MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Video Conference
October 21, 2020
10:00 a.m.

FINAL
MEETING SUMMARY

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

MEMBERS NOT PRESENT:
Chrissy Buteas
Theresa Edelstein
Dorothea Libman

ALSO PRESENT:
Sarah Adelman, Deputy Commissioner
Jennifer Langer Jacobs, Assistant Commissioner
Carol Grant, Deputy Director
Greg Woods, Chief Innovation Officer

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

DR. SPITALNIK: I want to welcome you to this meeting of the New Jersey FamilyCare Medical Assistance Advisory Council. In compliance with the New Jersey Open Public Meetings Act, this meeting has been publicized and is being recorded as well as transcribed to create a record.

I'm Deborah Spitalnik, the Chair of the Committee, and this is our third meeting, precipitated by the pandemic, that we've met virtually. We're getting better at the technology. And I thank, for everything, Assistant Commissioner Jennifer Jacobs and the whole Medicaid staff, but we still have some limitations. So the way that we've structured the meeting is that if you are joining by computer, you can physically see the members of the MAAC, the leadership of the Division and the Department. MAAC members will be able to ask questions verbally. We invite our stakeholders to ask questions through the Q and A box that is at the bottom of your screen. We will read those and try to address those.

In keeping with our practice when we join together in-person, after a presentation, we invite the MAAC members to ask questions or make comments. Then we turn to the stakeholders for their questions. We continue to pride ourselves on our ability to have that

level of interaction even though now it is on a virtual basis rather than just excluding comments to an isolated period unattached to our discussion.

Our agenda for today, after I ask the MAAC members to introduce themselves, we'll be addressing the minutes of previous minutes, a Behavioral Health update, information on nursing facility legislation, COVID-19 program impact, current programs, initiatives in planning and implementation stages, and then we'll also discuss our next meeting.

So with that, let me welcome the members of the MAAC and let me ask them to unmute. And Beverly, Mary, Sherl, then I'll ask you in that order to introduce yourself, please.

MS. ROBERTS: Good morning, everyone. I'm Bev Robert with the Arc of New Jersey.

MS. COOGAN: Good morning. Mary Coogan, Advocates for Children of New Jersey.

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

DR. SPITALNIK: Mary Pat.

MS. ANGELINI: Good morning, everyone. Mary Pat Angelini, I'm the CEO of Preferred Behavioral Health Group.

DR. SPITALNIK: Thank you so much. I hoping

that we have Wayne Vivian on the phone, and he will confirm that with me by text. And may I turn to Deputy Commissioner, Assistant Commissioner, and Greg. Please welcome us.

DEPUTY COMMISSIONER ADELMAN: Good morning, Dr. Spitalnik. Good morning, everyone. This is Sarah Adelman, Deputy Commissioner at Human Services.

DR. SPITALNIK: Thank you.

ASSISTANT COMMISSIONER JACOBS: Good morning, everyone. This is Jennifer Jacobs, Assistant Commissioner over Medicaid.

DEPUTY DIRECTOR GRANT: This is Carol Grant, Deputy Director of Medicaid.

DR. SPITALNIK: And Greg.

MR. WOODS: This is Greg Woods, Chief Innovation Officer at Medicaid.

DR. SPITALNIK: Thank you.

And I ALSO want to acknowledge, as always, the assistance of Phyllis Melendez and Karen Enoch in making it possible for us to be together.

As you'll see on the screen, our agenda, and you will see the slides. As is our practice, these slides will be posted. I also want to welcome, and who will speak in a little while, Valerie Mielke, the Assistant Commissioner for Mental Health and Substance

Disorder Division.

So far, we seem to have 110 members of the public joining us at this time.

Our first agenda item is something that has gotten backlogged, which is approval of the minutes, which are meeting summaries. Our backlog is somewhat attributed to the quorum issues, but most recently, our learning this new medium for communicating with each other. So by my calculation, we have enough members for a quorum. And if we can turn to our previous minutes and approve them, it will then make it possible for them to be posted on the DMAHS website and, therefore, provide access to the public.

So if members are in agreement with that, what I'd like to do is identify the dates and ask if there is any comment or correction that should be added to each one. And as you can see, with the first one being from October 24, 2019, we have a bit of catch-up to do.

So consideration of the 10/24 minutes, are there comments or corrections?

And if it's all right with members, I think I will do all of them and then ask for your approval of the set with corrections if any are supplied.

The next set of minutes that we fondly

remember as our last in-person meeting are from February 5th.

And also Wayne is joining us.

Any comments on the minutes from February 5, 2020?

Seeing or hearing none, April 22nd, any comments or corrections?

July 22, 2020, any comments or corrections?

I'm starting to feel the weight off my shoulder as we proceed. So I will ask one of the MAAC members to make a motion for approval of the four sets of minutes.

Mary Coogan moves.

Second?

MS. BRAND: I second.

DR. SPITALNIK: Two seconds.

And all those in favor, aye, or raise your hand and I'll record it visually.

THE MEMBERS: Aye.

DR. SPITALNIK: Okay.

Any abstentions or objections?

Hearing none, we have accomplished our first item, the karmic feeling of cleaning your bureaucratic desk.

We move on to a presentation that we have

been very much looking forward to on a Behavioral Health update. Valerie Mielke is Assistant Commissioner of the Department of Human Services in the New Jersey Division of Mental Health and Addiction Services.

Welcome, Valerie, we're so glad you're with us today.

And I'll ask members to mute during this time. Thank you.

ASSISTANT COMMISSIONER MIELKE: Thank you so very much, Dr. Spitalnik, for inviting me here. It's always a pleasure coming before this group and sharing updates as it relates to Behavioral Health Services at the Division of Mental Health and Addiction Services.

I just want to start out that under Governor Murphy and the Department of Human Services in our Division that we've always made increasing access to Mental Health and Addiction Services a major priority for us. And even more so during this time of the pandemic that we know that our services are critically important for individuals across our State.

And I also just want to highlight that our safety net providers particularly during this pandemic have really stepped up to work hard to continue to support individuals throughout this crisis. And so

while they have been facing increased costs related to COVID-19, they have all remained open, continue to serve new individuals, and creating access and finding creative ways to keep individuals connected so that individuals can receive the supports and the treatment they need while also complying with the public health and safety guidelines.

I'm going to talk about a few things. A couple of updates that are non-COVID-related updates that I think would be of interest to the Board and to the membership. And then I want to highlight some of our COVID-specific updates for you as well.

The first update, and this is non-COVID-related, has to do with our substance use disorder long-term residential rates.

So back in July 2017, long-term residential services became a Medicaid benefit. But what we've heard in terms of feedback over these last couple of years from our provider community is that the base rate for reimbursement, the daily rate that supports that service, was insufficient in terms of covering their ability to fully provide the service. And so this past June we increased the rate, both the Medicaid rate as well as the State rate. The State rate applies to individuals who are not -- who are uninsured, including

those that are not eligible for Medicaid. We increased that rate from $84.40 to $130 per day. And so all of our providers, if they're billing Medicaid, they're billing our State Fee For Service Initiative, they're receiving $130 per day.

One of the things that is not only a requirement under the Centers of Medicaid or Medicare Services, but is also -- as an evidence-based practice is also a high priority for our Division is the utilization of medication-assisted treatment, particularly to serve individuals who have an opioid use disorder or alcohol use disorder. And so with that in mind and to really incentivize the use of this evidence-based practice, we have also embedded tiered incentives that have been made available.

And so for all agencies who have a valid Department of Health medication-assisted treatment certification on their license, they receive a $5 rate increase for all of the individuals that they serve where they're billing Medicaid or our State dollars. And as long as that license remains active, they will receive that $5 rate.

In addition to that, agencies will receive a $10 rate increase for providing medication-assisted treatment or arranging medication-assisted treatment

for a minimum of 40 percent of the individuals who are served who have an opioid use disorder or an alcohol use disorder.

So what that means is that in long-term residential treatment, they serve and treat individuals who have a myriad of disorders, substance use disorders, not just opioid use or alcohol use disorder. But what we will be doing is looking at the specific cohort of individuals who have an opioid use disorder or an alcohol use disorder that they've served over a period of three months. And then for the following time period, three months, they will receive a $10 rate increase for all of the individuals that they serve. And so a provider could receive as much as $145 a day more for the services that they provide. They may only receive $5 more if they have a certification. Or they could receive $10 more if they are arranging for individuals to receive MAT from an external provider if that provider does not have a certification on their license.

So in addition to that, we have also heard feedback from our ICMS, Integrated Case Management Services, providers. And as we transition to Fee For Service, the State dollars are reflective of what's billable under CMS. And feedback that we were hearing

from our providers is that they are -- and legitimately so -- that they are providing services over and above what CMS will reimburse. And so effective June 2020 -- and this is only with State dollars; again, these are services that are not reimbursed under case management services, target case management services under CMS -- is that we are providing a bundled rate of $54.37 per month for each person that receives a minimum of 30 hours, which translates to two units of service. Each unit has to be 15 continuous minutes of services for eligible ancillary services. And those services must be provided with the goal of either maintaining a continuity of care for that individual or helping them to maintain their community tenure or to avoid hospitalization.

So some of those ancillary services will include transportation. It may include sitting with an individual at the Board of Social Services as they're applying to get entitlements. It could be waiting in court. It could be a myriad of things that are, again, not supported by Medicaid but are still critical services to keep individuals successfully living their lives successfully in the community.

And so now I'm going to talk about a number of our COVID-19-related changes. And again, as I

mentioned at the top of my presentation, our community providers have really done a phenomenal job in stepping up to continue to provide services to consumers and to family members while adhering to guidelines regarding social distancing and how to keep individuals safe during this time period.

So one of the things that we did back in March is our providers were -- as they were incurring increased costs. As they were concerned about staffing during the time period of the pandemic, is that we converted -- we provided emergency monthly payments. So what we did was in lieu of our providers billing Fee For Service, we just provide a monthly lump sum to our providers to help to support the creativity that they were engaging in to keep consumers engaged.

Those emergency monthly payments were made between March of 2020 and September 2020. And in October, we transitioned back to Fee For Service. And we were able to do that because there were a number of other mechanisms and funding mechanisms that we have in place that will continue to support our providers at this time. And I'll be talking about those in a little bit.

So one of the additional changes that we made related to COVID-19 has to do with our opioid

treatment provider flexibility. And so with our opioid treatment providers, individuals can earn take-home methadone, take-home medications, based on their ability to demonstrate an ability to take those medications safely and to avoid diversion, such as family members and the like having access to them.

And so under SAMHSA guidance, Substance Abuse and Mental Health Services Administration guidance during the pandemic, we were able to provide guidance to our OTPs that would enable them to assess individuals and their ability to safely take medications at home and whereby there are some individuals who are able to take home 28 days of medicine, other individuals who are able to take two weeks home worth of medicine, and then others who were identified as at higher risk, they were coming in every other day as opposed to every day. And what that did is that it helped to reduce the volume of individuals who were going to our OTPs. But in addition to that, it helped to keep consumers themselves safe from having to travel using public transit and the like to get to the OTPs to receive their medicine. So this has worked out extremely well. We did not see, really, cases of diversion. And in essence, what we also saw was a slight reduction in the number of overdoses, overdose

deaths of individuals who are engaged in OTPs during this time period of flexibility. And this continues.

In addition, our OTPs were able to take advantage of telehealth services so that the counseling and things that are provided are provided via telehealth, enabling individuals to remain at home and still receive active treatment.

Another change that has taken place both on the part of Medicaid as it pertains to reimbursement as well our State in terms of reimbursement is telehealth and telecommunications. One of the things that we were able to effect through the pandemic is that consumers themselves were able to participate from a remote location such as their home. And the provider themselves, the clinician, was also able to engage individuals from a remote location such as their home, whereby continuing, again, to keep people engaged while keeping individuals safe as well.

And during this time period, audio-only communications are also permitted. So this really helped in terms of there are individuals who don't have access to a smartphone where they would have audiovisual. And so, again, through reimbursement of Medicaid as well as State dollars, audio-only communications were permitted.

And this is one of the changes that also helped in terms of our providers. And so as we transitioned back to Fee For Service, our providers are able to now bill for the telehealth and telecommunications in the fashion in which they're being delivered right now. And that's something that did not exist back in March.

Another source of funding that, again, is helping to support our providers in terms of their increased costs related to COVID-19 is that we're able to take advantage of the Federal Coronavirus Relief Fund. Specifically, our Division has $25 million to support providers who are under contract with our Division who are providing community-based services. So with the Federal Coronavirus Relief Fund or CRF funds, providers can receive reimbursement for COVID-related expenses, including COVID testing for those that they serve as well as their staff who have face-to-face contact with consumers, the frontline direct-care workers COVID-related emergency rate. So there's recognition that during this time period that frontline and direct-care workers, as they're coming into work, there's potential hazards that are related to that because of potential exposure to COVID-19. And although our providers are taking the care that they

need in terms of PPE, there's still a risk. And so any agencies who are providing an emergency rate to their frontline and direct-care workers, they're able to receive reimbursement for that.

There's also reimbursement for personal protection equipment, PPE. So providers are able to purchase PPE for those that they serve as well as for their staff who are providing face-to-face services, and they're able to receive reimbursement.

In addition to that, during this time frame in a transition to telehealth and telecommunications, our providers have had to incur costs related to purchases of hardware and software to connect and to have continuing engagement with consumers. So there will be reimbursement for reasonable purchases related to hardware and software that's HIPAA compliant.

And then also what we've heard is that although there's the lifeline that exists where individuals who are eligible can receive phones, telephones through that program, that there are individuals who were unable to access telephones through the Lifeline Program. So with this Coronavirus Relief Fund, the $25 million, providers can also purchase telephones for consumers as well as pay for their telephone service.

In addition to that, through the Lifeline Program, there are limitations in terms of the minutes that individuals have for talk and for data. And agencies can also, with the Coronavirus Relief Fund, pay an additional rate so that consumers can have unlimited minutes and data.

So those reimbursements for COVID-related expenses are retroactive to March 9th, which is when Governor Murphy declared the public health emergency.

And if there are any questions, the e-mail address that's listed here, individuals can submit questions to the e-mail address for any questions regarding the CRF funding.

In addition to that, we have been fortunate to be able to receive some additional funding here in the State of New Jersey, again, to support the mental health of individuals during this time period. So we received two different funding streams. One of them is from SAMHSA to develop a central coordinating entity to connect individuals who are feeling anxious and need more than just verbal support but don't need the more traditional mental health long-term treatment that individuals would be able to access independent private clinicians for brief treatment. That's about six to eight sessions. And so Rutgers will be the

coordinating entity for us with this initiative. We are now working with the Department of Consumer Affairs to send out a survey to independent practitioners, licensed practitioners, to ask them to join us in this effort to join the cohort of providers.

And then we've also, through FEMA, received $9 million for our Hope and Healing Initiative. With our Hope and Healing Initiative, we just received the award at the end of September, so the initiatives are beginning to roll out now. Every county of the State has at least one provider. Most agencies have multiple providers.

And this is an initiative that focuses on crisis counseling and public education. All other services provided through our Hope and Healing Initiative are free, and the services include psychoeducation, stress reduction, emotional support, coping skills, and also connections with community support resources.

So these are rolling out. I encourage individuals to go to our website and look under our disaster and terrorism branch. We will be updating that site as these services come online. But this is something that I would encourage consumers, families, neighbors, your staffs, anyone at all who is beginning

to feel anxious, feeling undue stress during the time of this pandemic. Certain those feelings are natural and normal and expected, but there are some resources out there for individuals to access to help to support them.

And then as a last slide, I just wanted to put front and center for everyone the different call lines that we have. So the Hope and Healing call line is operated by the Mental Health Association of New Jersey. It's the New Jersey Mental Health Cares line. That telephone number is there for you. They're available 8 a.m. to 8 p.m., seven days a week. Again, it's a free service. People who are feeling anxious, they call. And, please, I encourage you to share all of these numbers to anyone you have interactions with.

We also have a Helpline for the Deaf and Hard of Hearing, which is operated under St. Joseph's Hospital, their access services. And this is a videophone and also is providing mental health support, and it's available Monday through Friday, 9 a.m. to 5 p.m.

We have a New Jersey Suicide Prevention Hopeline that continues to operate 24 hours a day, 7 days a week. And the telephone number is there.

And then our ReachNJ for access to substance

use disorder treatment, that also continues to operate 24 hours a day, 7 days a week, and that telephone number is there.

And then the last slide, please, that's just our contact information. I provided you with the website address to our homepage. If you go to our homepage, about two-thirds of the way down into the homepage, you will see all the coronavirus relief initiatives and links to our guidance documents as well, so you can get more detailed information there.

So, again, thank you so much for providing me with the opportunity to come and share some of the things that we've been involved with. And, again, I just want to express my deepest gratitude to our provider community who has remained open and actively engaged in providing services and treatment to individuals during this time period.

DR. SPITALNIK: Assistant Commissioner, our gratitude is to you for your leadership in the circumstances and for this excellent presentation and encouraging information about the resources that are available.

We do have some questions already. So what I'm going to do is encourage members of the public, if you have questions about the presentation and about

mental health services, to type them into the Q and A. I'm going to read some text questions I have from Wayne Vivian, and then I'll turn to Mary Pat Angelini who I believe has questions.

So if I may, I'll start. There are three questions.

Are you going to extend contracts past 12/31/20?

ASSISTANT COMMISSIONER MIELKE: Yes. So, Wayne, yes, we are. And so correspondence, I believe, has gone out. If not, it will be going out. And so our State Fiscal Year contracts will be extended to June 30, 2021.

DR. SPITALNIK: Great. Thank you.

Next, in 2020, are CSS provider agencies still going to be required to meet Medicaid reimbursement requirements or have to surrender contract dollars back?

ASSISTANT COMMISSIONER MIELKE: I'm not quite sure I fully understand the question. And so, Wayne, maybe we can talk offline. But in general, in terms of Medicaid billing, our providers do need to continue to follow any of the rules and requirements related to Medicaid billing.

Now, as I mentioned, there's been some

greater flexibility as it pertains to telehealth and telecommunications, so certainly those are billable services now that were not billable prior to March during the pandemic. But maybe we can talk offline just so I fully understand the question.

DR. SPITALNIK: And I think a corollary to that, I'm not sure you can answer it. Are individual CSS provider agencies going to negotiate their contracts if they're asked to pay back contract dollars for not generating the required Medicaid revenues due to the pandemic?

So I don't know if that lends itself to a response now or that you will follow-up.

ASSISTANT COMMISSIONER MIELKE: One of the things that I'll mention, Dr. Spitalnik, is that we have, to the extent possible, always sat down with our providers when they've seen a significant change in Medicaid billing. What I will share is that the State budget is really challenged and really challenging this year. Governor Murphy certainly has been out there talking about that. There's been some significant savings and reductions across the State. And in terms of our budget in the Division of Mental Health and Addiction Services, we also had some reductions. They don't result in less consumers being served. We were

able to leverage Medicaid billing over and above what is projected to use that as savings. So I just say that to say that there may be some less flexibility currently just because of the -- whatever we negotiate has to be within the resources that we have available to us.

DR. SPITALNIK: Thank you so much.

Mary Pat Angelini, with some questions?

MS. ANGELINI: Thank you very much, Deb.

Val, I want to thank you very much for the recognition of the provider agencies. For the most part, everybody rally pivoted very quickly to providing services in a new and different way. So I appreciate the recognition.

The one question I had is about the continuation of telehealth and telecommunications. I strongly -- I'm sure you heard this before -- urge, advocate for this to become a staple. So I don't know if you've got any insight into that. We keep hearing mixed messages about when it will end, if it will end. So any light you can put on that?

ASSISTANT COMMISSIONER MIELKE: Thank you, Mary Pat.

Our ability to support the telehealth and telecommunications has really been multiprong, one of

which had to do with the Legislature who passed emergency legislation enabling individuals, consumers that we serve, to remain at home because the previous statute required them to come into the clinic. And that was emergency legislation that was related specific to the public health emergency.

Secondarily, I also know that in terms of SAMHSA and CMS, that they also provided guidance and flexibility that enabled us to be able to offer this to our stakeholder group. So it's really hard to say in terms of what things will look like going forward because there are many different influences that has enabled us to be able to provide telehealth services and telecommunications the way that it is. I also think that it -- my recollection is it also required some emergency action on the part of DCA as well to enable it.

So I don't know if my colleagues at Medicaid want to comment further. I don't know if they have anything to share as it relates to Medicaid billing and CMS, but just in terms of high level, there are a lot of different influences, so it's really hard to say what it will look like going forward.

What I can share, though, is that I've been on calls with the Assistant Secretary of SAMHSA and

we've talked about this. And as a doctor, as a clinician, she certainly recognizes the important role that telehealth has played during this time period. She also recognizes that the importance of the milieu of individuals coming and receiving services face-to-face. And so what that telegraphs to me is that they may be interested in seeing like a hybrid-type model that includes both rather just eliminating one or eliminating the other. But, of course, she's not speaking for CMS. That's just her perspective as the Assistant Secretary over SAMHSA.

DR. SPITALNIK: Jen, please.

ASSISTANT COMMISSIONER JACOBS: I was just going to add on to what Val is saying. Thanks, Val, so much for that presentation generally and for your partnership on all this.

I think Greg will talk in a little bit in a few minutes about our work on the continuing flexibilities that we've been able to tap into during the public health emergency. So he'll talk to this in a little bit broader context. But what Val is describing right now is absolutely true, that people are evaluating just what makes sense for going forward making sure that we get the best care for people during these unusual times.

MS. ANGELINI: Thank you. And my final comment. We have really had very surprising positive responses from our clients and consumers, particularly our older clients that don't feel comfortable coming back and are really benefitting from telehealth. I was pleasantly surprised because I wasn't sure how this was going to work. And even in our substance use disorder departments, we've had very good success. So I'm sure I'm not the only one voicing that. Thank you very much.

Thank you, Deborah.

DR. SPITALNIK: Thank you. Mary Coogan, please.

MS. COOGAN: Assistant Commissioner, I just want to echo everyone's thanks. I think it's really helpful.

One quick question. On the SAMHSA program that you mentioned and you said something did DCA is surveying providers to see if they're interested in participating. Do you have any sense of when that program might be up and running?

ASSISTANT COMMISSIONER MIELKE: I don't. I fully anticipate that the survey will be out very soon. And then Rutgers will be able to begin to identify the clinicians for that service.

So I don't know at this time, but we want to get it up and operational as soon as possible. It's just a number of things that need to occur before that takes place.

DR. SPITALNIK: Any other questions from the MAAC?

There are questions in the question box, but they don't pertain to this presentation.

So with that, I want to extend Wayne's text thanks for your responsiveness, and from all of us for this excellent presentation and, again, your leadership and our gratitude for the stress that you're under in helping all of us deal with our stress. So thank you again, and we look forward to your being with us again soon. So thank you very much, Assistant Commissioner Mielke.

I now turn to Deputy Commissioner Sarah Adelman, who will give us an update on nursing facility legislation.

DEPUTY COMMISSIONER ADELMAN: Thank you, Dr. Spitalnik. And good morning again, everyone.

We did want to provide an update to this group about the status of a number of long-term care reforms and initiatives that the Department of Human Services is or will be implementing over the coming

months.

As many of you may know, earlier in COVID-19 public health emergency, the Department of Health engaged to make a series of recommendations to the State about measures we could take to strengthen and support long-term care resiliency. Our departments have been working to implement a number of those recommendations, many of which required or really benefited from legislative authority. So over the last couple of months, the Legislature has passed and the Governor has signed several bills to help address some of the systemic challenges and mitigate the impact of COVID-19 while strengthening preparedness for future outbreaks at our nursing facilities. There are still other bills moving through the legislature and being considered as well, so we know their work is not done.

I wanted to look back to last year for just one moment before I talk about looking forward. As you may be aware, last year, our Department took measures to establish a new nursing facility Medicaid payment floor that increased payments to some of our historically lower-paid nursing facilities by as much as $30 per day per Medicaid patient which resulted in annual increases on average of about a hundred dollars for impacted facilities. We also created a new quality

incentive payment program for facilities which provided about $20 million in new payment incentives to nursing facilities based on a series of nationally identified quality metrics and a patient and family satisfaction survey that's conducted by our Division of Aging Services. And these quality incentive payments averaged in about 60,000 more dollars on average in reimbursement for eligible facilities last year.

And then thirdly, we implemented an across-the-board payment of $30 million for facilities subject to our nursing home provider assessment.

I mention this because these funding initiatives represented an important step for our Department last year in our goal to align nursing facility care and quality with our payment systems in Medicaid. And our goal was to build on those initiatives this year and to help facilities particularly respond to the current public health emergency.

So in this new kind of unusual nine-month State Fiscal Year, we have added an additional $130 million to nursing facility rates which represents an increase to every nursing facility of 10 percent of their last year's rate. This new Medicaid funding began October 1st and continues through June 30th. And

this funding is tied to some specific expectations, a little bit different than the investments we made last year.

For the increases that nursing facilities received this year, 60 percent of a nursing facility's funding increase will be required to be used to increase wages for certified nurse aides. As I think we are well aware, CNAs are truly the backbone of nursing facility staff. They provide close to 90 percent of direct care and assist with really intimate and personal tasks like dressing and bathing and toileting. CNAs do challenging work, and we've all seen the dedication and commitment of this workforce throughout the pandemic. So this funding increase from Medicaid can help facilities recognize this work and increase wages in this workforce.

The other requirement for the spending increase this year that 60 percent is for CNA wages. The other 40 percent is intended to help nursing facilities and support new costs that they're incurring as a result of COVID-19, things like PPE, testing, cohorting, and hiring infection control specialists and things like that. Those funding increases will also help them comply with the costs of various preparedness and response requirements from our Department of

Health.

So there was legislation that passed to help us do all of these things. And the legislation and the appropriation does call for Medicaid to recoup any payment increases that we issued to a nursing facility if they did not comply with the requirements of the law. So if they did not pass through the wages to CNAs as expected or if they didn't meet and attest to the specific Department of Health infection control requirements, including if a facility is cited for repeat infection control violations, Medicaid will be working to recoup those funding increases.

So we've rolled out these new rates over the last couple of weeks. And that's the major one to highlight for the group at this point. But there are a number of other legislative requirements that we are and will be working on over the coming months. Just to highlight a couple of big ones for the group.

From the legislative package, we will be commencing a rate study that looks at the long-term care landscape, including some understanding of the acuity of our MLTSS population in New Jersey. And we will be reviewing Medicaid's options for value-based purchasing in long-term services and supports and nursing facilities looking at our existing quality and

incentive payment program to identify ways that we can evolve it going forward and to also evaluate the continuation of our Any Willing Qualified Provider requirements which is really a provision in our program that requires our Managed Care Organizations to contract with any nursing facility willing to participate in the Medicaid program.

So all of these were our requirements from the legislature that we'll be undergoing over the coming months. We do anticipate significant stakeholdering around all of these issues and time to talk to your various groups and to the MAAC more in the coming months and potentially at the winter MAAC meeting.

So at a very high level, those are some of the things that going on right now in DHS to implement the various provisions both in the report recommendations and the new requirements from the legislature.

Those were all of the prepared comments I had, Dr. Spitalnik.

DR. SPITALNIK: Thank you so much, Assistant Commissioner.

There is a question from one of our stakeholders public.

If a Medicaid paid nursing home resident or their doctor has a concern about infectious disease in the facility on a temporary basis, would Medicaid consider a longer bed hold and temporary transfer to a community setting with MLTSS until such time as the outbreak is under control? This is not just for COVID, but for flu, norovirus outbreaks as well in facilities. Some residents are immunocompromised and are looking for temporary options that assist their well-being.

I don't know if that's a question for you, Deputy Commissioner, or for the Assistant Commissioner.

DEPUTY COMMISSIONER ADELMAN: Jen, please feel free to jump in, too.

I would say that on examples like that, those are things that folks should feel free to reach out to Medicaid about and to our Division of Aging Services. We have on a case-by-case basis looked at requests like that. There's a little bit of devil in the details of some of the terminology you talked about. So as folks may know, New Jersey does not pay for bed holds, but there are some expectations about a nursing facility's requirement that a nursing facility allow people to return home after a period of time. So we can look at that question as a follow-up to this in maybe more specific detail with the person who asked

the question. But we would look at those things on a case-by-case basis.

I don't know, Jen, if you want to add anything to that.

ASSISTANT COMMISSIONER JACOBS: I just agree with you, Sarah. We've had a number of cases of members who asked to take a leave from the facility in which they were residing, typically to stay with family, but also under other circumstances. So we've worked with the Division of Aging, our Managed Care Organizations, Care Management Programs, and then the long-term care ombudsman, depending on the circumstances, to make sure that we're addressing the individual's needs.

DEPUTY COMMISSIONER ADELMAN: I will say while we're waiting for Dr. Spitalnik, if there are any other questions that we have set up a process for nursing facilities to submit questions to the Department if they have specific questions about how to implement various provisions of the rate increase, and we've been doing some webinars with the nursing facility industry to make sure they understand the various requirements and feel supported on how to report on those things. We are trying to make these new changes as easiest as possible to implement because

we know there's a lot on everyone's late right now. So if there are nursing facilities who have specific questions for us, there is an e-mail set up and you can go get all the information about these new requirements on our Department's COVID-19 web page. We have lots of information about what I talked about in much more granular detail than what I went over here.

ASSISTANT COMMISSIONER JACOBS: Sarah, I have a message from Dr. Spitalnik indicating that she's having technical difficulty. I think she may have just dropped off and she's trying to get back in. So if I could, I would like to see if we have any questions from the members of the MAAC. And then there are one or two questions that I can pull out of the Q and A after that. I'm just scanning the virtual room here to see if we have any questions from the MAAC.

In the Q and A. Sarah, we have someone asking about the timeline for updating the value-based payment program and implementing changes. I don't know if we're in a position to speak to specifics on the timeline yet.

DEPUTY COMMISSIONER ADELMAN: Yeah. I think one of the challenges, very candidly, with the group here is that the timeline in the legislation doesn't necessarily align to the new fiscal year process. So

this is a shorter fiscal year. And we in our departments and with Treasury begin preparing for next year's budget now. And so I think as we evaluate these things and go through the timeline that the legislation has implemented, it may be that in preparing for the next fiscal year, which begins in July but is designed right now over the next month or so, we probably won't benefit from some of the changes of we're evaluating right away because we need some time to do that process. I don't know if this precisely answers the question, but I would say that over the next weeks, the Division of Aging Services will still be going through all of the process that they would in a normal fiscal year to collect all the requirements for our current quality incentive payment program, including conducting the family and resident satisfaction survey. Those are the things that we have used over the last two years since we started this program to design and implement our quality payments from your year. So we intend to do that for this upcoming budget while we are looking at how to grow the program going forward. So we'll be doing those things kind of concurrently, and we intend to evaluate Any Willing Qualified Provider and the Quality Incentive Program and our various value-based strategies and options at the same time over the coming

months.

DR. SPITALNIK: Thank you. My apologies.

Any other questions from the members of the MAAC? Seeing none from the public.

Thank you so much Deputy Commissioner, not only for this presentation but, of course, for everything you're doing on behalf of all of us.

We will now move to a presentation by Greg Woods, Chief Innovation Officer, on the COVID-19 program impact.

And before I turn to Greg as he unmutes, I should have announced we will have a hard stop on our meeting at noon. We had a little cut-and-paste typo in the agenda, but our meeting is from 10 to noon.

So with that, I turn to Greg and welcome him and ask for his presentation and also to tell us what his very interesting backdrop is.

MR. WOODS: Thanks, Dr. Spitalnik. My backdrop is actually the Trenton skyline. I thought, like many of you, I'm struggling with having small children going to school in the same house where I'm working, so I wanted to spare you seeing the various domestic mess behind me, so I thought the Trenton skyline would be a fitting background.

So recognizing we do have a hard stop at

noon, I'll try to be relatively quick here, but happy to take any questions.

During the last MAAC meeting, I had given a presentation on a number of different flexibilities that Medicaid has obtained from our federal partners at CMS during the COVID emergency. I won't repeat all of that now, but just suffice to say there's a number of different legal authorities that put together in a somewhat confusing patchwork and a number of different processes we needed to go through with CMS over the course of the late spring and early summer to make sure all authorities were in place.

Many -- not all, but most of these authorities are tied to Federal Public Health Emergency Declaration. So this is the declaration that the federal HHS Secretary makes that a public health emergency exists. And these authorities continue so long as that public health emergency is in place.

The good news that earlier this month, the HHS Secretary did extend that Public Health Emergency Declaration for an additional 90 days. So it was actually scheduled to expire this week, and now it has been extended another 30 days which brings us into the middle of January. So those emergency authorities will remain in place at least through then. So that's good

news for us.

What we have been doing, though, is since we don't know whether the public health emergency will end January or whether it will be extended again. If so, for how long. We internally have begun a process of looking at each of those authorities and thinking about what does happen when the public health emergency ends. And I think, in general, these things with fall into a few different buckets. Some of them, I think, when the public health emergency is over that there won't be any continued need for them. We'll need to think about transitioning out. And I think in some instances we will want to look at whether some of the innovations that we've pursued during the public health emergency are things that make sense to continue in some form even after the pandemic is over.

So that's the process that we're going through now. I think we would really encourage MAAC members and all stakeholders on this call, if you have specific input on individual flexibilities or changes that we've undertaken during the public health emergency and how we should be thinking about the end of the public health emergency, we really welcome that input.

I did want to briefly call out two specific

areas of focus. One is telehealth, which I think we've already heard on this call and we have heard generally from stakeholders that this is sort of a silver lining of this crisis is that we have really moved very quickly to allow more services to be provided via telehealth and actually work well for certain services and certain beneficiaries. So I think the good news here is that CMS, our federal partners, have indicated a real openness to continuing additional flexibility around telehealth permanently. I do think what we need to do here and what we're in the process of doing is go service by service. The one caution I would give is there is both a federal component to this, sort of what our federal partners will allow. There's also a State law and regulation component for many services. And I know the Legislature has been looking at options around that. And so I think it will need to be sort of a new service-by-service process to look at what's appropriate in a post-pandemic world. But that's something that we have been engaged with internally and certainly welcome any input from stakeholders in that.

The other thing I wanted to call out was eligibility redeterminations. Per the terms of the Family First Act, which is one of the federal relief bills and sort of per hour policy, we have not been,

with very limited exceptions, Medicaid members have not been disenrolled during the public health emergency regardless of whether they completed an eligibility redetermination.

When the public health emergency ends, we're going to need to look at sort of how we can begin those redeterminations again. I think we and most states said that it's not realistic to do them all at once when we've had nine or more months of what would have been sort of normal eligibility redeterminations that are there in the backlog. We're going to need to come up with a strategy. We're waiting for additional guidance from our federal partners on that. That's something they have promised is coming, so we're hoping to get a little bit more clarity there. But that's another area where we know that special planning to think about how to transition out of the public health emergency is going to be needed.

I'll stop there on that, and then I guess I can give the enrollment update and then take questions.

Briefly, we just wanted to give a quick update on what we're seeing in terms of Medicaid enrollment trends during the pandemic. As the slide shows, since February, enrollment has gone up quite a bit, about 10 percent over the last six months. Our

current enrollment is about 1.85 million, and that's higher than it has been over the last five years.

The one point I would just make about this, this is obviously multifactorial and it's always a little bit hard to disentangle different causes of what's driving enrollment changes, but I think what we've seen thus far is that the biggest driver of this is, as what I referred to earlier, that during the public health emergency, we are not disenrolling or only disenrolling members in very limited and specific set of circumstances. And so because of that, people are staying on the program. In addition, we are still getting sort the normal volume of new members coming in. And so when you put those two things together, that drives our overall enrollment up.

I will say to date, we have not seen a massive surge in new enrollments sort of tied to the economy. That's not to say that we won't see that, and think we're planning for all eventualities, but to date, it's sort of been a combination of continuing ordinary new enrollment combined with preserving people on the program during the public health emergency.

So with that, I'll stop and take any questions.

DR. SPITALNIK: Thank you so much.

Are there questions from members of the MAAC? Beverly and then Mary, please.

MS. ROBERTS: Thank you.

And thanks so much, Greg, for this report.

Two quick questions. The first is a very specific question on redetermination. So if someone is getting a redetermination letter, I talked to somebody recently, NJ WorkAbility redetermination was due in November. There have been issues with the family. And she actually called to request an extension on that and called four times. No one's called her back. So my question is should people just not worry about a specific November deadline for mailing in the redetermination paperwork?

MR. WOODS: We'd be happy to look at a specific case offline.

And, Jen, you should also weigh in on this.

I think, in general, there's going to be some variation. Some redeterminations are taking place, but what I think is important to emphasize is regardless of the outcome of those redeterminations, people are not going to lose coverage during the public health emergency. And so I think if the question is should they worry about losing coverage, the answer is no.

MS. ROBERTS: Also, just to have an extended date, is it something where she can request it in some way so that the computer shows that she didn't get it in late?

ASSISTANT COMMISSIONER JACOBS: I think would help us to look at a specific case or the set of details rather than trying to answer generally. But I agree with Greg, you know, the counties are really trying to keep up with their work. And so there's some redetermination activity that's going on and people will want to be responsive to that. But as Greg said, I think the message we all want to send very clearly is you will not lose your eligibility during the public health emergency. So I think that's where we want to focus generally. But we also want to be responsive to specific cases and give people answers to their questions. So if it's not one that we can answer directly with the details you have offline, Bev, we can go to the county on it.

MS. ROBERTS: Okay. Terrific.

And then my second question, Greg, you said almost nobody is being disenrolled. But then you said there might be some people and I'm just curious -- I thought nobody would be disenrolled during the pandemic.

THE WITNESS: So there are some very limited specific exceptions. This is based on the federal rules. And I should say, I was a little bit speaking like a bureaucrat. One reason, obviously, people are disenrolled if they pass away, they're no longer on our rolls. There are some very limited exceptions around voluntary disenrollments where someone calls us up and says we no longer want Medicaid. It's not a big number. And no one is being disenrolled because they've loss eligibility or some of the normal reasons that we see people coming off.

MS. ROBERTS: Thank you. Thanks very much.

DR. SPITALNIK: Mary, please.

MS. COOGAN: High. Thank you for that update. I guess I'm a little curious as to why the numbers of FamilyCare, the enrollment numbers, are not even higher, given all the people who are unemployed. So just in terms of outreach, I remember reading there some grants that have been sent out to encourage groups to do some outreach, which is wonderful. But when people apply for unemployment, are they being told about FamilyCare? What do you think is the reason that we haven't seen like a 50 percent increase? I mean, that's a little extreme, but given all the people who have been laid off from work why we're not seeing more

people even rolling in FamilyCare?

ASSISTANT COMMISSIONER JACOBS: That's a really good question and one that Greg and I have talked about both in the context of our own organization here in New Jersey, but also with Medicaid programs throughout the country. And there are a number of different ideas about why we aren't seeing more new applications coming in for Medicaid right now. And so examples of that across the nation, for one thing, people have not been focused on going out and using health care. They have largely, especially early in the pandemic, been staying home and not thinking about that. So that was one sort of plausible reason. Another is that these may be individuals who have become unemployed during this time may be people who were, in fact, uninsured already and hadn't accessed FamilyCare or other programs.

So that's where the outreach is really important. And I would use this opportunity to just underscore the launch of the State-based exchange and the open enrollment period that's starting November 1st. There is now a lot of communication happening about that. We're expecting a significant number of referrals. And we have been working with the counties and our health benefits coordinator to make

sure that we're ready for that incoming volume. So I do suspect -- and Greg or Sarah, feel free to jump in -- but I do suspect that the next time we meet with you, we will see that increase in volume coming through in our enrollment numbers.

DR. SPITALNIK: I know Sherl has a question, but there was a question typed that is germane to the last comments.

Do you have specific data indicating how much is due to the moratorium on terminations and how much due to new enrollments?

MR. WOODS: I can take that back. I think it's a little bit tricky sometimes to disentangle the two things. And so we sort of have to look at hints in the data. Each month, we can certainly look at how many people enrolled and how many people fell off our rolls. And as I said, that latter number is not quite zero, but it's pretty close to zero recently. Sometimes it can be a little tricky because we don't know what the counterfactual would have been. We don't know if some of the people who under ordinary circumstances would have disenrolled and might have reenrolled a few months later. So it's a little hard to be numerically specific about this. But I think we can go back and look if there is additional information

that we can share. We're trying to put the puzzle pieces together looking at a few different indicators to tell a story about what is happening here.

DR. SPITALNIK: Thank you.

Sherl, you have a question.

MS. BRAND: Thank you.

I'm interested to know, again, because of the public health emergency, are you seeing because of limited resources any backlogs related to the Medicaid application process?

ASSISTANT COMMISSIONER JACOBS: That's a good question, Sherl. So we have been meeting with the counties every week during the public health emergency, and we have snapshot reports where we've been tracking their inventory levels and the pending applications aging and that cues. So I would say to you that early on when the counties shut down suddenly, particularly up north where there was just tremendous impact on the workforce that would be processing Medicaid eligibility, we did see some impact on production. But they quickly got back into the game. Like us, they had to move many of their employees to remote work. And then they also set up special arrangements inside their offices so that they had safety in their workplace and could bring people back. As soon as they did that, we

started to see improvement again. So late spring, early summer. And I actually have the report on my wall and we watch it every week and we have been seeing progress across all of the counties and really getting them caught up. And that's important because we have been anticipating an increase in application volume. We wanted to make sure they were ready for that and not backlogged at all.

So I would say that they have really been doing a good job staying on top of inventory and moving applications as quickly as they can while also giving people the opportunity to send in missing information and making sure that they were actually really fully processing each application.

DR. SPITALNIK: Thank you. There's a comment that redetermination letters threaten the loss of coverage in their format and a request that all county form letters need to be reevaluated so as to not to cause undue panic.

I'll turn to either of you. Is this something that you've been hearing as an issue?

ASSISTANT COMMISSIONER JACOBS: We did hear that issue. I think Bev was the one who brought it to us originally. There's a particular letter that goes out that Bev identified a concern with. We've taken

that letter offline, so it's not going right now. We just pressed pause on it. And we're looking at what language we can include with that letter to show that you will not lose eligibility during the public health emergency, that we're maintaining eligibility, but also to encourage people to keep up with that renewal process so that we don't end up in a compliant situation going forward. So we're working on that language. And then we will look at other letters that may also benefit from the inclusion of that messaging around the public health emergency.

DR. SPITALNIK: And in a similar vein around enrollment, is there an update on the new web portal for enrollment?

ASSISTANT COMMISSIONER JACOBS: So, yeah. This is referring to some online functionality that we have created that will allow our county eligibility workers and also people who are assisting others in doing their Medicaid applications to complete those applications, that process, online. And so I would say to you it's really a modular approach, and there are components of it that have come online that are in active use by the counties, and then there are a component or two that are still in testing. And so just to be really specific, when the counties get a

paper application, which many people still prefer to use, and that's fine, we really want the data entered into our one single system so we have a level of transparency about that. You'll remember Senate Bill 499, right? If Amazon knows where my package is every minute, then you should know where my Medicaid eligibility is. So we need everybody in one system with some transparency. And so we've set up that system now so that the counties can enter both imagine MAGI and ABD paper applications into the system. People can also apply online. So ideally, everything is now coming through that online environment.

What is still in testing is the assister portal, and we're working with one of our large nursing facilities systems to test that. And that really is I am entering multiple applications for the people who are residing in my facility. I need to be able to check status on all of them. I'm not an individual, I'm supporting these individuals. And so I need a roster essentially and what is the status of each application on my roster.

And then there are some back-end components also in testing that are going to facilitate a smoother processing, really make a more efficient verification process for our county workers. And so that is also

nearly complete. So the answer is work in progress, but you can see because it's modular that pieces are at different points along the way.

DR. SPITALNIK: And if there are concerns about redeterminations, what's the best contact? What procedure should people follow?

ASSISTANT COMMISSIONER JACOBS: The real best contact is going to be the county that's doing that redetermination. And then if you have a challenge reaching the county or if the answer you receive from the county is not making sense to you for one reason or another, then we have the availability of the Medicaid team based in Trenton to support you on that. So we can provide Director's referral mailbox to folks, but I would also suggest you all have the MAAC mailbox and you could send a question through to the MAAC. So either way will work.

DR. SPITALNIK: Thank you. From Mercedes Witowsky from at the DD Council, a question about continuance of flexibilities.

Many families of individuals with IDD or anxious about the end of public health emergency as it relates to DDD flexibilities like parent, spouse, guardians as self-directed employees and access to provider-managed virtual services. Both have been

critical during the public health emergency but are flexibilities their families hope will continue beyond the public health emergency. What would be contact information that individuals and families could communicate these concerns?

MR. WOODS: We've been working very closely with our partners at the Division of Developmental Disabilities. And I would encourage that kind of input to be sent both to me and to DDD. I can put my e-mail address. I don't think it's on the slide, but I can put it in the chat if that would be helpful. And the more detailed feedback about what's working and what specific things the stakeholders are looking to see continue would be more helpful.

DR. SPITALNIK: Thank you. One last question, both because of topic and time.

Are you allowing Medicaid contract changes during the public health emergency period?

ASSISTANT COMMISSIONER JACOBS: I would want to make sure I'm answering the question that's being asked. We are certainly making changes within our managed care contract during the public health emergency, and CMS hasn't put any restrictions on that. I hope that's answering the question, but I do want to encourage a follow-up if I didn't.

DR. SPITALNIK: I would courage the follow-up with more specificity again to the MAAC.

Thank you very much.

Greg, I'm delighted to see the Trenton Makes Bridge. I haven't seen it for a long time. And certainly, all the work that's being done does give voice to the idea that Trenton, however remotely, does make.

We'll now turn to Carol Grant the Deputy Director of DMAHS for an update on New Jersey FamilyCare autism services.

Carol, welcome.

DEPUTY DIRECTOR GRANT: Thank you. Happy to be with you this morning.

At least autism benefits is new and we think kind of exciting that we're providing this and non-COVID. So that's a bit refreshing.

I just want to do a little reminder about the new benefit. The Division of Medical Assistance and Health Services in collaboration with the Children's System of Care really launched this new program to support families with children who have been diagnosed with autism spectrum disorder. It is an EPSDT benefit for all New Jersey FamilyCare plans for children diagnosed with autism spectrum disorder under

the age of 21. These services may be provided in a therapist's office, community setting, or in a child's home.

I want to remind you about the timeline. We actually began a number of these benefits in January of 2020. Seems like years ago. Services include physical therapy, occupational therapy, and speech therapy, sensory integration, community assistive devices and therapies, skill building and capacity building, which remains still with DCF, and clinical outpatient services.

The transition to Managed Care and the inclusion of Applied Behavioral Analysis or ABA began in April 2020. And in July we added developmental and relationship-based intervention therapist. So we have a pretty well-rounded package of services designed to serve children with autism spectrum disorder.

I just wanted to give you some initial utilization information. There will be more to come, and we will follow this in subsequent MAAC meetings. So between the period of 1/1/20 and September 30 of '20, from Managed Care encounter data, in ABA we've served 592 recipients; PT, OT, and speech, 1581 recipients; clinical therapy, 915 recipients, which includes DDD and MLTSS members only; sensory

integration, 53 recipients; and the DIR services, currently enrolling. We're spending some time in making sure people understand the available options that include ABA and these other therapies, including DIR. And we believe that over time, these services will, in fact, grow and be better utilized.

In terms of the Department of Children and Families and Fee For Service claims, skill acquisition and capacity building services, 616 recipients; and clinical therapy, 1965 recipients, which includes all non-DDD and non-MLTSS members.

So this program is actually in a growth process. It's a relatively new benefit to Managed Care, so we're really helping members and providers to be able to navigate the program, to know about the program.

For members: Developing online educational tools to assist families to identify and understand available services -- people have options -- to provide online access to autism spectrum disorder organizations and resources, and to expand available networks, which is where we are now. We transitioned a number of benefits from the Division of the Department of Children and Families and Children System of Care, and now we are, in fact, growing that network within

Managed Care.

This is Medicaid. We have lots of rules. People need to learn those rules to effectively participate. We want to make that as easy as possible for them.

So on the provider side, we're sort of doing I'd guess you'd call Medicaid 101 for people who have not been familiar with the Medicaid system before. Educating providers regarding things like coordination of benefit requirements and prior authorization procedures. And MCOs are providing targeted provider training to help support providers as we grow this network.

Our goal is to have it be robust so there is access and ability to families whose children need these services.

And basically what we have for today.

DR. SPITALNIK: Carol, thank you. We're excited to see that this is moving along.

Could you please explicate what services are provided through the Managed Care Organizations and what services do families have to access through PerformCare and the Children's System of Care?

DEPUTY DIRECTOR GRANT: It's really the skill acquisition and capacity building CMO, SEL,

intensive in-home, and the clinical therapies, because children may need more than the EPSDT benefit in managed care which is ABA, the PT, OT, and speech and sensory integration and so on. It is expected and we have grown this benefit and started this benefit understanding we needed a close collaboration with our sister department and Children System of Care. The thing is you may start with Managed Care benefits on the one hand and a child may need sort of a deeper dive into more intensive care management, more in-home supports, and things like that. So we try to work hand in glove so that there is a comprehensive plan of care for that child.

DR. SPITALNIK: Thank you for that. And we're appreciative of that. I think the question I'm asking is: I'm a family who receives FamilyCare. My child gets an autism diagnosis. I'm told with the diagnosis that they're going to need therapies. How do I know which door to knock on?

DEPUTY DIRECTOR GRANT: These are Managed Care enrolled families, and they should start with their Managed Care plans who will also link them to other services as they are needed.

DR. SPITALNIK: Great. Thank you so much.

Bev, do you have questions?

MS. ROBERTS: Yeah, a quick question, because I know time is of the essence here.

You talked about online information for families. Is there one website at this point that we could direct families to that would really provide for families that want to be starting this process, what they need to know?

DEPUTY DIRECTOR GRANT: There's probably multiple doors. Obviously, we have information out on Division websites. The Managed Care companies have them as well. The one thing that we didn't mention is that we're able to reconvene the executive steering committee that really helped to design this benefit. And I think we would definitely continue to be working with that group and with others to determine how best to give information to families so that they can make the most effective use of this benefit. That group will be meeting quarterly. They've had one meeting already. It got a bit interested due to the pandemic. But I think that we're very interested in hearing people's input about how information might best be conveyed and provided to them. So if you would help us with that, that would be great.

DR. SPITALNIK: Thank you so.

MS. ROBERTS: We'll be happy to get it out

there with whatever the best information is to distribute.

DR. SPITALNIK: Thank you. I'm going to close this section with a question and turn to either Jennifer or Greg. Access to children's hospitals that's been raised by the New Jersey Health Care Coalition and New Jersey Family Voices.

ASSISTANT COMMISSIONER JACOBS: I can take that Dr. Spitalnik.

The question was about children's hospitals being included in managed care networks and in particular out of state children's hospitals. So I think there's a long and short answer there, and I'm going to stick to a more efficient answer for the sake of time. But though Managed Care Organizations are required to have the network in place to serve their members and also to make sure that all members get the services they need regardless of that network. And so there are technical conversations about network adequacy that are going on every day to make sure that the health plans are compliant with those requirements. And then there are individual case conversations that are occurring between DMAHS personnel and health plan care management. And so anytime someone has a concern about access to care or services, we are eager to get

that and deal with it early rather than having something out there lingering and being a problem and causing stress for a family. So we would encourage you to reach out to us. The plans have both instate and out-of-state providers, adult and pediatric, but they won't have every provider. So I would just remind you, there's a technical component about the adequacy of that network and then there's also the individual case component. So it's really, really helpful for us to have these conversations about specific concerns so that we can make sure that they're being addressed.

DR. SPITALNIK: Thank you so much.

We're now going to turn to our last segment about initiatives and planning and implementation. I also want to call the stakeholders' attention to the chat where Greg Woods has provided his e-mail address for input around flexibility and other issues.

So Jennifer Jacobs and Greg Woods, we turn to you for these three initiatives.

ASSISTANT COMMISSIONER JACOBS: Thanks, Dr. Spitalnik.

Greg, would you like to kick us off here?

MR. WOODS: Sure. I want to talk just for a minute, and I'll try to be brief, given the time, around our 1115 Demonstration renewal planning. Just

briefly, I think many of you are familiar with this, but New Jersey operates under the authority of a Comprehensive 115 Demonstration. This is something that has been negotiated between our federal partners at CMS and the state. Our comprehensive demonstration is 10 years old almost. It started, I think, in 2012. It is approved in five-year periods. So we were approved for one five-year period back in 2017. We were renewed for a second five-year period. Now we are coming on the end of that second five-year period in the middle of 2022. And so that working backwards from there, that means we need to be planning right now fairly and sensibly around what we want the third five-year period to look like and beginning that program development process.

In the interest of time, I'm not going to go into a ton of detail about what's currently in our 1115 Demonstration. But as you can see here, we have some examples. It gives us the authority to implement the key Medicaid program element innovations, including all of our ACDS programs and also some of the other SUD community supports, the several what I think we would all consider core parts of the Medicaid program in the State are authorized under this demonstration.

So I know the current period ends in June of

2022 and so that feels like a long way away, but given there's a fairly complex bureaucratic process and negotiation that needs to happen between us and the federal government, when you work backwards, we are actually at the time right now where we need to be engaging in that in a lot of detail. So this timeline lays out the overall structure. So between now and the end of the year, we are going to be doing informal listening sessions, be receiving comments from stakeholders around what you would like to see as we think about 1115 renewal. We internally are also already engaged in a fairly intensive planning process around what we think should be in the next renewal period for the 1115 Demonstration.

Then in the new year, what we expect is we will put together a detailed concept paper that sort of lays out the different core elements of what we'll be asking for in the renewal. We will then put that out for formal comments by stakeholders, and that will sort of be the formal State's comment period that I think that many stakeholders will be familiar with. We will also do some public hearings during that period specifically on the details of what we put in the concept paper. Those, I suspect, will be virtual public hearings. We'll obviously have to see where we

are in the spring, but there will be plenty of notice around that. And then we'll receive those comments during the spring and then incorporate any changes that we want to make based on the comments that we receive from the public. And then our deadline for submitting the full renewal application to CMS is in June of 2021, one year in advance. And then after that, there will be a federal comment period in addition to the State comment period that I just described. And then we will have a year's worth of negotiation with our federal partners with the target date of renewal in July of 2022.

Obviously, there are a lot of unknowns at this moment. Some of you may have heard, there's an election coming up in a couple of weeks. And so we don't know exactly who we will be negotiating with next year, but I think we're doing the planning process now to be prepared for sort of all eventualities.

So I just wanted to say we are going to have a couple of virtual listening sessions next month, one on November 2nd, one on November 12th. I think information about how to register for those listening sessions either has already or is about to come out to the MAAC distribution list, so that information should be available. These will just be opportunities for

stakeholders to give out suggestions about things that we should be considering, including in our renewal application. As the name would indicate, these really will be listening sessions. We're not anticipating presenting any details at that stage about what we expect to have in the package. And if you're unable to make those, this is not the only opportunity. There's an e-mail address here where any input or thoughts about things we should are considering as we look towards renewal, if you can send it to that e-mail box, we'll be monitoring that closely. You can also send it to me since my e-mail is in the chat. And I know we've heard informally from a number of stakeholders already about this, but we're happy to take any ideas. And if it makes sense to discuss something offline, I'm happy to do that as well.

DR. SPITALNIK: Thank you so much. And the MAAC looks forward to being able to provide the type of stakeholder forum that we have with the previous two iterations of the comprehensive waiver.

Not seeing any questions from the MAAC, let's go on to the update on NJ FamilyCare maternal and child health initiatives and the doula program.

ASSISTANT COMMISSIONER JACOBS: Thanks, Dr. Spitalnik. I was having a moment there when Greg said

our demonstration is 10 years old because Greg and I have spent a lot of time talking about the demonstration but we haven't often said it's 10 years old. And so I just had a flashback to a MAAC meeting 10 years ago where a number of you were present when we were talking about the new demonstration. And then I felt a little wistful that we're not all together in that space.

But let's talk a little bit about maternal child health. We did want to give you a few important updates about work that's underway. I think most of you know that First Lady's Nurture NJ initiative is really multifaceted and trying to make sure that we are doing everything we can and coordinating as well as possible across many State agencies to move the needle on maternal child health and get better quality outcomes. So we have a few updates for you here.

One is around early elective deliveries which have been tied to increased likelihood of infant mortality, NICU admission, and other serious complications. So we have a statutory mandate that says we will not cover early elective deliveries, and that will begin January 1st. It's really very specific. This is fact-sensitive, so this is an induced or C-section delivery before 39 weeks that does

not include a diagnosis code indicating this was a high-risk situation. So it's really an elective early delivery and we will deny those claims, so will the health plans. And providers may, in fact, find that there was a certain delivery that was appropriately induced, for example, and they would have the opportunity to appeal on that case. But overall, we really want to reduce or eliminate early electives. And so we wanted you to be aware that that policy will be in place, per the legislation, January 1, 2021.

This is also in effect as of January 1st. And this is about early detection of conditions and social needs of an individual and their baby. And using the perinatal risk assessment form, which is a common form across all of our OB providers, we will be able to collect data on the initial visit that a birthing member has. And then using the data, the provider and the health plan will be on one page about what that person's additional needs might be. So we can coordinate a better care plan for that individual when we have the data. Again, it's like a common system. People will know how to access it. They are largely already accessing it. So this is really an update to current practice to say in order to be reimbursed for prenatal care, we know you saw the

member, we need you to have completed the PRA form and submitted through our system for us to pay that claim. So that way we know you've assessed the member and the health plan has access to that information as well so that we can coordinate the best care possible for that individual's circumstances. So, again, that goes into effect as well on January 1st.

I'm trying to move through quickly so I'll go to the last one for January 1st. January 1st is going to be a big day. We also are implementing our Community Doula Program. I think we have talked about this at past MAAC meetings. I don't need to dive deep, but do want to recognize that New Jersey has identified community doulas with special training in the particular needs of our Medicaid population. These are the doulas that we will be working with going forward to support our members who are giving birth. And what's really important as we do this is that we gain the partnership of the other providers and social service organizations that are working with this member so that we are all doing that together. We do know that research shows improved outcomes from moms working with a doula. So this is a good example of let's make sure that we're doing everything we can to move the needle.

So just real quick, we have gone through an extensive process that started really in mid-2019 for Medicaid, but before that for Department of Health where we have been engaging the doula community to understand what best practice looks like so that as we build our Medicaid program, we are reflecting that best practice and really trying to draw down the best outcomes for the families that we work with. So that process has been going on. We did engage the health plans in the spring so that we could start building bridges between those doula providers and the health plans that they'll ultimately be working with. And we're working now on operationalizing this so that we can go on January 1st.

So here's a little bit of the timeline. We're hoping to have the public notice on this out very shortly. And then on January 1st, we'll have the benefit live in our system and we will have the ability to enroll providers. So shortly thereafter, we should start to see members getting services and providers getting paid.

Here's a little bit about what the looks like. I think this is my last maternal child health slide, Dr. Spitalnik, before I move on to EVV.

We will apply the benefit for all our

members who are pregnant and giving birth. The doula will be able to do eight visits with our member in the community in addition to the labor and delivery. In some cases, the prenatal visits are really the most important ones. In some cases, it's the postpartum visits that matter the most. We did not want to drive or prescribe exactly what that needed to look like for each case. So we simply said eight visits in the community, with enhanced care available in certain cases. And then those visits could continue up to 180 days postpartum.

So examples of conversations that would be happening there would be let's make sure and do the follow-up visit with your OB provider. Let's see if there are any services that you and baby need access to that we can help you connect with, support for breastfeeding and other aspects of new parenthood.

So we are really excited about this program. We have been, frankly, inspired by the doulas we work with. And we'll be watching this closely because we are hoping that we will be able to move the needle with this combination of innovations in our program.

DR. SPITALNIK: Thank you. I haven't seen any questions in the chat about this.

Any questions from the MAAC members?

Seeing none, but so appreciative of this, let's go to our last agenda item, electronic visit verification, please.

ASSISTANT COMMISSIONER JACOBS: I will try to do this in four minutes, Dr. Spitalnik, because I know that we're tight for time here and you need to do a little wrap-up. But I think we have spoken to you all before about the federal mandate that requires us to implement electronic visit verification for personal care services. And what that really means is that when an aide is coming to your home to provide support with bathing and dressing and other things, that person will need to check in with an electronic system that says they've arrived in the home, here are the services that are being provided to you on this date, this is the location that we're in. It's often in the form of an app on a smartphone, but it doesn't have to be. And if there's no smartphone access or even a landline, there are little devices that can be provided in the home that will take care of this. So it's a technical implementation of a federal mandate. There's a lot of detail to it. I think the thing for folks to understand is we are looking to implement this mandate really thoughtfully and in partnership with our community.

I think this format might be familiar to you. It is certainly familiar with our team at DMAHS. I showed you this format before when I described the North Star principles that we laid out to our handling of the public health emergency. When we are doing something big and important, we need to pause and ask ourselves a question: What would people like us with values like ours do in this situation? And we lay that out ahead of time so we're all following that same guide.

And so with EVV we felt that because it was a mandate that was coming from federal legislation, it wasn't something that was New Jersey-driven, we needed to be very clear about how New Jersey would implement it. So we said, look, our vision is to implement this system in a way that meets our state and federal requirements, and we do with broad public support and a strong stakeholder process. So we have attempted to do that by setting up a steering committee and workgroups with representation from all impacted stakeholders.

We are really being very thoughtful about keeping our communication clear and simple on this. We can't assume that people have a baseline understanding of this because it's brand-new. So we have to talk to each other in English and not in lingo. So we've been

trying to do that. We need to set up systems for data exchange so that when a provider is collecting their visit data, it can come over to the State and the Managed Care Organization in the way that the federal government expects.

Once we get really good at the data transactions, we can also use that information to improve quality across our program. And an example of that is in the future we will be able to talk to each other about the providers who are most frequently on time, doing all the services that that member needs, at the appropriate amount, and on the schedule that that member has requested, compared to providers who have been once or twice or three times a week they're not showing up or they're not showing up on time. We don't get that clear information today. So somewhere down the road, we'll be able to do that kind of research work to really understand how do we use the data to drive better quality in our program.

That being said, that's not our focus right now. Our focus right now is compliance with the federal mandate, make sure that we comply with the mandate. We're doing this implementation. We make sure that members get services and providers get paid. And then somewhere down the road, we figure out how to

really take advantage of the data that we've been given.

So I just want to underscore that's what's really important in this for us is to be working with our Medicaid community as we walk through this implementation. It's technical, so there will be challenges in the details, and we will figure that out together.

So as I mentioned, we have to implement this for January 1st. We have an aggregator that was selected through a competitive bid process. That aggregator will do the technical work, interacting with the providers and the health plans to make sure everyone has the data they need. And we've tried to adopt and no wrong door approach, so wherever the data comes in, we're able to use it, transmit it to the health plan or provider who needs it, and it's not becoming any more of a burden. And so what that means is we have given providers some options.

Sometimes options can be a little challenging, like when you go to the grocery store and there's 25 kinds of ketchup and you're like, I just wanted ketchup. But we do want the providers to be able to choose. So there are free tools that are provided by the health plans that they can use. They

may have their own EVV system already. Many were aware that this mandate was coming and made their own choices on that. And then we, the State, will provide free tools through our vendor which is called HHAeXchange.

So more to come on this with lots of technical discussions through our steering committee and our technical workgroups and partnership with HHAeXchange, our provider. We do have a mailbox that we set up which is projected here on the screen. So that if members or providers have questions, we have one place for gathering that instead of trying to make sure Carol or Greg or I see it in our inbox. So that mailbox has been helpful so far because providers have asked us questions and we've tried to give all the answers we have but also taken those thoughtful questions and used them to drive our own thinking as we go forward here.

So I know, Dr. Spitalnik, we're tight on time and I should wrap this up. I just want to point out I do think we'll probably be talking about this as we go forward into the future. And if there's anyone who's interested in joining a technical workgroup that's addressing these questions, they should feel free to send an e-mail to that mailbox.

DR. SPITALNIK: Thank you so much. And

thank you for the succinctness and the opportunity for input and also for intuiting the first item that I've written down for our next agenda which is a continued updating on where we are with electronic visit verification.

As we do at the close of each meeting, we try to identify items that have come up that we will, in addition to what is emergent, address at our next meeting. In addition to EVV, the status of the public health emergency as well as flexibilities as well as the Comprehensive Medicaid Waiver.

From the MAAC, just in a listing, anything else to be included next time?

Beverly Roberts.

MS. ROBERTS: Yes. Just the additional update. Carol Grant had said that the steering committee is going to be starting again, and I would love to hear additional updates on what's happening with autism.

DR. SPITALNIK: Thank you.

Other updates? And I'm checking with Wayne. He doesn't have any.

Sherl.

MS. BRAND: I would just ask that we get another update on the enrollment and also some detail

if we do see backlog issues, expecting that we may see a substantial increase down the road.

DR. SPITALNIK: Thank you.

Anything else?

Wayne did not have anything.

So let me, in closing, note that our next meeting that we've laid out the meetings for Calendar Year 2021, I will point out the first two, Thursday, January 21st, definitely virtual; April 22nd, probably continually remotely.

With that, in closing, there are many thank yous to the stakeholders in our program, of course, to the MAAC members, a thank you to Ms. Bradley who does our transcription, and the reminder now that our minutes will now from the past year be posed on the DMAHS website as with the slides.

To Deputy Commissioner Adelman, Assistant Commissioner Jacobs, Assistant Commissioner Mielke, Deputy Director Carol Grant, Greg Woods, Chief Innovation Officer, our thanks to all of you.

Our wishes for good health and safe holidays in this very difficult time. Our support and good wishes to all of those who have suffered and are suffering during the pandemic. And our thanks for such a visionary Medicaid program and the dedication of

everyone involved.

We are adjourned. And thank you again for being with us. We'll see you in January. Be well, everyone, and thank you all.

(Proceeding concluded 12:01 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