelists have the ability to speak, so we'll be able to answer. As always, we'll answer the questions and comments of the members of the MAAC first. If you've submitted a

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question already, we are appreciative of it. And there is a question and answer function at the bottom of your screen if you would like to pose a question. We'll stop after particular sections. I apologize in advance that we won't get to every question, but we will certainly attend to that. And what's not discussed or answered here will certainly be brought to the Division.

We now see the agenda. This was the call to order and explain the format.

First, I just will very quickly before I turn to Commissioner Johnson ask the members of the MAAC and the Department to identify themselves.

Commissioner, I know you're with us. And would members of the MAAC just unmute for a second and identify yourselves.

MS. ROBERTS: Good morning. Beverly Roberts, the Arc of New Jersey.

CHAIRWOMAN SPITALNIK: Good morning.

MS. BRAND: Good morning. Sherl Brand, CareCentrix.

MS. EDELSTEIN: Good morning. Theresa Edelstein, New Jersey Hospital Association.

CHAIRWOMAN SPITALNIK: Thank you.

And Assistant Commissioner Jacobs.

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I am so grateful to actually to get even see, even virtually, Commissioner Johnson. All of us and our fellow citizens have been the beneficiaries of her leadership throughout the course of this Administration, but particularly now. And I'm grateful that the first public meeting she came to even before she was appointed was the MAAC, that she was with us at our last meeting, and, Commissioner, I welcome you again and thank you for all your efforts.

COMMISSIONER JOHNSON: Thank you, Dr. Spitalnik, for your leadership of the MAAC. Thank you to the MAAC membership and to all of the leaders who are joining us today virtually. I'm sorry we can't meet in person. Hopefully, we will be able to do that again one day soon.

I very much appreciate what we've heard from you over the last weeks and months. Your input has been incredibly helpful to us as we try to pull every lever we can to make sure the New Jersians that we serve are getting high-quality, timely health care services at a time when that's been particularly challenging for health care providers and for everyone involved in our health system. Priority one is the health and safety of those we serve and those who provide the service. And we've faced unique challenges

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together, and I'm just grateful for the collaboration and the work that we've been able to do together.

I also really want to take a moment to thank Jen Jacobs and Sarah Adelman and the team at the Division of Medical Assistance and Health Services. It has been a sprint and a marathon, and they have worked collaboratively with our colleagues at the Centers for Medicare and Medicaid Services on flexibility and waivers and everything we can with the federal government to get the opportunity to create more access and more services.

The federal government has been a very helpful partner here on the Medicaid side, but that doesn't mean it's simple. There's a lot of paperwork involved, there's a lot of negotiations, there's a lot of back-and-forth that has happened with our federal colleagues, and the team has done yeomen's work to make that happen.

We also really want to acknowledge our county partners who are our partners on enrollment and eligibility. We're anticipating that if Congress doesn't act and the $600 extra unemployment insurance weekly benefit isn't extended in some form that a number of people who have benefited from that and have been able to use those dollars to hold on to whatever

circumstances they were in, there's a real possibility that those folks come to Medicaid quickly. So we are working closely with our county partners on making sure that we have the capacity and the ability to handle that kind of incoming because we want to make sure that we're there.

The purpose of Medicaid, the reason that we have been there all these years and the reason we'll continue to be here is to make sure we're here for people when they need those services and benefits. And so we stand at the ready to be able to deliver that to families across our State.

That doesn't mean it's not a challenging time on many fronts. As you all may have heard, the State budget is in a very difficult -- we're in a very difficult spot with the state budget. And Medicaid is an counter-cyclical program. When the economy is good, our enrollment is lower. When the economy challenged, our enrollment is higher. Thankfully, Governor Murphy recognizes that and has be incredibly supportive of us and making sure we can do the work that we need to do. But that doesn't change the fact that the State budget is dramatically short of where our revenues need to be, and that is why the Governor has been so loud and vocal about needing additional federal resources to make sure

that we can sustain and meet the needs of individuals and families across our State.

Jen asked me to talk a little bit about some of the other things that are happening across the Department because I know you'll spend some time this morning talking about a number of the very specific actions that are happening in Medicaid. But I wanted to start -- because I know there have been several questions about the nursing home review that the Governor initiated and potential follow-up actions there. I wanted to start just to say that we had a long conversation with our colleagues at Health yesterday about that. The Commissioner of the Department of Health will spend some time talking about that today at the Governor's press conference. That's what anticipate. So there is more to come today on that front.

I've also and many of the team from Medicaid have had the chance to talk to many of the individuals on this call about that review. We're going to continue to do that outreach. We also are very interested in your feedback and input on the long-term recommendations. I think the Commissioner of Health will talk about some of the short-term recommendation today, but there are a variety of longer-term

recommendations, including recommendations about a standing Governor's task force. And so I think both we and the Governor's Office are interested in feedback on those longer-turn recommendations and your thoughts and input on those. And so we will continue to seek your input on that and think about ways that this could be a forum for some of those conversations.

But just to talk a little bit about additional things that the Department has been engaged in. I think I mentioned briefly at our last meeting that we had expanded and stood up our NJ Mental Health Cares Line. I think this is just a critical issue for so many of the individuals across our State who need and are seeking additional emotional support at this time. I think everyone -- I would count myself this bucket -- has experienced the challenges of sort of balancing the unknown here with the ability to keep moving forward with the work we all need to do. So we have seen incredible call volume at our NJ Mental Health Cares Line. And just for everyone to take note, our phone number there is 866-202-HELP, which is 866-202-4357.

We've also launched a mental health support line for individuals who are deaf or hard of hearing. That number is 973-870-0677. We have a text option on

the NJ Help Line. We are continuing to try to identify ways to make sure that people can seek that emotional support.

We had the opportunity to talk to some of the individuals who run our New Jersey Hope Line, which is our suicide prevention line yesterday. And our call volume there is quite high, although what's interesting is that a lot of what we are seeing there is related to individuals seeking emotional support and calling back for additional emotional support. So our numbers are not -- we are not seeing the emergent calls that we might otherwise have anticipated, but we are seeing a lot of need for additional emotional support.

So what we are doing through our NJ Cares Hot Line is a host of sessions targeted at specific groups who we know are particularly feeling the anxiety of this time. So there are targeted support sessions for health care workers and for individuals involved in the education field, so teachers and support workers. For pregnant women, this can a particularly challenging and stressful time for pregnant women. And so we're going to continue to expand those opportunities as we -- right now we're using some funding that we were able to get from FEMA and the Feds, FEMA and the Department of Health and Human Services. We think that we are on

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track to get an additional tranche of money from FEMA which we hope will allow us to continue to expand those services into the fall, because we all know that this is an ongoing challenge and it will continue for a little bit here. And we want to make sure that we are prepared and have those kinds of support services available.

I also want to talk briefly about child care. We all know that child care is critical to both early childhood development and ensuring that the economy can reopen as it's safe to reopen. And so while we stood up a brand-new emergency child care program at the start of the pandemic for essential workers, we have transitioned that, as child care has reopened more broadly, as more and more employees came back to work. That doesn't mean that we've solved the problem. There is a lot of challenging work to be done in child care, particularly as schools make decisions about what they are going to do this fall and what's in-person versus online and how parents are able to access child care to help complement that.

So we are working closely with our colleagues at the Department of Education, the Department of Children Families, on our planning around child care services. But right now one of the

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additional things that we have been doing here is making money available to child care centers for their startup needs. Many of them need PPE and additional cleaning supplies and more toys because there isn't as much sharing of toys and those kinds of things. So we put some grant dollars out to allow child care centers and summer youth camps to be able to purchase those immediate needs.

We also have been continuing to pay our subsidies for children who have not been in child care just to ensure that those slots remain available for those children as they come back online. So that has been an important bridge, but our child care subsidy is only part of the child care equation in the State. Obviously, there's a lot private pay as well. And so we are trying to leverage our investments and the federal dollars here to help do our best to sustain and support a critical part of the early education continuum.

I'll just briefly mention two other things. One is food assistance. We have been able to work with the US Department of Agriculture in the same way the Medicaid team is working closely with CMS. Our Division of Family Development team has been working hand in glove with USDA on all the flexibility we can

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get in the SNAP Program to make sure we can deliver those services as quickly and as timely and as robustly as possible to families. So we have been able, thanks to the work the Congressional Delegation did in some of the relief packages, to be able to deliver about 180 million dollars in additional SNAP benefits since the start of pandemic because Congress gave us the ability to give everyone the maximum of their SNAP benefit regardless of what their income level is. So everyone who was getting the SNAP now gets the maximum of it as long as USDA allows us to continue that, and that has been on a month-to-month basis. So we only know month to month whether we're able to continue that.

Similarly, we've gotten a lot of flexibility out of USDA for SNAP applications, including not having to do the in-person interview and not having to do a lot of the in-person parts of the application process. Those, again, are month to month waivers. We are starting to get some signals that those may come to an end some time in the relatively near true. Some other states have actually already started to not be able to extend those. And so we are working closely with our county partners on what that means if that flexibility were to go away.

We also are in the middle of distributing

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more than $200 million in pandemic EBT benefits to school children who otherwise would have received free and reduced school lunch, but for school closures. This is a complicated program for us because we don't run the school lunch program, so we had to go work with school districts across the State to identify the children who would have gotten benefit and then get them these federal resources.

We have been fortunate because we have such a good partners in Ag and add that they have worked closely for the school districts for this. Some other states -- most other states have made families apply for this benefit, and that's been really complicated and a lot of outreach to families and families haven't known that it as available and so takeup has been low. But in our instance, we've been able auto enroll children and get those benefits out. And so all the children who we've been able to identify who are SNAP eligible who got free and reduced lunch have already received this benefit. It's about $416 a child. And we are now in the process of mailing the benefit to all the other children who were not SNAP eligible but get free and reduced lunch that we were able to identify through school districts. So we are rolling that out as we speak. Those are being printed and mailed to

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families.

The Governor also worked with the Legislature. As you all know, Speaker Coughlin is a huge champion of making sure that we address food insecurity, and so the Governor and the Legislature have secured $20 million in additional resources to be able to go to food banks across the State. So we're continuing to identify those places where, in that instance, using some of the Corona virus relief fund from the federal package that we've been able to help support and meet food insecurity needs.

So this is an ongoing challenge. We don't expect that any of these are the silver bullet here. We need to come at this from all angles and make sure that we are continuing to put as much effort and muscle behind addressing food insecurity as we can because it was a challenge pre-pandemic, and now there are a host of families who never anticipated this being their circumstance who are now experiencing food insecurity. And we want to make sure that they know and get to SNAP and can get long-term support there.

And then the final thing that I'll just mention is that you all may have seen nationwide -- and our numbers and data in New Jersey support this as well -- that our opioid overdose numbers have seen a

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spike during the pandemic as well. We know that early on in the pandemic what a number of people who provide mental health services treatment and substance use disorder treatment told us was that not unlike going to the hospital, people didn't want to go to congregate facilities to get inpatient treatment and so that may have delayed care for some individuals, which is really concerning and troubling for us. But alternatively, our thanks to the team here who worked really hard to get telehealth set up. The telehealth services have really expanded access to treatment and counseling. And a lot mental health and substance use providers have reported that their no-show rates are down considerably and a number of people are participating in treatment who either didn't in the past because of barriers like transportation or who didn't in the past because they weren't experiencing what they're experiencing in the pandemic.

So we have a lot of work to do there. We're particularly concerned about this. We are working, as we speak, on getting more in a lock zone out to EMS and others who are on the ground in the community and working with our provider community to help support them with PPE and other things that they need to make sure that access to services is as available as

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possible. But this is an ongoing challenge as well and yet another just really devastating impact of the pandemic.

So I will wrap up there so that you can move on with the Medicaid specific parts of the meeting, but I wanted to have a chance to at least flag for you some of the other things that are happening Department-wide and to thank you for your work and your partnership and for the critical activities that are happening every day in communities across the State thanks to the critical work that you're doing.

Thank you, Deb.

CHAIRWOMAN SPITALNIK: Thank you so much for everything you're doing.

Do any of the members of the MAAC have any questions?

And welcome, Mary Pat Angelini. We're delighted you're able to be here.

Seeing none, I know the myriad demands on you. We'd love to have you with us as long as we can today, but we certainly appreciate the demands on your time. So thank you again and thank you for everything you're doing. And be well, take good care also.

Because of our somewhat limited number of MAAC members with us today, we will postpone the

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approval of the minutes until our October meeting, and we will have the opportunity to review them between now and then.

So I turn to Assistant Commissioner Jen Jacobs, and we have a series of updates she and Greg Woods, the Director of the Office of Innovation, will be providing about COVID-19 program impact. So we'll advance the slides to that. And at the end of this section, I'll open the floor both to the MAAC in speaking and then to questions and answers from stakeholders. I would encourage you to type your questions even before that break so that we can try to bring them to the Division.

Jen Jacobs.

ASSISTANT COMMISSIONER JACOBS: Thank you, Dr. Spitalnik.

Well, good morning, everyone. Happy to be here with you today. Very much wishing we were in our normal format, which has become an important opportunity for our Medicaid community to gather together every so often. But for now, we'll do it virtually, just as we are doing with our own families and friends. But it is really good to be connected to you in this way this morning.

We're going to talk to you today a little

bit about some things we have already done and, to some extent, some things we have already talked to you about. But we're going to give you some updates and new thinking. And you know this situation has been evolving for us, as it has been for you and for all of the people that we serve. And so this is going to be a little bit of a fluid time for us, I think, even into the next meeting in October. It's just that a lot is changing in our system and in our world right now.

So I didn't want to just jump into the latest updates without stepping back to the conversation that framed out in April at our last meeting and just kind of revisiting some of those points together. I'll give you a sense of how things may have evolved in that time and where we're headed. And Greg's going to also jump in a little bit here to share with you a sense of how we've accomplished the changes that we've made in partnership with the federal government, and we'll also give you a sense of the enrollment trends we're seeing.

We did get a lot of questions from people in advance of this meeting, and we're doing the best that we can to give you answers in the course of the meeting. But as Dr. Spitalnik said, we have the Q and A there and we'll be able to pause and touch on other

topics that we might not have covered.

So where I wanted to start out with you was this slide which I shared with you at the April MAAC meeting and which the members of my team have looked at probably 300 times. This is the slide that we use to frame out our approach to this very unprecedented situation. We said when this all began on March 4th with New Jersey's first case, we said we cannot do our work going forward the way we have always done our work. We need to think differently. We need to recognize that this is just a very different scenario. And so we established these five principles. And as we had in the early days of the pandemic, we had daily COVID response meetings. We've now moved to two to three times a week, but we always had these principles in front of us because we knew it was critical to help us carry forward in the way that we wanted to.

And so I shared this with you in April. The five principles have not changed. My perspective on the five principles may have changed a little bit for where we have been in that time. And so, for example, the first principle, we will serve people the best way possible, that was one of our goals for 2020 before this all began. And we immediately recognized when the pandemic started that serving people the best way

possible was going to look very different than we originally thought. And that continues to be true. So in our case, I think serving our community the best way possible has really meant reframing, shifting our mindset, making sure that we were, in fact, ready to solve problems in realtime; and I think also in this later chapter since the April meeting, figuring out how to bring our pre-COVID priorities into this new chapter. Because when COVID first came to New Jersey, it was the only thing we could focus on for a little bit. And we did that and it made sense. We did it well. Everybody locked in. But then after a time, we had to bring back some of those things we had been working on on March 3rd and on February 15th and in January. And so that has been a major component, I would say, of our work in the time since we last talked to you in April.

Keeping communication clear and simple felt really important at the beginning of this because we knew that we would be using different language, different ideas, different approaches than we had before, and we couldn't assume a baseline understanding as we might normally do. So in previous MAAC meetings, we would get up and present to you using all of the normal sort of lingo and presenting in the normal ways.

And we knew that not only did we have to upgrade in realtime, but we had to define our thinking more clearly. We had to be very specific in why we were doing things and how we were doing things.

Since April, I would say that has evolved a little bit in the sense of needing to take a step back at various points and clarify some of the new things that we had been doing. So in the early days of the emergency period, we were making decisions fast. Since April, there have been a number of cases where we have had clarifying questions come in and we've needed to kind of go back and revisit language that we had previously issued and say, "Here is some clarifying information in our intent or in our expectations."

And then experimenting with new ways to solve problems has been really interesting because the way I really think about an experiment is you establish a hypothesis. We hypothesized that if we take a certain step, if we issue certain guidance, it will go a certain way and we're going to prove or disprove that hypothesis; it will be helpful or it won't. And so Greg and I will talk a little bit about things that we envisioned early on as being important that were less important than we thought, things we didn't know would be important that became important.

As far as showing people we care, I think the major evolving piece since last time we spoke, we said it was very important to us to present as collaborative and positive and solution-oriented, certainly showing empathy with the people around us, with the people we serve, with our sister agencies, and partner organizations. We just needed to bring that into the room. I think we have built bridges of understanding across a lot of different organizations that didn't work as closely together in the past. I would have said that to you in April. I think what has evolved here in this time on this particular point is really how incredibly well I think my team has managed the fatigue of this situation, the challenge of this situation. I know you're all feeling it inside your own organizations. And I see people reaching out both internally and externally to be extra understanding of where we all are four months into this thing.

And then finally, with respect to honoring shared sacrifice, I mean, look, this hit us early, it hit us hard here in New Jersey. It hit every organization we work with, and that continues. So although we are so thankful to be out of that early surge, we're also very watchful about what is coming. And we're asking our folks to take good care of

themselves, and we're trying to make sure that they do that.

This slide feels important and highly relevant in everything we do every day, and I try to make a point of starting there.

The next slide, I also shared with you in April, but I want to frame it up again because our work continues to kind of fall into this framework. We have a lot of rapid response work we're doing every day. In the first quarter of the year, I would say we were really turning our program upside down and shaking it; and everything that fell out of the pockets, we figured out what we needed to do with it to make things work in a pandemic situation. And our providers have been incredibly helpful in communicating with us the issues that they were seeing on the ground. Certainly, we're hearing from members every day and trying to make sure that we're putting policy solutions in place as quickly and as smartly as we can.

But then there's an element of this that is also about planning for future needs. And when we were talking in April, we were thinking about things that are now here in July in motion. And here in July, we're thinking about what's coming that needs to be in motion over the next few months. And certainly, we're

all looking further down the road than that with hope. And so a lot of planning, I think is really critical for us to make sure that we're being prepared and agile as this thing evolves.

And then finally, the concept of solving problems in new ways was not a choice for any of us in our organizations. Everybody wherever they are working on this, whatever work you do, however your organization is oriented, it all changed. And so we have used new technology and old technology differently than we ever did and really established a lot of new partnerships, which I think you can see kind of reflected here on this slide.

I shared this one in April as well. These partnerships have become really critical for our realtime response. So the one thing I would say is very different from the past is in past if we needed to get together for a meeting about the delivery of services to members with developmental disabilities, we would have set up a meeting and that meeting would have been in three weeks. And then we all would have sat down and we would have had a discussion in a meeting room, and there would have been some notes and some takeaways and we would have had some next steps. And now, when we need to get together on something like

that, it's like, how about Saturday morning, how about Monday afternoon, like, we got to go. And so the partnerships that we've had with our sister agencies, the Long-Term Care Ombudsman Office, external organizations like advocacy groups, managed care, operational partners, these have been tremendously important and tremendously fast-moving during this period.

So this is an opportunity for me to pause and say thank you to all of the organizations and individuals that we partner with because the pace of Medicaid life, as is the case universally, the pace of life is just not what it was before and things are moving really, really fast. People have been incredibly helpful as we have been working to solve problems to clarify new, confusing situations. We're waiting maybe on clarification from other partners or from the federal government. We're all talking to each other, and that is happening at the pace of life. And so thank you for that.

The next piece I would like to touch on is where we are in terms of operations because we've had some questions from folks lately like, What's going on at DMAHS? Nobody's been to Quakerbridge Plaza in a long time for meeting. What's going on with the staff

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there? How are you doing the work?" And so I thought I would just speak to that briefly here today.

As is probably the case in a lot of organizations we know, most of our team is working remotely most of the time. So we do have folks who are here onsite, and we're incredibly thankful to everyone who's been coming into the office to make sure that things that have to be done here at Quakerbridge Plaza or at the MAAC centers or in our vendor buildings, all of that is still happening. Most of our folks are now set up for remote work. And so to the extent that we can work remotely, we do. That has included taking many of our paper processes and moving them to electronic. You wonder, why in 2020 do we still have paper process. And the answer is because in 2020 we still have paper and we still have people who need to use a paper process. In particular, we want our communications and our processes to be member-friendly. And not every member has access to a cell phone, a computer, a printer, e-mail, and so we do still have required processes that just operate the old-fashioned way. And Bob Sherman's IT team has been incredible at making sure that everyone has as much remote access as possible. Marla Golden has been our person who's making sure that the computers and cell phones are

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getting ordered and people are getting what they need. Bob Popkin and his legal team have been shifting a lot of our legal process that was paper-based into a digital world. So that transformation is happening, and we won't go back from that. So sometimes crisis does present opportunity.

As I mentioned before, we were doing our COVID rapid response meetings five times a week. I would have had them on weekend if I thought I could. In fact, I think sometimes we did. And we have now shifted down to three and sometimes two a week.

The strike teams that we set up originally, which I think I mentioned to you in April, continue to meet frequently. So those are teams that are designated for a specific purpose. They are tackling a certain issue and developing expertise that they're then sharing with the rest of the organization. An example of that would be the CMS strike team which has been responsible for all of the emergency waiver activity that Greg is going to talk to you about in a few minutes.

We also have a cadence of weekly meetings with partner organizations. We have frequent touch points with our community partners in the form of advocates and providers and community groups and,

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frankly, families and individuals. And then one interesting observation at this point, and maybe some of you have found this to be the case as well, going to all-virtual interaction or primarily virtual interaction threw us for a loop for a minute and really seemed very disruptive, maybe more for those of us who are extroverts than anybody. I don't know. But what we have found the intervening time is that although the virtual setting can be a little bit more challenging, it also can be a little bit more inclusive. And an example I would give you is we have continued meeting, for example, with our community doula workgroup. And we found that attendance at our meetings is higher than it was before because people don't have to travel to our office. What a big difference. So I would really much rather see you all in-person and have these conversations live, but I also recognize that even within our own organization, having our meetings online has allowed us to be inclusive in a way that the limits of four walls and so many chairs wouldn't have done.

Here, what I would like to do is revisit with you some of the changes we've made with a few updates. So I'm not assuming everyone heard what we talked about at the April meeting, but I also don't want to be completely repetitive for those of you who

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did. So we'll move quickly through things we've talked about before. And for anyone who wasn't at the April meeting, there is more detail in our April slides on some of these changes which are really important. So I'm not going to cover all that detail today, but if you're seeing something that interests you and you weren't here in April or you've forgotten April because of COVID brain, then please feel free to revisit our April slides on the MAAC website. And the flexibilities I'm going to talk about here are very much made possible by the work that the CMS strike team and our subject matter experts have done. So I'm going to talk to you about what we've operationalized. And then in a minute, Greg is going to talk to you about how.

So the three important operational priorities I mentioned in April, which remain the same, number one was protect and extend access to Medicaid coverage. This was absolutely critical. We knew, for example, that we needed people to switch to online applications as much as possible, don't use paper, and we're still encouraging that. An online application we can process from anywhere; and a paper application really depends on wherever it is. And it's important that to acknowledge that our county offices were hit by

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the pandemic in the same way as the communities around them were. So online applications are the way to go. NJFamilyCare.org is the most direct route, and we're really encouraging people to continue doing that.

We also have a number of emergency flexibilities in place that have allowed us to move applications through faster and easier. As I think most of you know, we're continuing coverage for our Medicaid and CHIP members through the emergency period. We have suspended FamilyCare premiums.

And here's a couple of updates. We are now allowing providers to conduct Medicaid presumptive eligibility assessments over the phone. So, for example, if a provider is doing a telehealth visit, they can do a Medicaid presumptive eligibility assessment during that visit.

And an additional flexibility that we didn't have yet ready for prime time at April's MAAC meeting is enabling hospitals to conduct presumptive eligibility for our aged, blind, and disabled population which allows us to support discharge planning for those members, potential members.

So that was a really heavy lift for Heidi Smith and her eligibility team. A lot of work went into making that possible. And the hospitals scrambled

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their presumptive eligibility workers to get the training to be able to do the ABD application. We have 11 hospitals currently submitting presumptive eligibility for ABD members. That is 11 more than we had when we spoke to you in April. So we continue to train the hospitals on the ABD PE, but that is a new flexibility that we were able to put in place to support discharge planning.

I also would be remiss if I didn't point out here that continuing coverage for our members through the emergency period is a heavily automated and heavily manual process, if you can imagine. So there's an autopilot that runs our enrollment system every month and a lot of programming behind it. And that autopilot wants to dis-enroll members every month, as it should. And we have said, "No, autopilot, don't do that. We're not going to do that during this time." And there's a lot of manual work involved to make sure that all of that goes well.

Looking back, we have learned lessons over the course of this period that have enabled us to get better and better at that process, the maintenance of eligibility, continuing eligibility. And we have also improved understanding across hundreds of state and county workers so that when they see a case come

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through where there may be an eligibility issue or question, they know that that maintenance of effort, that continuing eligibility, is absolutely critical. So we had some early challenges making that work just right, and we have improved our operations and our understanding across all of those hundreds of state and county employees to make sure that that's going as well as possible. And the IT team has been amazing on that.

The next subject that I wanted to talk about -- this is the second one that we had identified as an important operational priority in April, remains an important operational priority, and that is making sure that our members get the care that they need. And the first and most important thing to know during this pandemic is that there are no co-pays for our members who would ordinarily have a co-pay for COVID testing and office visits.

Health care is adapting to support social distancing in a lot of ways. We want to help people avoid needing to go to the pharmacy any more often than necessary so we immediately put the early refill opportunity out there. People can get a 90-day supply. I think most of you know we moved all of our care management activity to telephonic outreach. Members are using telehealth. This has really been kind a

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breakout moment for telehealth, and the State took steps, the federal government as well, to relax telehealth rules to make it as easy as possible for people to access telehealth, essentially using any phone being able to communicate with any doctor that you need to and making sure that behavioral health services were available. So the broadest possible interpretation of telehealth is in place for our members, and we've taken the steps we needed to take with providers to make sure that they could deliver telehealth to our members for very specific services. So there was a lot of clarification that was needed over the last few months in how to make all of that real. And it's been a very interesting experience. One aspect of this is, frankly, making sure that people have access to cell phones and that they have enough minutes on their cell phones to take full advantage of telehealth.

So I have learned that not everyone is aware that Medicaid beneficiaries qualify for the Federal Lifeline Program. The Federal Lifeline Program is very different from the State Lifeline Program. So please don't confuse them even though they have the same name. You may know the federal program as the SafeLink Program or the Assurance Program. Those are the two

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providers here in New Jersey who offer free cell phones and minutes to Medicaid members. So we are having discussions here, frankly, with community organizations as well to really figure out how can we maximize the distribution of these Lifeline phones across our Medicaid population so that we know people are getting access to telehealth and, frankly, maximizing the minutes that we have available through that program.

So hopefully, more to come on that in the future, but we did want to highlight it here because I didn't realize that not everyone was aware of that. Our managed care partners the care managers within those organizations know very well how to help people get set up for these cell phones. But we also need to make sure that people are aware that it's outthere. So we're working with our managed care partners on that and developing understanding across our community, I think, is going to be a priority in the weeks and months to come.

LogistiCare is still running transportation for us. All our dialysis rides are happening every day, as you would expect. Volume is down across the board, as you would expect, but essential trips are happening. And I would say the volume hit a low point in early June and has begun to pick back up again. I

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would have thought the low point would have been earlier than that but, actually, it was early June where we really bottomed out. Now we're starting to pick back up.

So LogistiCare has been working with us to make sure that everybody is getting to the medical appointments they're going to, but also creatively delivering meals with us and piloting a home health aide visit program because we had folks concerned about access to public transportation, people being concerned about using public transportation, we need to make sure that aides get to members. So we piloted, using LogistiCare, to help an aide to get from his or her home to the member's home and back again. So that pilot is running.

And then finally, the fair hearings. I don't recall what the status of fair hearings was in April, but fair hearings are happening again and typically virtually. So that process has picked up, and little by little things are starting to get back to normal on that end.

Finally, this was the third key operational priority that we had identified. And then, Dr. Spitalnik, I'm going to come back to you for a minute. We said it was really important that we work creatively

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with our providers to solve problems in this unprecedented situation. And so we have continued collaborating with our providers and MCOs. A lot of flexibility around site of service, making sure that people are able to get their care from home, typically telephonically, as much as possible. And really a lot of back-and-forth phone calls, e-mails, and text messages with our provider community as we're hearing about issues that are developing and trying to make sure that we're solving them in realtime, as I mentioned before.

Food delivery and home health aide pilot with LogistiCare, as I mentioned, we've kicked that off creatively. It's an experiment. We'll see how it goes.

We set up a expedited provider enrollment process. This is Dr. Lind and IT team working together to make sure that we're able to enroll providers as quickly as possible. We didn't know what kind of volume we would get from out of state, how many providers we would see applying to serve Medicaid members, and we wanted to make sure that that process was moving faster than it ever moved before. That has been a successful experiment. It's been a small volume of providers that have come through that expedited

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process with the emergency flexibilities. What we have learned from that process is some ways that we'll be able to use technology to facilitate our provider enrollment process generally going forward for the future just to make it a little bit easier and smoother and more digital for providers to apply to join Medicaid networks. So that's been a good experiment.

And then we fast-tracked family members as personal care assistance providers. Carol Grant, Becky Thomas, Joe Bongiovanni have worked to make this real for us. And this has been really important for family members who didn't want someone coming into the home to provide that personal care assistance to another family member, we just wants to quarantine in our home and the family will provide that care. So we've been able to set up the family members on an expedited basis to provide PCA.

We did suspend provider audits. We mentioned that to you in April. They remain suspended at this time. We asked the health plans to significantly relax prior authorization requirements, really in particular around inpatient stays because we understood that hospital resources would be heavily constrained. When the hospitals returned to elective surgeries and started to get back to normal, the health

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plans are also starting to get back to normal. We have asked them to maintain relaxation of prior auths. where we would normally be doing face-to-face visits, and so they're working with us on that. Everybody is sort of finding their way into this new chapter.

And then finally, and this is really important, the federal government came to us and they said, we have some relief funding we want to provide to Medicaid providers across the states and we need you to tell us who the Medicaid providers are. So Greg and the business intelligence team turned this around on a dime; a very, very short turnaround time to produce every New Jersey provider and their payments for the past couple of years. It was an enormous task. So that relief funding is now available to our Medicaid providers. And the deadline for applying for that has been extended to August 3rd. So this is really particularly focused at providers who are not Medicare providers, so think pediatricians and therapists and other provider-types who may not have been able to access the Medicare relief funds, but the federal government has extended the filing for that to August 3rd, and we do want to make sure that we're getting the word out to all of our providers that that deadline was extended. So that's a really important

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piece of this. Whenever someone applies to that federal relief pool and the folks on the federal end don't recognize that provider as a New Jersey Medicaid provider, they're coming back to us to validate that provider. So that exercise goes on and the business intelligence team has made that happen.

I should point out here that the customer service teams across Medicaid have been incredibly busy during this time, and people have just really rallied to make this work the best way possible in a situation where they pick up a phone, they don't know what the question is going to be, none of the answers are anything that is familiar to us from years and years of Medicaid training. So it is a moment to just say to all of our providers and partners, but also to our team, thank you for working with us on this learning curve as we've all been making adjustments to a new reality.

So I would like to pause there for a moment, Dr. Spitalnik, and hand it back to you for any questions from the MAAC.

CHAIRWOMAN SPITALNIK: Thank you so much. And thank you both for the completeness of this presentation and grounding us in the principles.

There are some questions from the MAAC.

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Beverly, let me turn to you and then I'll turn to Theresa for her question.

I also want to acknowledge that Wayne Vivian has joined us by phone. And, Wayne, if you have any questions or comments, I'll pause after Beverly and Theresa for an opportunity for you to raise them.

Bev.

MS. ROBERTS: Thanks very much, Deborah.

Thank you, Jen. This was a very good presentation, and I know that you and your staff have been working tirelessly to deal with the myriad issues that has occurred because of COVID-19.

So my question is regarding the fast-tracking of family members to do PCA services. I'd like to know more about exactly how that can be done. And is that different from the PPP Program? When parents through PPP want to provide that service, that can be a six-month process or longer. So I'm really excited to hear about fast-track on this.

ASSISTANT COMMISSIONER JACOBS: Thanks, Bev. It is a fast-track for the PPP Program. So let me just step back and give people a little bit of context there. PPP is our Personal Preference Program. It allows a family member, a friend, or some other individual to become the employee of the member and

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provide personal care assistance. Bev is very familiar with that program. And in the context of that person becoming an employee, there's a lot of paperwork and process that goes along with it and back-and-forth, and so there's lag. And as Bev points out, it's not always a fast process.

In this time, we said we need all the emergency flexibility we can get to be able to sign people up as quickly as possible. So on the business end of things, in the details of that process of hiring someone, signing them up, filling out tax forms, background check, anything else that needs to happen, we were able to shortcut some of the usual activity using the federal emergency flexibility.

So it is the PPP Program that I'm referencing, it's just that we're able to move things along a little bit quicker during the emergency period because we have the flexibility.

MS. ROBERTS: Terrific. So can you just tell me how much time should it take for fast-track? And does a family have to request fast-track? Do they have use that terminology in order for this to happen?

ASSISTANT COMMISSIONER JACOBS: You know what, Bev? I haven't worked on this at that level of detail so I can't answer that question specifically

today. But certainly, there's no harm in a family asking to move it along as quickly as possible, if we could expedite. But I believe that the team is expediting all the cases as much they're able to, given the flexibility that we have.

MS. ROBERTS: Thank you.

CHAIRWOMAN SPITALNIK: Theresa, you had a question about PACE.

MS. EDELSTEIN: Building on Bev's question, I had a little bit of discussion with Louise Rush on this, but our PACE organizations have turned into a home-based model during this pandemic. And as time has gone by, a lot of the family members who were able to support the participant at home have now had to return to a job. And there may be another friend or neighbor or another person who is able to pick up the slack. And the home health aides, of course, are also in very short supply. So the PACE organizations have not always been able to identify a home health aide to go into the home when the family member has to go back to work, and they're asking if they can now also use the Personal Preference Program like the MCOs can to have a family member or friend be that caregiver. This is done in other states that have PACE, like Wisconsin, and it's been very successful. And I think in a time

when we have shortages of personnel and we're trying to deploy personnel very judicially to the people who are highest risk, if we can enhance the supply of caregivers in this way for PACE participants, it will help sustain them at home and keep them from having to go into a nursing facility. So I'm just asking for consideration of PACE as another entity that can participate in the PPP.

ASSISTANT COMMISSIONER JACOBS: Thanks, Theresa. That's an interesting point. Thank you.

CHAIRWOMAN SPITALNIK: Wayne, if you have any questions at this point, I would ask that you unmute. Yes, Wayne Vivian.

MR. VIVIAN: Hi, everybody. Actually, I was on with a phone call when Commissioner Johnson was speaking. I didn't have access to the computer so I couldn't join.

CHAIRWOMAN SPITALNIK: I'm glad you're with us now.

MR. VIVIAN: I have a couple question. Regarding PPP, you said, is that the name of the program? Does that require training? Does somebody have to go for training to be eligible to become a personal care assistant to a friend or something?

ASSISTANT COMMISSIONER JACOBS: You know

what, Wayne? I don't think I've been asked that question. I think it will depend on the needs of the individual who's being cared for. But I'm sorry, I don't actually know that one off the top, Wayne. I'll follow up with you. We have staff who are on the phone. I know they're hearing this question and may be able to get you an answer before the end of the call.

MR. VIVIAN: And I just have one other quick question. One of our staff members in our supportive housing program, the CSS Program, tried to get somebody a SafeLink phone. Now, I heard you say something about don't confuse New Jersey with federal because SafeLink did not provide a phone. Assurance did. But SafeLink did not provide a phone to New Jersey residents.

ASSISTANT COMMISSIONER JACOBS: So this is a really important point, Wayne. Let me take one step back because I got multiple text messages saying no training is needed for PPP. Thank goodness. Where would I be without my amazing team?

And on SafeLink and Assurance, those are the two designated providers for the State of New Jersey. Frankly, I am still learning about this program, but it is a federal program. They've identified those two providers. Some of the health plans work closely with one provider or the other to be able to provide some

additional benefits to their members. And we're going to be able to put some more information out about that soon. I don't know why one provider would be saying they cannot serve somebody.

MR. VIVIAN: They didn't say they couldn't serve then. They don't provide them with mobile phones. They don't provide them with a phone.

ASSISTANT COMMISSIONER JACOBS: Okay. So thanks for pointing that out, Wayne, because we're really trying to get our arms around the nuances of this. There two different vendors. I believe Verizon also provides land lines. I though SafeLink and Assurance were both doing cell phones. So I'm going to need to look into that a little bit more. And like I said, we're going to aim to put out some information on this to really make it as -- you know, it's a federal program, but to make as visible and available as possible to our community. So thank you for sharing that nuance with me because it will give us another thing to look into.

MR. VIVIAN: Because Assurance does provide phones. SafeLink provides phones, but not to New Jersey residents. It was like Louisiana -- there were several states that they do, but not New Jersey.

ASSISTANT COMMISSIONER JACOBS: It is my

understanding that those are our two vendors for New Jersey but, as I said, I really want to do some work to clarify, make this really very well known and understood across our Medicaid community. So thank you so much for sharing those sort of nuance points. And I'm definitely going following up and make sure that we're able to put out some good information for everybody so that we can maximize use of that program.

MR. VIVIAN: Thank you.

CHAIRWOMAN SPITALNIK: Thank you.

Sherl and then Theresa have questions.

Sherl, please.

MS. BRAND: Thank you.

Jen, thanks for the great update. One of the things that I'm interested in is if you could talk a little bit more about the home health aide transportation pilot. I think it's a great idea. I'm curious if it's happening in a certain part of the state or are there certain agency involved and where would someone get some more information about the opportunity.

ASSISTANT COMMISSIONER JACOBS: Thanks, Sherl. We started this partnership with the Home Care Association, and I believe two of their members are now in the pilot. One has been piloting for maybe eight or

ten weeks. And I think the other began more recently. So as we are ready to go sort of prime time with this, we'll be partnering with the Home Care Association and the providers generally.

Frankly, it's an experiment. It's trickier than it would be to get an aide to a member's house in time for the start of a shift and then during that shift to have the transportation ready to pick him or her up at the end of the shift and take them either home or to the next site. So there definitely a lot of moving parts there. It's an interesting experiment. We had some lessons learned in the early days, made some improvements. So not quite ready for prime time, but a really interesting idea.

MS. BRAND: I think it's a great idea. I know from having been in the home care world not every home or beneficiary is on a bus line or near a train station for those that don't have their own vehicle. So kudos for coming up with the idea.

ASSISTANT COMMISSIONER JACOBS: Thanks, Sherl.

CHAIRWOMAN SPITALNIK: Theresa, a question about eligibility.

MS. EDELSTEIN: Yeah, and I also have a question based on Sherl's conversation with Jen just

now.

My first question has to do with is it possible to know which 11 hospitals are doing the ABD PE? And how can we work with you to expand that effort? I'm more than happy to talk with the heads of case management or whoever needs to be contacted to encourage that they get involved. So if you have a list that you can share, maybe we can have an offline conversation about how we can be supportive.

My question about the home health aide pilot is how are those trips being billed, I guess? Is it being billed like a client roundtrip would be, or is there some other -- the same thing with the food delivery, how is it being documented, I guess, is the question.

ASSISTANT COMMISSIONER JACOBS: Thanks for both of those points.

On the ABD PE, presumptive eligibility, we did a state-wide outreach. All hospitals, all PE coordinators, we offered a series of trainings and we trained dozens -- I forget the number -- of PE coordinators. So the 11 hospitals that are currently submitting ABD PE are the ones are the ones who are currently submitting. We have more that we've actually trained. And, Theresa, I'm happy to share with you the

list of hospitals that have done the training and hospitals that have submitted PE. That's not a problem at all.

On the pilot with LogistiCare, we were able to amend their contract to include those two pilot activities that I described, so delivering meals and transporting home health aides. So that language is in their contract. It is available through Division of Purchase and Property or I think will be because it's part of their contract. I don't have the details in my mind of exactly how that gets billed because I haven't seen it in six weeks and I have COVID brain. But generally, we just amended their contract to enable them to do it.

CHAIRWOMAN SPITALNIK: Thank you.

There was one further question from the MAAC and then I have two from the public. There was a question about electronic visit verification. And my understanding is that that is with the Division of Purchase and Property -- I may have the acronym wrong -- and that there's no public available at this point or no public announcement. If I'm in error about that, please let me know, anyone from this State. If not, I just wanted to acknowledge that.

We have a question from a stakeholder:

Could you please clarify the policy related to preadmission screening for home and community-based services individuals? Should they still call the ADRC even though OCA is not going out to do assessments?

ASSISTANT COMMISSIONER JACOBS: I have that policy on my desk. I cannot answer the question in detail, I regret to say. So let me see if I can get an answer on that prior to the end of the meeting. I haven't been directly involved in that myself. So I apologize for not having that answer off the top.

CHAIRWOMAN SPITALNIK: Thank you.

There was a question raised in terms of going back to work that had begun pre-COVID from a provider of autism services about the transition from service provision from the case management organizations to the Managed Care Organizations and a request that the Autism Stakeholder Executive Planning Committee be brought back together. So I would raise that. If memory serves, that was a joint committee with the Department of Children and Families. So I can pass that on on behalf of the MAAC if that's helpful.

I have a comment from the question box which I think is a wonderful way to end this segment. A thank you to Jen from Family Voices and SPAN for the presentation that you provided on changes to Medicaid.

I think that reflects, not only the commitment to communication as you talked about earlier, but really making information available.

So I think we will close this segment and we'll now move to the section on federal COVID flexibilities and Greg Woods. Greg is the Chief Innovation Officer for the Division of Medical Assistance and Health Services.

Good morning and welcome, Greg, and thanks for everything you've been doing.

MR. WOODS: Thank you, Dr. Spitalnik. So thanks very much for the opportunity to talk about some of the specific federal flexibilities and authorities we've been able to receive as part of our response to the COVID emergency. Before I dive into some of the details about the specific authorities that we have, I did want to just frame this in a couple of ways.

So the first point I wanted to make is that the environment we're operating under, working with our federal partner, unfortunately, it's a complicated patchwork of authorities, some of which are governed by one set of rules, some of which are governed by other sets of rules. They sometimes overlap with each other. This is, I think, on our side, on the federal side, it's been a question of having a response to an

emergency that was not anticipated using the tools that are available legally and from an authority point of view. And I will just say candidly, at times it has been challenging for us to understand which authority is most appropriate for each specific need. We work very closely with our partners at CMS who have really been helpful and have been very dedicated to getting to the right answers with us. We've consulted extensively with other states who are often dealing with either similar or the same problems or challenges that we've been dealing with. It hasn't been a clean or simple process. So I just wanted to put that out there, apologize in advance that this is confusing. I know it's confusing. It's confusing for us. And I appreciate everyone bearing with us both through this presentation and in general as we work through some of these federal authority issues.

The second framing point that I wanted to make is just that many of these requests for federal flexibility, we had to submit early in the emergency right when the pandemic was beginning. What we did is we've made our best guesses at the time about what specific authorities we would need. And in general, I think we tried to take a no-regrets posture to this, meaning, if we thought that there was a chance that we

might need a specific authority, we erred on the side of being overinclusive. And this is back in March and April when we were trying to stand up our response.

What that has meant is that in some instances we requested from our partners at CMS and received specific authorities that as it has turned out, at least thus far, we haven't used. And then conversely, there have been one or two occasions where we submitted an initial request and then as events have gone forward, we recognized that we needed to modify that in some way or request additional authority. So this is an evolving world, and I think that's an important context to understanding if you look at some of the authorities.

And third, and related to the that point, I would just say that it's important to underscore because we have the federal authority to do something does not in every instance mean that we are doing it or that we are doing it in every situation that we have the authority to do it. There, obviously, are other considerations around specific state challenges, around our state laws and regulations in some instances, and just based on the facts on the ground. So I do think that that's occasionally been a point of confusion. I just wanted to point that out. We have tried, as I

said, to maximize our federal flexibility, but that is closely related to but not synonymous with what we are actually operationalizing.

And then last, before I dive into the detail, I will just give a caveat ahead of time which is that while I have been leading the CMS strike team that has been working on receiving all the various federal flexibilities, this has very much been a team effort. I am not the subject matter expert on all or most of the details of each authority because each of them is in their own way complicated and is sort of a back-and-forth dialog between our federal authorities and implementation. So I welcome any questions about this. I will just say in advance there's a good chance in the spirit of a right answer better than a quick answer, I may need to take a lot of these back and bring them to our subject matter experts.

With that said, I'm going to dive into a quick tour of the world of the specific authorities that we either have in place or are working on putting into place. To start, I want to talk about what's called 1135 waiver authority. This refers to Section 1135 of the Social Security Act. This section allows the federal government to waive certain Medicaid provisions during times emergency. The overwhelming

majority of states -- and perhaps all states, I don't know -- have applied for and received 1135 waivers during this crisis. In general, I think they have been pretty similar from state to state. The language has been pretty standardized and I think there's a menu of things that can be accomplished through 1135, and each state has had the flexibility to pick off of that menu, but I think across states the specific authority that we've received within each area have been pretty similar.

I'm not going to go through everything that's included in the 1135 because it's a long list, but I did want to just call out a couple of critical points.

So first, as part of the 1135, we did receive authorization to waive prior authorization on the Fee For Service side for services where that's required. That's obviously closely related to but distinct from what I think Jen was talking about earlier in terms to the guidance that we issued to our MCOs. So that's one big area. And we have that flexibility.

Second, the 1135 is the vehicle that we use to allow some of the streamlined enrollment of new providers that Jen referred to earlier. It also gives

us the authority to, in certain well-defined circumstances, to reimburse providers who maybe are not enrolled in New Jersey Medicaid but are enrolled in either Medicare or another state's Medicaid program. We have been using that authority. The volume has not been enormous thus far, but it is something that we have been using and I think, as Jen said, has lessons for the future for us.

Third, the 1135 authority -- and actually, we received two separate sets of 1135 approvals, and this was the second set of approvals -- has given us the ability to have greater flexibility which I think most of you will be aware around the level of care determinations and how and when we do those for individuals requiring long-term care and that population. So we have made extensive use of that flexibility.

And as I said, there are a number of other things. You can see some of them on the slide that also were included in 1135, many of which we have used, some of which we have not. I'm happy to talk about any of those in more detail or to direct those questions to the subject matter experts.

Turning from 1135, I also wanted to flag some of the flexibilities we have under federal

regulations. This is the 42 CFR 435 that you see on the slide. This is a little bit different than many of the other authorities that we've been using in that it's not something where we have needed to apply for CMS and receive an approval or a waiver. This is a situation where states just under existing federal regulations have certain flexibilities around eligibility that can be invoked during an emergency. So we've notified CMS that we are invoking these, but it's a bit different; it's not a specific waiver. And the primary places where this gives us additional flexibility are around some of the time lines for redetermination of eligibility. I think this interacts but it's somewhat distinct from the ongoing effort that has been described earlier. We are not dis-enrolling anyone in our Medicaid and CHIP programs at the moment, but there are also related question around timely completion of redeterminations and also allowed in certain circumstances where we're not able to independently verify in Human Resources. So just wanted to quick allude to that.

So the next authority I want to talk about is Appendix K. I know that seems like an intentionally obscure name for something. This is normally an appendix to 1915(c) HCBS waivers. In the case of New

Jersey, because our former 1915(c) waivers have been integrated into our comprehensive 1115 demonstration, for us, this is actually technically an amendment to our 1115 demonstration. And if you didn't understand any of the words I just said, I don't think it's actually that critical.

So this is specifically focused, though, on our home and community-based service program, so specifically our Managed Long Term Services and Support Program, also our programs run by our sister agency, so the Supports and Community Care Program run by the Division of Developmental Disabilities and the children support programs run by the Department of Children and Families.

So one thing to note, as you look at Appendix K is the flexibilities that have been approved through Appendix K, those flexibilities apply specifically to those populations and to providers serving those populations. There are also confusingly -- and I apologize again for the fact this is confusing -- there are also sometimes similar flexibilities that have been approved through other authorities that apply more broadly. And so it's just important to make that distinction.

So there are quite a lot of flexibilities

incorporated in Appendix K. I'll just highlight a couple.

So I think the primary focus of our Appendix K, which I should say has been approved by CMS, is allowing HCBS services to be provided more flexibly. This is both in terms of the settings where care is provided in terms of what services are provided. For instance, just to give an example, normally under our MLTSS Program up to one home delivered meal is covered per day per member. We, under Appendix K, increased that to two which we thought was an important flexibility. But there are a number of flexibilities around those lines, around the specific benefits provided. There's also some flexibility in terms of who provides the services. Some of the requirements around the qualifications of providers are loosened in certain targeted ways to make sure that members continue to maintain access to care.

And I think if you review Appendix K, you'll see that in that bucket, it's pretty targeted. We have tried to strike a balance. It's carte blanche to allow anyone to provide any service. But we, in working with CMS to get approval for that, tried to strike a balance between allowing some flexibility, recognizing that life is different during the pandemic, but also making

sure we have critical protections in place.

Appendix K also does eliminate some of the hoops that might impede provision of services. Jen alluded earlier to easier enrollment into our self-directed program. Part of our authority is here. There are also flexibilities in Appendix K around prior authorization. It's one of those areas where it's complicated because prior authorization was in several different places, but sort of trying to make sure there are not unnecessary barriers there to prevent beneficiaries from receiving care.

It also does allow changes in how HCBS providers are paid in certain limited circumstances, so that's an authority that we have available.

I will also just note, because some of you may be familiar in the context of Appendix K, recently in the last couple of weeks, CMS issued some additional guidance on how Appendix K flexibilities can be used. I think right now we're working and working with our sister agencies to see if there are any modifications needed to our Appendix K to reflect some of those additional flexibilities. So I would stay tuned for more information about that.

I just want to quickly flag -- and I think most of you are familiar and we talked about it, I

believe, in the April MAAC -- just the maintenance of effort requirement built into the federal Families First Act. This is not technically a federal flexibility. It's actually a requirement that pertains to us as the State. But I think from an on-the-ground perspective, from the perspective of beneficiaries and enrollment, it is, in essence, a flexibility.

So just as a quick reminder, the Families First Act provided an enhanced federal match for states for Medicaid. In return for accepting that federal match, states, by terms of the federal statute, had to agree to certain provisions around maintenance of effort. I think critically states are not able during the public health emergency to change rules to make eligibility more restrictive. And I think most relevantly for us, with very limited exceptions, the maintenance of effort requirement requires that individuals enrolled in Medicaid as of March 18th, which was when HHS declared a public health emergency and when the president declared a public health emergency, need to remain enrolled during the period of the emergency. So I just wanted to flag that.

This is our last slide in our of patchwork of federal authorities. So there are actually two different amendments that we have either in the works

have been approved to our state plans, one specific to Medicaid and one specific to CHIP to support our response to the COVID emergency.

To talk about the Medicaid one first, I will just flag. This one has not yet received final approval from CMS. I am comfortable talking about it because I think we're close with them and have had substantive conversations. And when it is approved, it will be retroactive to the beginning of the emergency. This State Plan Amendment is specific to the COVID crisis. So it is a specific set of authorities that we use in this public health emergency. As with some of the other authorities, there are a number of things in here. I'll call a few out.

First, the Medicaid State Plan Amendment is how we have authority to do some of the enhanced presumptive eligibility that Jen referred to earlier, particularly allowing hospitals to conduct presumptive eligibility for the aged, blind, and disabled population, which I think is critical for care transitions.

Secondly, the Medicaid SPA also provide broad authority for expansion of telehealth. I think this is a little bit of a tricky area because for some services, we didn't actually need any additional

federal authority to allow services to be provided via telehealth; for others we did. But this sort of provides a blanket authority for any service that can be provided via telehealth or telephonically to allow reimbursement for that.

Third, the Medicaid SPA also includes some flexibilities around the pharmacy benefit. One is with something that was critical, particularly in the early stages of the emergency, but I think on an ongoing basis, allowing longer refills of prescriptions so that people don't need to continually go back to the pharmacy to refill. In the category of flexibilities we have not used, also gives us some additional flexibility around at our discretion potentially covering new or experimental pharmacy drugs for COVID. I'm not sure that's something we will use, but it's also in there.

Then turning to the CHIP State Plan Amendment which has been approved, this is slightly different than the Medicaid State Plan Amendment in that this builds in permanent authority that we can evoke both for the COVID crisis and also in future emergencies. So if there's a hurricane in the future or some other emergency, some of this authority will still be available. I think the critical things here,

waiver of the premiums and certain cost-sharing, which I think Jen alluded to earlier, and some additional flexibility around time lines and requirements for enrollment and renewal for CHIP members.

And then lastly, I wanted to allude to the fact that we have also submitted a separate -- this is different from the Appendix K. Again, I apologize for how confusing this can be. This is different from the Appendix K that I alluded to earlier, but we have also submitted fairly early in the emergency a separate request for an emergency amendment to our 1115 comprehensive demonstration. This was where we put some flexibilities that we didn't see another pathway to getting approval for, so a few different things around benefit flexibility and eligibility and enrollment. We are still in discussions with CMS. Unlike with the Medicaid SPA, I don't really feel confident at this moment making a prediction about whether and when this will be approved. So I will just say that we're continuing to have productive conversations with OUR partners at CMS, and I think we are planning for all contingencies whether this is approved or not, making sure we have a pathway forward to do the things that we need to do operationally.

Before I conclude, I did want to just talk a

minute about our thinking around the end of some of these emergency authorities. There are somewhat time lines, depending on which authority we talk about. Some of these are specifically tied to the end of the public health emergency, that declaration at the federal level. Some of them will have a life a little bit beyond that. They have an independent timeline that goes a little bit further. Currently, I will say, because some people may be aware of this, that the federal public health emergency, the current period is scheduled to expire this week, at the end of the this week. We have received assurances from CMS, from HHS, from the HHS secretary and vice president who said publicly that they expect to extend that. The HHS spokesperson tweeted this. The legal team has told me that that doesn't necessarily have the force of law, but we have every expectation that the public health emergency will at least be extended beyond this month. But we are actively planning for whenever it does end, what does that mean. And looking both at things that we would need to transmission back to the pre-crisis status quo and also looking if there are lessons learned from some of the special steps we've taken during the emergency, things that we might want to try and continue permanently. That's an active

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conversation that we're having internally at the moment and expect to continue.

I'll stop there and see if there are questions.

CHAIRWOMAN SPITALNIK: There is one, but before that, to my thanks. The only way I would reflect back is that you needn't apologize for the complexity. We realize that it's not of your making and that you have done yeoperson's service in clarifying all of this for us. So thank you both for what you're doing on an ongoing basis for this presentation.

Theresa, you had a question.

MS. EDELSTEIN: Yes. Thanks, Deb.

Greg, it's nice to see you even virtually. I think you may have answered this question when you talked about the 1115 amendment request, but just to be sure, there have been an amendment request to allow the Office of the Public Guardian to do PE for beneficiaries that they were overseeing. Is that part of that 1115 amendment request or was it separate?

CHAIRWOMAN SPITALNIK: May I just interrupt? PE is presumptive eligibility. We're all in our own internal baseball game.

Greg, please.

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MR. WOODS: Theresa, I think what you're referring to, but correct me if I'm wrong, is in the previous pre-COVID approved amendment to our 1115 demonstration, there was approval sort of for streamline enrollment under certain conditions of Office of Public Guardian members. I think what I would say about that is that's one of the things that we're continuing to work on implementation of. It's not a question of CMS authority. It has, like many things, been a little bit slowed up by the COVID crisis, but it continues to be on our list and we're hoping to move forward with that.

CHAIRWOMAN SPITALNIK: Thank you.

I did not see any other questions or comments from the MAAC. I know that there were some follow-up pieces that Jen has acquired some answers to, particularly about ADRC. And there was also the a question about the food delivery experiment through LogistiCare.

Jen, you could tie up those loose ends right now.

ASSISTANT COMMISSIONER JACOBS: Sure. On the ADRC question, this was really about should we call the ADRC about a member's potential pre-admission screening for home and community-based services. And

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this comes out of one of our sister agencies, the Division of Aging Services, Office of Community Choice Options. So as I said to you, I have their guidance on my desk and had not yet fully digested it, nor did I do that during this call. But I have really amazing people on my phone who are texting me and saying, yes, that people should continue to call the ADRC for the home and community-based screening because they have guidance from the Office of Community Choice Options for this emergency period which they will then follow.

The other thing to mention is if the person is already enrolled in a Managed Care Organization, it helps to alert the Managed Care Organization if they thing they need home and community-based services.

So the answer to the question that came in is, yes, do contact the ADRC.

CHAIRWOMAN SPITALNIK: Thank you.

There was one more question about the experiment with LogistiCare about food delivery.

ASSISTANT COMMISSIONER JACOBS: So a couple of things about LogistiCare. There were two questions: One was food delivery and the other was safety precautions during the pandemic.

With respect to food delivery, again, we've been partnering with Division of Aging Services for the

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most part on those food deliveries. We amended their contract to give ourselves the opportunity to experiment with different forms of delivery. The way we started was making sure that we were partnering with the Division of Aging Services meals programs so that if they needed support in distributing meals that we were able to provide that through LogistiCare. And the example I would give you is for people who would normally be getting in congregate setting who are now quarantined at home, that meal delivery needs to happen and we were not initially in this period set up to do that because they were congregate meal sites. And so LogistiCare has been helpful in delivering meals to members who are staying home instead of attending those sites.

CHAIRWOMAN SPITALNIK: Thank you.

ASSISTANT COMMISSIONER JACOBS: With respect to the safety precautions, which was another question that came in, LogistiCare immediately at the start of the pandemic reached out to all of their drivers with specific guidance on the steps they needed to take to ensure the safety of the drivers and also the safety of the members and, really, the cleaning protocol for vehicles in between rides. And so that has been kept up to date with CDC recommendations.

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And the one thing I really specifically wanted to mention, Dr. Spitalnik, is that LogistiCare is absolutely transporting members who are COVID positive. They are simply doing that with a different set the precautions. So when someone calls to set up a ride, there's immediately a conversation about their health status. And if there is a suspicion that they may be COVID positive, LogistiCare has special protocols in place, again, to ensure the safety of all involved.

CHAIRWOMAN SPITALNIK: Thank you so much.

There was a recently arrived question from Bev Roberts for Greg about Appendix K.

MS. ROBERTS: Thanks very much.

Thanks, Greg, for this information. My quick question is could you be a bit more specific on the Appendix K flexibilities for persons who are served by DDD?

And also related to that, are there any flexibilities that New Jersey wants CMS to grant but that they did not yet provide for folks served by DDD?

MR. WOODS: Bev, I'm happy to work with you offline to share. The approved Appendix K is public and I think is pretty specific, and I'm happy to point you to where to see that and happy to talk through any

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details, probably working with our partners at DDD.

In terms of were there any flexibilities that we wanted that CMS did not grant, yes. I'm not going to be specific. I'd rather not be specific. I think with all of these authorities, it's been an ongoing negotiation and I think they have really been good partners and have gotten to yes wherever they can. Like anything like this, it has been a back-and-forth, and we've tried to get to the best place that we can.

CHAIRWOMAN SPITALNIK: Thank you so much, Greg.

We'll now turn to enrollment updates. I think that's Jen and Greg.

MR. WOODS: I can speak to this quickly. So we just wanted to give the MAAC a quick update on where we are in terms of overall enrollment in our program. So just to quickly talk through what the slide shows, enrollment peaked back in May of 2018 at around 1.8 million members, slightly below that. As I think we've discussed with this group before, over the almost two years that followed that, there was a pretty steady gradual reduction in total program enrollment. Over the course of about 20 months, it was overall about a 5 percent decrease in total enrollment down to about 1.7 million when it sort of bottomed out in February. I

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think that is consistent with national trends, consistent with what you have expected to see in what was a fairly strong economy.

Since the beginning of the emergency, I think also unsurprisingly, this trend has reversed itself. So as of June, we're almost back up to sort of where we were at the previous enrollment peak two years previous. So we're back up to almost 1.8 million enrollees.

I would say interesting, at least thus far, as far as we can tell -- and there obviously a number of things happening due to COVID, but as far as we can tell, this has not been driven by a surge of new enrollees. Each month when we look at the change relative to the previous month, we can aggregate that into new enrollees coming in and enrollees leaving the program. And I would say over the past few months, so March, April, May, June, we have generally seen pretty normal levels of new enrollees typical to the pre-COVID trend coming into the program. What has driven the increase, per the previous discussion, with some very limited exceptions, no one is leaving the program. So you have the combination of normal volume of new enrollees coming in and people are not coming out, so you see some pretty steep increases in overall

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enrollment as a result of that.

So I think that's perhaps a little bit surprising. I think, at least at the beginning of the emergency, there was certainly some speculation that we would also see a major surge of new enrollments. My understanding is that the experience we've had has be generally consistent with what other states have seen. And I think to the point that I think the Commissioner made at the beginning, obviously there are some short-term unemployment and other relief that's slated to expire at the end of this month. I think, to us, it's really an open question. Will that surge come in the future? And I think we're certainly prepared for the fact that it might. This is a new experience for us and quite different from an ordinary recession in certain ways, so we're trying to monitor that on an ongoing basis. And we'll continue to provide updates.

I'll stop there if there are any questions.

CHAIRWOMAN SPITALNIK: Thank you.

Are there any questions?

Not seeing any, again, thanks. And we'll look forward to seeing how our trends continue.

We're going to move to eligibility processing.

ASSISTANT COMMISSIONER JACOBS: Thanks, Dr.

Spitalnik.

The amount of work that Greg and our legal team and our subject matter experts have done on those labors is just staggering. So it is about 99 times more complex than Greg made it out to be. And they have done an incredible job of keeping track of all those different moving parts and the conversations with our federal partners who have been great to work with. So my appreciation, Greg, to you and the whole team that's been working on all of that because it has enabled us to respond to this emergency, and that's huge.

It is important to note here, as Greg did, that we've had a shift in our enrollment patterns and that we anticipate greater enrollment to come. And I wanted to double back with you because of that. I wanted to double back with you to a conversation we had in February and talk a little bit about Chapter 246 of 2019 which was passed by the Legislature. This was the bill that I think I described to you as Amazon knows where our package is every minute and the State should be able to report out on where Medicaid eligibility is every minute. It's just a new world and it's a new model.

So we have been implementing that

legislation during this period. And we talked to you in February at the MAAC about a particular piece. I don't have time to go into a lot detail on this today, but I did want to update you because we talked about the performance incentive program that we needed to set up as part of this legislation. And we said that we had a plan to incentivize the counties based on the timeliness of their redeterminations which was really responsive to federal audits that said you're not doing your redeterminations timely, adoption of the technology platform that would give us a little bit more Amazon-like view of where our Medicaid eligibility processing stands, and then finally, timely processing of initial applications. When someone is applying new, we want that application to move through quickly.

Those were the three operational things we wanted to focus on in February. And then a few things happened in our life. And one of them was this policy of maintaining eligibility for our Medicaid and CHIP members during this period, which meant that redetermination timeliness was no longer as relevant and important as it had been a minute ago. It will always be relevant and important, but what is really critical right now is making sure that our counties are focused on processing this unanticipated volume of

applications which we think is coming.

So certainly at the beginning of the surge of the pandemic, we thought it was coming immediately. We and other states found out that it wouldn't. And there are a lot of reasons why people hypothesized that, that pattern is what it is. But we still think that significant enrollment volume is coming, and we need the counties to be ready for that. We realigned our incentives to make sure that they are reflective of this new reality.

So if you look at the three incentives that I described to you from the February MAAC, we took that redetermination one out and we replaced it with an incentive based on the application volume and the enrollment growth that we're expecting. I don't have time to go deep on it today, but I did want to give you that little update because it is a change from what we described to you two meetings ago. And I hope it's clear that it's reflective of this new reality. That has been a significant conversation with our county partners, and they have really worked very carefully with us on this to figure out how to make it work the best way possible going forward. And part of that was putting a memorandum of understanding in place between each county and DMAHS, our Division, to codify that

agreement, to say this is how we will proceed with this incentive program. So the counties have all signed an MOU, each of them individually. And they have all begun to adopt the new online portal.

So each of those represents progress. And when I'm able to report back to you on this, I will look forward to talking to you about the dashboards that we are able to put in place because of that new technology platform that we'll all be using.

CHAIRWOMAN SPITALNIK: Thank you so much.

Theresa had a question about the incentives.

Theresa, please.

MS. EDELSTEIN: Just quickly, Jen. I don't want to be labor the point, but did you leave yourself the flexibility to adjust that MOU if things don't materialize the way you expect? That might be a little Pollyanna thinking on my part, but just in case.

ASSISTANT COMMISSIONER JACOBS: I appreciate your Pollyanna mindset, and I hope we have good reason to use it.

The way we set it up, we said we expect this to continue through the end of the year, because we're realists. But we're also optimists, and so as of the end every year, we expect to go back to the original plan. But we will continue talking with the counties

because our reality is evolving and our incentives need to match the reality that we're working in. So, yes, we do intend to go back to that original plan. And I hope you're right, that it comes soon.

CHAIRWOMAN SPITALNIK: Thank you so much. And thank you for that question. We'll now move on to another aspect of MLTSS which Jen will present on, care management for nursing facility residents.

ASSISTANT COMMISSIONER JACOBS: Thank you, Dr. Spitalnik.

This portion of the presentation is in response to many questions that we received during this COVID emergency period about the role of the health plans, our Medicare Managed Care Organizations, in supporting nursing facility residents.

When we last spoke in April, we talked to you about the role of the managed care care managers who were interacting with their members during this emergency period, and we were specifically talking about members in the community. So you may recall that we walked through a number of stories that included some specific details. I'm not walking through those same stories today, but the focus for the community centered around these five themes. It was very important for Managed Care to recognize the need to

coordinate services, continue services, restart services that may have stopped for some reason during the pandemic. Example being, provider officers were closed, aides might not have had showed up, but health plan needed to recognize the need and address that service, restarting or getting coordinated in some way. Certainly they had a role in explaining to their members how to access telehealth because that was new for, frankly, most of us in the State. They played a significant role in expediting the delivery of supplies to people who may have been ill with the virus or may have just had some other supply need that arose or that was disrupted during the time. Many calls that were made to members during this period included the recognition of a need for urgent or non-urgent medical care. So for example, people did not want to go out for medical services when health plans were calling their high-risk members, which we instructed them to do beginning in March, early March, they may have recognized on the phone that there was a need for that care and so they were advising the member, no, you really cannot wait, you need to get to the doctor or you need to get to the hospital.

And then finally, you may recall from those stories, there was a lot of food insecurity in our

population during this period. We expected the health plans to coordinate with us and with local community organizations so that we would not have people going hungry. We are not a food program but, as you know, the Department of Human Services run food programs. There are local community organizations running food programs. And our health plans helped us to access those for our members and address other social needs.

That was all around the community members. We didn't talk a lot in April about the nursing facility residents. And so folks asked us, well, what is the role of the health plan care manager for a nursing facility resident? That's what we wanted to talk to you about today. It's a different role. There are really three primary functions. The first one is partnering with nursing facilities in a situation like this to get updates on their members, the health plans' members, and then sharing those updates with concerned family. That was probably, by volume, the largest responsibility that the health plans had during this time by shear volume of members. That was the need that the nursing facilities, phones were ringing off the hook, the health plan had contacts. They would find out everything they could on specific members, and then those loved ones would get the information from

the Managed Care Organization that they might not have had otherwise.

A second really important role that the plans had was recognizing the needs of their members who are in a nursing facility and coordinating with the member, the facility, family, and other caregivers, to make sure that those needs are addressed.

And then the third piece which is really kind of the most exciting sometimes and certainly the most challenging is supporting the transition for someone who is residing a nursing facility and chooses to move out to a community setting. What does that really look like on the ground? For me, the easiest way for me to describe it is to really look at specific cases. That is what I do. It's what I've always done. And so with what I would like to do is walk you some specific cases, not to say that everything goes perfectly all the time or even that it did in any of these cases, but rather that this is what we are holding them accountable to these are our expectations.

And so the first example I have here is a member we'll call Henry and the focus of this particular case is around person-centeredness. Many of you have experience with person-centered thinking or person-centered care planning. For folks that maybe

that's new terminology, I would just describe it to say this is not sort of a cookbook, textbook kind of approach to care management. It's really very personal. It is about the relationships that this person has, the goals and activities that matter to them, their preferences for their services and their care, what they want their life to feel like. So it's really not a cookie-cutter approach at all. It's very individualized.

And this one is an example of that. Henry was a nursing facility resident. He reached out to his care manager. In most cases, it's really the health plan reaching out to the member. We said to them, we want you to reach out to your high-risk members during this period, and our MLTSS quality team has been tracking that outreach. Henry called his care manager from a nursing facility and the was the first week of restrictions. He said, "I'm scared and confused. I am losing track of time. I'm all alone. I feel isolated."

And the care manager used that person-centered thinking to help him think about how he spends quiet time. When you have time alone, what do you typically do during that time alone? And then she talked with him about how to stay oriented in time by

marking off a calendar. He had a calendar. And they spent quite a while on the phone. Importantly, the care manager here knows that her role is to follow-up with the facility. There's a partnership there so that they're aware how Henry is feeling.

It's a simple example, but I didn't want to leave it out because person-centered thinking is really core to the work that we do with MLTSS care planning, and this was a good example when I saw this case of really just the simplest form of very personal interaction between the member and the care manager.

The next case, Natalia, is, again, sort of a simple example. The care manager additionally is expected to provide options counseling to our members. So this member is pretty medically complex and has some depression, living in a nursing facility. And her granddaughter says, "Grandma, come home with me. You can live with us."

And so they connected with the care manager and had a whole conversation about the logistics of a potential move from the nursing facility to granddaughter's home and what that would mean in terms of making sure she had the medical care that she needed in the community. Frankly, at the end of all of that, Natalia made a decision to stay right where she was.

She told her granddaughter that she appreciated the offer but that she had relationships in that facility and a social network and she didn't feel like she wanted to make the move right now. That was Natalia's choice. In this case, the role of the care manager was options counseling and support for that family while everyone discussed what was the right thing to do, and then Natalia made the decision that she wanted to make.

Another important example of the role of care managers expectations that we have for them is Armando. Armando, in the early stages of the pandemic was in advanced stages of brain cancer. He ended up having a violent outburst at his facility, got transferred to an acute setting, and the nursing facility would not accept him back even after he had been stabilized. So the expectation here is that the care management team at the health plan would conference with the hospital team and collectively make a discharge plan. Between the health plan and the hospital team and outreach to community providers, everyone agreed that given where Armando was and the support that help needed at that time, hospice within the hospital would be provided. And Armando passed away peacefully in early June. This inpatient coordination is an important component of the role of

managed care for a nursing facility resident.

Elmer was admitted to a nursing facility, frankly, from of a place of being homeless and a very medically complex a couple years ago. Elmer had no income and no community support. Here, the role of the care manager in this person centered care planning process was to hear Elmer's goal that he wanted to live independently in an apartment of his own. And the first thing that needs to happen there is get some income. And so they worked on securing his Social Security benefits which started in December of 2019. That enabled them to search for subsidized housing. And there was partnership with the nursing facility social worker and with the Money Follows the Person Program through our sister agency, Division of aging Services, Office of Community Choice Options. And then in early July, Elmer transitioned into an accessible apartment in the community. Through the transition services that the health plan can authorize, they provided him with furniture, they set him with personal care assistance, home delivered meals, and the personal emergency response system, and additionally, recognized the need to coordinate primary care, specialist care, and behavioral health for Elmer.

So our expectations of the health plan in

this case are obviously pretty extensive. It is challenging to set someone up who is residing a nursing facility with zero income in an apartment of their own in the community and, frankly, particularly challenging to do that during a pandemic. But it is our expectation that the health plan will follow through on that.

Another example of a transition was Annabelle who went home to live with family during this period. She does have cognitive impairment. She is dependent for all of her activities of daily living. She was residing in the nursing facility. There was no plan to go home, but her daughter was concerned, frankly, during the emergency period here. So the care manager arranged for an interdisciplinary team meeting. That needs to happen anytime someone is transitioning. Everyone discussed the possibility of doing the transition, and they were able to quickly set up a hospital bed at the daughter's home, the personal emergency response device, personal care assistance, and some groceries to get them started.

So this was a less complex example than the fellow who's moving out to live on his one. Probably more frequently the case that someone is moving to live with family. And our expectation of the health plan

are clearly the coordination with the nursing facility and the family and the member.

I wanted to talk about Gus. Gus is a really interesting example to me. Caregiver support is not always the first thing you think of for care management, but those who work in the care management field know that with our MLTSS program, caregiver support is a really important component. Gus had a traumatic brain injury. He is nonverbal and requires assistance with all of his activities of daily living. His mom was his primary caregiver. He's 41. Mom passed away during this pandemic period. Gus's younger sister had not been involved in his life since the injury, but she wanted him to come home and live with her. That's what mom would have wanted. And so Gus's care manager now needed to do some of this options counseling that we talked about earlier to talk about the services that are available to support Gus and, frankly, the family, including chore service that they needed to really create a safe home environment for him. And this was a really interesting detail in Gus's story because the sister didn't know any of the background. She didn't even know who is medical providers had been in the community before he had gone to the nursing facility. So the health plan was able

to pull all the information they had on existing medical providers and share that with his sister. So Gus is now getting therapy in the community through telehealth. He would like to start a TBI day program. And his sister, importantly, is getting a lot of support. Answering all of the questions that she has in this situation, that gives us the highest likelihood of success for Gus remaining in the community. And so it is our expectational ways that health plans will provide caregiver support. This case was a really good example of what that can look like.

I wanted to mention Raymond because Raymond was an interesting case. The challenge here is Raymond was admitted to the facility after a stroke. He does require care and he's receiving his nutrition through a G-tube. His wife was living about 25 miles from the facility and working and driving back and forth to be with him. She really wanted to bring him home. When Raymond enrolled in MLTSS in March as the pandemic was starting, she explained to the care manager that she had been trying to take him home and didn't feel that she was getting the support she needed from the facility to do that.

We hold the health plans accountable to advocacy when our members need that support. And,

frankly, this has been a very important component during the pandemic period.

So the care manager made phone calls around the facility. She connected with the social worker, with nurses, and the nursing facility administrator. She did connect to a nurse who was able to help kind of identify the obstacles that the facility felt were in place. And then we expect that the care manager will address those obstacles.

That's not to say that every single time they can address those obstacles in a way that lets the member transition to a community setting, but they need to address those obstacles.

So in this case, training his wife to deal with the G-tube, to provide all of the care that Raymond was going to need in terms of transfers, that required an agency to do a little bit of training with her before the facility felt it would be a safe discharge. The care manager was expected to set up that training through the agency, and did. So Raymond ended up going home with his wife in June. It's a happy ending on that story. The advocacy role is clear there.

So in addition to all of the responsibilities that we hold the health plans

accountable to, I just thought that I would point out community transitions are complex in the first place. They are certainly more so during a pandemic. And as you can imagine, housing options are more limited; accessing furnishings and groceries, more challenging; making sure the right medical equipment is in place and getting medical care either to the member or getting the member to the medical care. You know, the day programs being closed has certainly been challenging for some families.

Behavioral health is a big deal right now, just as the Commissioner said. Certainly, we have all struggled with this. But anyone with addiction, anxiety, depression -- a challenging situation, and we expect the health plans to help us manage through that.

I think I have been muted, so I am trying to figure out if that is the case or not.

I am going to continue talking, in hopes that you can hear me.

The behavioral health coordination that the health plans are doing in this program is really important. And certainly, supporting the family, the caregivers, through this has been a major component.

Let me pause for second to make sure that people can hear me.

CHAIRWOMAN SPITALNIK: Yes. You're back you lost you just between medical care and long-term services. I think you muted. So would you repeat?

ASSISTANT COMMISSIONER JACOBS: I don't know what happened there, but I could see something wasn't right.

So I was briefly describing that, as the Commissioner said, from a behavioral health point of view, this emergency has been very challenging for all of us. I think anyone who tells you it hasn't been challenging for them is probably lying. So for our members, and in particular our members who have struggled with addiction, with depression, and with grief, and especially with new grief during this period, coordinating behavioral health has been absolutely essential, and we expect that health plans will do that. They have done that well.

Finally, I mentioned supporting families, the kind of caregiver support that I described with Gus's sister, with spouses and partners. And each of these has been an important component in what was already a complex scenario.

Then I wanted to just touch on this. This documentation that was found in a case file, which I think is a really solid example of something. I don't

want to over -- I'm going to make up a word. I don't want to over-sentimentalize this. Although it is certainly a sentimental. There's an emotional component of what I'm showing you here, but I want to walk you through it technically.

So in the first bullet, a call is received at a health plan. And the caller is asking to speak to a care manager named Alicia. The caller is Yvonne, and she is telling the health plan that the member passed away. And the person who answers the call, which is the CCC, essentially a Clinical Care Coordinator, this person who's taking the call to support the team of MLTSS staff, she expressed her condolences, obviously, to the woman who was calling. That is an expectation, right? We talked about this being a very personal program. The caller, Yvonne, explained that her mom had lived a wonderful life and that she wanted to thank the care manager and the MLTSS team for what they had provided, for what they had done for the member and for her family. She said she would be forever grateful for their work.

And I pause here, frankly, because Yvonne did not need to make that phone call. It's noticeable when somebody does. This is a busy time in Yvonne's life. It is a sad time in Yvonne's life. She does not

need to make this phone call right now, but she's making this phone call. And I note that. She has decided to make the call and this is what she said.

The next part, I think, is really interesting. She's not asking to talk to her current care manager who is amazing, in her words; but she wants to speak to the former care manager who they had been working with for a long time prior and who was with that member for some time, wanted to thank them for everything they had done.

I think that speaks to the person-centeredness of this program to say the current care manager was apparently amazing, to put air quotes on that, but this other care manager apparently that he developed a better relationship with even over a very long period of time, and they really just felt the need the connect and have that closure. And so, obviously, the call was transferred to that original care manager and the file was closed out.

Our members passing in MLTSS world, it's part of our life. And every so often, the family calls and you have, frankly, for your care manager, a sense of closure that you wouldn't have had before. I think it's important to note when it happens because the family doesn't need to make that call. And when they

do, it tells you something about the relationship that was established, and in this case, the longstanding relationship that had been established over time.

CHAIRWOMAN SPITALNIK: Jen, thank you for sharing the soul of our work and grounding all of our deliberations and why we come together. Thank you.

Theresa, you had a question, an MLTSS question.

MS. EDELSTEIN: Thank you, Deb.

Jen, these were very helpful examples to hear. My question, and I don't want to take away from the connection that you've clearly demonstrated that some of the care managers have been able to establish and work through, but I'm wondering if you have data from each of the health plans on the number of care management contacts, what the theme or topic was, was it a transition, was it something else, and what the outcome was? Because, frankly, over the last four or five months, I haven't heard a single instance from the nursing home side of this equation of any such contacts like this. And they are telling me that the health plans have been absent from the conversation. So somewhere in between lies the truth, and I think data would help us all understand much better exactly what this looked like during this time and how it should

look going forward. Because we were struggling together, health plans and providers, with defining this relationship around care management before COVID. We really didn't have it well established. The linkages just were not, frankly, there the way we all hoped they would be by now in a mature MLTSS program, at least on the nursing home side. The community, I really can't speak to. So I just think data would help us all understand better how we are performing on both sides.

ASSISTANT COMMISSIONER JACOBS: Sure. I can answer that question in a COVID-specific context and in a more general context, Theresa. Certainly, there were challenges during this period. Frankly, there were points where health plans could not make contact with the nursing facilities and express those concerns to us, to the long-term care ombudsman, to the Department of Health. We have worked through that. I think sometimes nursing facility administrators are not aware of all of the contact that is occurring between health plans and their social workers or their nursing staff. So there's sometimes a difference of opinion about how much contact is happening, depending on which person at the nursing facility you're talking to. But certainly, what I've described is our expectation.

With respect to the COVID period and the outreach the health plans were doing, we instructed them, beginning March 6th officially, that we expected them to identify high-risk members and begin reaching out to those high-risk members immediately. We have been tracking that high-risk outreach through our MLTSS quality team. We also told them that we wanted to know anytime they were having a hard time reaching a nursing facility, frankly, and we have been taking that information back to the Long Term Care Ombudsman's Office and Department the Health. They have been reporting to us on any disruptions of service or quality of care, and we have been meeting with them weekly for verbal discussion, about an hour a week, with their CEOs and clinical leads.

So we have a pretty clear sense of where they are and what they've been doing. Certainly, a lot of outreach to members in the community and making sure that those folks who did not have nursing facility staff around them had the care and services that they need, including and especially people living alone or people living with another high-risk member. And then the outreach to the facilities as well, and in many cases, being the only source of information, frankly, for worried families on the other end of the line.

So I think that the partnerships between health plans and facilities have been stressed during this time. I think everyone struggled across the industry with resource constraints, but a lot of lessons learned, and we have been tracking closely. So we do have some data from this period, but I also want to describe to you -- and I will in the future when we have more time to dig deep -- that we have substantial performance metric data for the health plans that we are tracking on a monthly, quarterly, annual basis. So when we follow-up again in future meetings, we'll be happy to describe that to you as well.

I know, Dr. Spitalnik, you're probably getting concerned about time here, as am I.

CHAIRWOMAN SPITALNIK: I am, but there's one more question about eligibility before of we sort of take future look and also scope out our next meeting which this most recent exchange continues to be on our agenda in terms of the performance metrics and care management. It's really a question for Greg.

Is the flexibility, the 1135 approvals for of the provision of services and alternative settings for telehealth, is that just for Medicare beneficiaries? Is the flexibility for both Medicaid providers and clients to be in any location is

something allowed with federal approval or is this the state could approve this independently? So it's really a question about where is the authority for flexibility. And I don't know if Greg or Jen wanted to speak to it, or we could revisit this at another point.

ASSISTANT COMMISSIONER JACOBS: I think we may have lost Greg, but let me pause.

I think he can follow-up on that one.

CHAIRWOMAN SPITALNIK: That would be great to follow-up on.

Your last two slides lead us to what we put on our agenda for next time. And when we finish those, I would ask any of the MAAC, including Wayne on the phone, if there's anything that anyone wants to add. And I'll try to recap what we have identified so far for our October meeting.

So back to you.

ASSISTANT COMMISSIONER JACOBS: Thank you. I'll speed quickly through these two last slides.

These are a similar format to what we showed you in April but with updates. Here, our work continues under that framework that I described at the beginning. We are continuing to leverage these flexibilities that Greg talked about, and we're looking at our long-term options. So I don't think Greg went

into a lot of detail on this, but we have had meetings with CMS where they've said, we understand that you may be interested in continuing some of these things going forward that you weren't doing before, and we may be able to approve some of that on a nonemergency basis. So Greg and the team will be looking at what that would look like, what might we want to continue. Certainly, some of these flexibilities have made a lot of sense. And then how would we -- back to his patchwork of authorities, how would we go about doing it.

We are working really closely with our eligibility determining agencies, which is code for our county boards of social services and our HBC health benefits vendor that works with us on eligibility, with our MCOs and with other operational partners, frankly, to manage the growth that we see coming. And we know that we will continue to have to adapt.

For example, people are asking a lot of questions right now about PPE, about testing, about new treatment protocols. Frankly, what we thought was going to be the case with testing and treatment and PPE a month ago turns out to be different today, will be different in three weeks. And we will have to continue to adapt to that, so agility is the word of the day on that. And, frankly, we have seen the impact of this

pandemic on our Medicaid community, frankly, on communities of color all over the nation, on low-income communities differently than other communities. And we need to recognize that there are health equity questions there. We're going to have health workforce development needs. Social determinants are going to look different in this new normal. And so we are participating in local and national forums where people are thinking through these questions and what does it mean, practically speaking, for all of our programs.

CHAIRWOMAN SPITALNIK: I'm sorry, I should have raised this before. Given that you were talking about the rapidly changing environment, there was a specific concern that was raised about PPE and enhanced infection control in dentistry and that private insurers are supporting that financially. This has been an ongoing negotiation. And Dr. Whitman, one of our former colleagues on the MAAC, raises this again and the challenges for dentists. So I wonder even though we're looking forward, how do we get this more on the agenda?

ASSISTANT COMMISSIONER JACOBS: So dental is definitely a part of the discussion that's happened with respect to PPE broadly. We know that payers and providers are having a lot of conversations about that

right now as well.

CHAIRWOMAN SPITALNIK: Thank you very much. And forgive me for interrupting the flow. I know you want to go on to the second slide.

ASSISTANT COMMISSIONER JACOBS: Let's finish this up. Importantly, we have other critical priorities that we are really needing to keep moving while we are incorporating a lot of new COVID-related projects. So I would say for sure you saw a slowdown in some of our other projects in March and April and maybe even early May, but we have begun to pick up the pace with those projects again as we've been able to -- we have a number of important priorities that are moving right now, and we look forward to giving you updates on those. Hopefully, over time, the amount of time we spend in this meeting on COVID will reduce as things get a little bit back to normal.

We're also continuing to support our team through these remote adjustments and new work life challenges. As 600 school districts are coming out with plans for the fall, that's creating stress for folks. We have had to be as flexible as we could be with one another and, frankly, with ourselves. And we are managing, as the Commissioner mentioned, a very challenging State budget atmosphere. So there's a lot

going on with respect to that. Certainly, we'll have more updates on that at the next MAAC meeting and probably at various public forums in between.

And then we know that we need to continue to stay close to the pulse of this thing. So we're very close with our Medicaid community. Lots of scheduled meetings and conversations, but also ad hocs, spontaneous conversation.

In particular at this moment, two things: I want to say thank you for everyone who has reached out to us with a challenge during this time because sometimes your challenge is only yours, and sometimes you're signalling to us a more systemic issue. Either way, we want to solve the problem. But know that whatever you might be struggling with, a hundred or a thousand other people might be struggling with. So it helps us to know what's going on out there. And thank you to everyone who has reached out to us to help us recognize when there were problems or challenges we didn't know about.

Lastly, Dr. Spitalnik, I just wanted to finish by saying that my team has done incredible work here, and we recognize that nothing has gone perfectly. Our work is not done. It probably never will be. But they are a fantastic team. They've done a really great

job with this. And in front of all of you, I want to say thank you to them.

So thank you for the opportunity to present to the MAAC today.

CHAIRWOMAN SPITALNIK: Thank you. And our thanks to all of you. We know that State Government is challenged with furloughs and the budget and the commitment to keep meeting with the MAAC and the many stakeholders that you continue to reach out to.

At this juncture, I wanted to ask if there is anyone from the MAAC that either wanted to make a brief closing comment or bring anything up. And I was going to turn to Wayne first, as he's on the phone.

Wayne, was there anything you wanted to add to today's conversation on put on our agenda for October meeting?

MR. VIVIAN: Yes. Thank you for the opportunity.

First of all, I agree with what Director Jacobs has said about the work that Medicaid has done. It really has been phenomenal. You're all to be congratulated for everything. But I do have a couple issues.

Commissioner Johnson, during her presentation, talked about the issue of substance use,

the rise in substance use. In the mental health community, it's definitely becoming more and more problematic. People are -- their acuity level is going up, and the substance use is definitely increasing. I don't know what you can do to relax the rules to get people into treatment as quickly as possible or fast as possible, because we're losing many, many people through substance use which is definitely on the increase. I don't know if it had to do with the stimulus checks. I think that kind of initiated it. I think people misused their stimulus checks to engage in substance behaviors.

The other issue I have is that it's not a seamless process with the counties regarding recertifications, where people are losing their benefits because of their welfare and their Medicaid because of recertification issues. And I really would like to see the counties be a little more flexible and a little more forgiving in the recertification process.

So that's all I have to say.

CHAIRWOMAN SPITALNIK: Thank you. I don't know if you, Jen, want to respond. But I think we ought to also put the issue of substance abuse, treatment, and the metrics of people presenting themselves and the responses on our October meeting.

But is there anything else you wanted to add at this juncture?

ASSISTANT COMMISSIONER JACOBS: Well, with respect to substance abuse, I'm right with you. I think it would be great if we could get some information from Assistant Commissioner Val Mielke from Division of Mental Health and Addiction Services. She has worked really closely with us to make sure that we were able, for example, to provide telehealth for substance use disorder treatment. And I know that she has been very active with her community. And I would love to start a dialog about what else we see as need and what the role of Medicaid might be in sort of filling in to address those needs.

So I agree, Dr. Spitalnik, I think it would be great to talk about that in October.

And thanks, Wayne.

On recertification, we have been working closely with the counties on this, Wayne. So maybe offline we can have a conversation about some of the challenges that you think are still out there, and I will be happy to incorporate those into the conversation that we're having. Absolutely.

MR. VIVIAN: Thank you.

CHAIRWOMAN SPITALNIK: Thank you, Wayne.

Beverly, you had something you wanted to briefly add?

MS. ROBERTS: Yes. Thanks very much.

So I had communicated with Jen because I've talked to parents of individuals with IDD who have been employed, but they've been furloughed from their jobs. So they're getting unemployment, a substantial amount; they're getting the $600 a week of the extra amount, plus what they would have gotten on their own. So in one recent case, it was over $800 a week in money coming in and they're not even able to go out and do anything because of COVID. So my question to Jen had been can the $2,000 maximum amount be relaxed. And she said, no, there is no way federally to allow for that relaxation except for the $1,200 stimulus amount. So people who had gotten the $1,200 economic stimulus, that's okay for a 12-month period which would end, I guess, next April that they could exceed the $2,000 in assets by 1200 because of the stimulus payment. But, again, we're talking about so many people that have a lot of money coming in at this point. The solution seems to be an Able account. And there was a really great presentation that DDS had done last April on Able accounts, a great slide presentation. It's on the website. If anybody wants to actually go on and just

get more details for themselves or for people that they're serving, the website for New Jersey Able is nj.savewithable.com.

CHAIRWOMAN SPITALNIK: Thank you.

One of the things that we've tried to do over time, I think, since beginning of the managed care enrollment is that we think of each of our membership on the MAAC and our appointment as both coming to this Board but also as serving ambassadors back to the constituencies we represent, as you do. So I hope that we get that information out to people again, and that will be reflected in the minutes. So thank you very much for that.

I don't see anyone else either visually or by unmuting. Does anyone from the MAAC have any comments?

We next meet on October 21st. I'm assuming that -- as Jen talked about, the benefit of being able to be more inclusive virtually in some ways, I think we would need the Meadowlands if we were going to meet in person than to maintain appropriate distance. So I'm at least making the assumption that we will be meeting virtually. We will have more updates then about the state of federal legislation and what has happened with the flexibilities either that were time limited or

ongoing. So I would put that on our agenda.

Wayne has raised the issue for us of substance abuse that we will invite Valerie Mielke.

We had the issue on care management that Theresa raised and that we would like to take a deeper dive into that.

Are there other -- people keep saying, well, if you could only tell me only to expect in the future. None of us really can. But from where we stand now, are there other things that people would like to bring to our collective attention for our October agenda?

MS. ROBERTS: Deb, I'd like to see the update on EVV with whatever can be shared at that point.

And also, if we could have an update on autism services for individuals who are served through CSOC, that would be great.

CHAIRWOMAN SPITALNIK: And one the stakeholders raised the issue of the autism services, so that's clearly on people's minds.

Theresa, I notice you have unmuted.

MS. EDELSTEIN: I'm just going Commissioner Johnson's comments earlier about the longer-term recommendations and the report that touched on Medicaid payment strategy and policy. I think it would good it

we could hear what some of the Department's thinking is along those line. It may be early in the process, but I think it's important for there to be open dialog.

CHAIRWOMAN SPITALNIK: Thank you.

Anything else?

I think that brings us to adjournment. I want to thank everybody for participating. I know that this is a challenging medium, but I'm delighted that we can get together. All of us who serve on the MAAC are deeply gratified by the number of people who've participated. And, again, we encourage you to send questions and comments prior to the MAAC. We will at our next meeting review the minutes of our previous meeting.

Again, our thanks to Jennifer Jacobs, Greg Woods, and the entire staff of DMHS; to Commissioner Johnson; to Deputy Commissioner Adelman.

We wish everyone a healthy and safe summer in whatever form we can safely participate in that. And our thoughts and condolences with those who are suffering who have had losses in this time.

Be well, and we look forward to being together again in October.

Thank you, everyone. And we now stand adjourned.

(Meeting adjourned at 12:44 p.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