MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
Via Zoom Video Conference.
October 21, 2021
10:00 a.m.

FINAL MEETING SUMMARY

MEMBERS PRESENT:

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

MEMBERS NOT PRESENT:

Sherl Brand
Chrissy Buteas
Mary Coogan
Dorothea Libman

ALSO PRESENT:

Jennifer Langer Jacobs, Acting Commissioner
Heidi Smith, Chief of Operations,
Greg Woods, Chief Innovation Officer,
NJ Division of Medical Assistance & Health Services (DMAHS)
Michael DiBiase, President, New Jersey Program of All-Inclusive Care for the Elderly Association

Transcriber, Lisa C. Bradley
THE SCRIBE
6 David Drive
Ewing, New Jersey 08638
(609) 203-1871
The1scribe@gmail.com

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

DR. SPITALNIK: Good morning, I'm Deborah Spitalnik, the Chair of the NJ FamilyCare Medical Assistance Advisory Council (MAAC). It is my pleasure to welcome you to the October 21, 2021, meeting, our last meeting of the calendar year. I want to make sure that people are aware that the meeting was scheduled in accordance with the requirements of the New Jersey Open Public Meetings Act, and I will share with you our process for this meeting.

Let's go to the agenda, please. First, we'll have a welcome and call to order, approval of the minutes, the New Jersey Program of All-Inclusive Care for the Elderly (PACE)presentation, NJ FamilyCare updates, policy implementation, social drivers of health, and as we normally do, some planning for the next meeting.

We have always prided ourselves on the ability to have interaction with our stakeholders, and we're delighted that as of now, 142 stakeholders are with us this morning in this virtual format.

After each presentation, the MAAC members will be unmuted and able to comment or ask questions. Unfortunately, due to the limits of technology and fortunately the size of our audience, we're not able to make that live for stakeholders. So what we ask is that

if you have questions or comments, you use the Question & Answer (Q&A) function on your screen; and we will try, within the limits of time, respond to those questions. Questions that the Division can't respond to, I know that those questions are always taken back and attended to faithfully.

So with that, let me ask the members of the MAAC to unmute. And first I'll ask Beverly and Mary Pat to introduce themselves, please.

MS. ROBERTS:Thank you very much.

Good morning, everyone. My name is Bev Roberts, and I'm with the Arc of New Jersey.

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

DR. SPITALNIK: Thank you.

And now I'll turn to Theresa and Wayne, please.

MS. EDELSTEIN: Good morning, everyone. My name is Theresa Edelstein. I'm one of the Senior Vice Presidents at the New Jersey Hospital Association. And in full disclosure, I also assist with the work of the New Jersey PACE Association.

DR. SPITALNIK: Thank you.

Wayne.

MR. VIVIAN: Wayne Vivian, President of the New Jersey Coalition of Mental Health Organizations of New Jersey.

DR. SPITALNIK: Thank you.

And I'm Deborah Spitalnik. I'm the Director of the Boggs Center on Developmental Disability at Rutgers Robert Wood Johnson Medical School where I'm a professor of pediatrics and family medicine and community health.

Thank you all for being with us.

Our next task for the meeting is to approve the minutes of our past meeting. Do I have either questions or comments, or do I have a motion from the MAAC members for approval?

MS. ANGELINI: I move that we accept the minutes, as presented.

DR. SPITALNIK: Thank you, Mary Pat.

A second?

MS. ROBERTS:I second.

DR. SPITALNIK: Bev Roberts.

With the motion on the floor, do I have approval? Please just say yea.

MAAC MEMBERS: Yea.

DR. SPITALNIK: Thank you. I'm hearing no. Abstentions or 'no' votes. We've approved the past

minutes.

We now have a guest presentation from the New Jersey Program for All-Inclusive Care for the Elderly, the acronym, the PACE Program. And we're delighted to welcome Michael DiBiase who is the President of the PACE Association. Michael, thank you for being with us today.

MR. DIBIASE:Absolutely. My pleasure. Thank you for that. It's so great to be here today and speaking with everyone about the PACE Program in New Jersey.

So I'm the President of the New Jersey Pace Association and also the Executive Director of the AtlantiCare LIFE Connection, AtlantiCare's PACE Program. And I've been in a PACE in a variety of roles for about just over a decade now.

If I could start by telling you a little bit about what is PACE. So PACE goes by a couple of different acronyms. As was previously mentioned, nationally it's known as a Program For All-Inclusive Care for the Elderly. The next couple minutes of my talk, I'll really be talking to you about really about what that all-inclusive care portion really means.

In many states, it's also known as LIFE, which stands for Living Independently for the Elderly.

It's really the same program, but you may hear that across the states, across the country.

So really, what PACE is at its core, it's integrated system of managed care. I think what really makes this different from other managed care organizations is that we are the insurer and the provider of care all at the same time.We provide services and are the insurance instrument for all of our program patients or participants. We have our own network of community specialists. We're not restricted by traditional insurance limitations. I'll tell you a little bit more about what that means in just a few minutes. And we really have a pretty wide array of interdisciplinary team of professionals, about 11 different disciplines operate within a PACE Program.

So a little bit about PACE on the national scene. There's 130 PACE organizations nationally, with about 275 centers in total. PACE is really growing. It's growing in New Jersey as well. Currently, there's six operational programs, and there are several that are in development over the next year to 18 months or two years or so, including Union, Essex, and Ocean Counties, as well as an RFA issued for some uncovered portions of the State in Burlington County.

So this map kind of details where PACE is

currently and lists which programs have the particular counties to provide PACE services. You can see the southern part of New Jersey is pretty much covered with PACE programs, and I believe that the State is looking to expand PACE to some of those other counties but perhaps don't have it just yet. So you can see where we are and where we plan to be as a program or potentially be as a program.

So the PACE philosophy and approach: So we coordinate care in all settings 24 hours a day, 7 days a week, 365 days out of the year.So whether one of our program participants is here at our center or in their home or in the hospital or in a skilled nursing facility, it's our team that follows that program participant no matter where they are to assure their care needs are met. Really, our goal of the program is to keep our participants living independently and safely within the community.

I've heard PACE described as a nursing home without walls.

So that's one way to think about the program. And I'll give you some more detail about what that means in just a little bit.

So, again, keeping with our mission and trying to keep our program participants living in the

community, we want to prevent or delay facility placement. And as I mentioned, really follow our participants wherever they are and also work to make sure that we're reducing unnecessary ED visits and hospitalizations. A lot of PACE Program participants are used to going to the emergency department as kind of a primary care office, so we work with them to meet them where they are and meet those medical needs so that they don't have to do that any longer.

We do also work to address the participants' goals of care. Those are conversations that we have upon entry, within a few months of entry, to a PACE Program.We also provide care to the end of life to all of our program participants.We provide hospice-level services as well with our own staff typically.

So I mentioned the PACE interdisciplinary team, with 11 or so different disciplines. So when you join a PACE Program, these are the folks that really meet your care needs. So we have a primary care provider on site. PACE Programs have a clinic set up within their centers, social workers, physical therapist, registered nurse, recreational therapist, dietician, occupational therapist, the PACE center manager, home care nurses as well, home health aides, and our transportation staff really all have a say and

input into the care plan for our program participants. When I mentioned earlier that we are the insurer and the provider of care, it's this team of individuals that you see on the screen here that works to develop that care plan and serves as the mechanism to address different service requests that a program participant might have. So they act as the decision-maker on how to meet the needs of the participant. And really kind of the informal member of the interdisciplinary team as well is also the participant and their caregivers as well as they participate in the program.

So some of the service highlights for PACE: We do medication administration. We do that in our PACE centers which are also adult day centers as well as housing clinics and our administrative staff as well. So medication management happens either in our center or at the home. PACE uses a wide variety of electronic devices for dispensing medications in the home as well to make sure folks are compliant with their medications and to avoid any unnecessary med errors.

And we also provide transportation. Transportation is a valuable service for us. We provide transportation to and from our centers. We provide transportation to all specialist appointments.

We also provide transportation to other community-based events. We do outings via our recreational department as well. And if someone needed to go to the Board of Social Service or the bank or one of those other key institutions, we would provide transportation to those as well.

One of the things I think is particularly interesting about our transportation is that we provide door-through-door transportation. It's door-through-door, not door-to-door. We don't just take our participants home and kind of drop them off at the curb and say, "Good luck getting into your building." We have an escort on all our vehicles in addition to driver that goes and assists that particular participant into their home, helps get them settled, making sure that they're safe and all tucked in and ready to go basically. And we do that not just from a care perspective, but also we found that it's good as many eyes into peoples' homes as possible. We train our escorts on things to look out for for fall risks. So, for example, if you're taking one of our program participants and you see a throw rug on the floor and you're an escort, that's something that you would mention to the program participant or at least bring back to perhaps the

physical therapist or another disciplinary, there's issue here that might create a fall risk. Or if you see unused medications on the kitchen table or if you see two empty vodka bottles in the trash can, that's all valuable information that we take back to our care team and constantly update that care plan for that particular individual. So transportation and our home health aides are really kind of the eyes and ears of the PACE Program that relay information back to the team on a regular basis.

So Medicare and Medicaid standards plus: So I mentioned, we're the insurance organization instrument also for our program participants. And typically, we do get most of our funding from Medicare or Medicaid. So by regulation, we have to provide the services that you would get with Medicare and Medicaid, but oftentimes to meet our mission of keeping our program participants out of the hospital unnecessarily and living in the community, we go above and beyond those regulations.

A quick anecdote as an example, I think, that really talks about the power of PACE, we've noticed over the past several summers that folks with COPD exacerbation when it gets really hot and humid outside, they have an exacerbation and wind up going to

the emergency room, getting hospitalized, staying in the hospital for a number days, wind up becoming deconditioned, and then have to go to perhaps some sort of subacute rehab afterwards to get their strength back. We really saw an uptick in this with our COPD folks when it got hot and humid outside. So one of the things that PACE Programs have done was buy window unit air conditioners for folks that didn't have them and hire a handyman to install them. So we do that little bit of outside-the-box thinking to begin with on the front end, and that avoids that ER visit, it avoids that hospitalization, it avoids that subacute rehab stay, all with just a little bit of ingenuity, I'll say, and a little bit of cash expenditure that's not within the regulations, but that's the flexibility that PACE has to do things a little bit differently to really impact people's lives.

So we also provide behavioral health services as well. Many PACE Programs have geriatric psychiatrists that provide clinics onsite. We also have licensed clinical social workers that are integrated into the interdisciplinary team for therapeutic services. And many PACE Programs also have methadone management as well.

So really when I talk about the PACE

Services, we have our adult day centers. We have a primary clinic within our centers. I spoke about transportation, home care aides, home care nurses, therapy between physical therapy, occupational therapy, and speech. We're on call 24/7. We always have a physician, nurse, an administrator on call 24/7 to be able to support our program participants even when the center is actually closed. Not all of our participants come to our center. You can choose to receive all of your services on a home-based setup as well if that's what you want and if that's your care plan dictates, then that's what we'll do.

Just some quick information about PACE across the country. PACE typically serves about 22,000 meals a day. Most PACE participants are on about six prescriptions. There's about seven visits to the PACE center, and 16 trips per month.So, again, that transportation piece of coming to and from the center, going to your specialist appointments, going to an outing. I can tell you that AtlantiCare last week, we just took about 25 or 30 seniors to local a pumpkin patch to have a nice outing and get them out in the nice fall cool air.

So enrollment-wise, most of our enrollments come from physicians' offices, social service agencies,

local hospitals, just different educational events that we do out in the community. So once we get a referral, one of our staff will go out and do a level-of-care assessment to determine if they meet some of the criteria that we have for clinical eligibility and making sure the federal criteria is met. So you have to meet a nursing home level of care to enroll in a PACE Program. You also have to be over 55.You have to live within the zip code that is serviced by a PACE program and also be able to be serviced safely in the community with PACE services.

During the enrollment process, we check for eligibility for Medicaid, Medicare, and will work with those individuals to get eligibility going if they haven't yet. Typically, we enroll prior to the 25th -- excuse me. The cutoff is the 25th of the month for enrollment and then the next month, we start on the 1st. So we're coming up for the 25th of October for November enrollment shortly.As I mentioned, you have to be over 55, live in our service area, and meet that nursing home level of care.

So even though you meet that nursing home level of care criteria to join in PACE, 95 percent of PACE participants across the country live in the community, don't live in the nursing facilities. So I

think that's really a pretty impressive number and speaks to the power that PACE brings to the community to those folks that want to stay living in their homes. The average age is about 77, and most of our folks need assistance with about five to six activities of daily living. You can see the breakdown. It's typically about 69 percent women to 31 percent men.

So even given the frail nature of the population that we serve, PACE across the country has less than one ER visit per year per participant. I think it is really pretty tremendous. The average PACE participant has an acuity rating of more than twice the normal Medicare beneficiary rating. So to be able to have that acuity level of at least two times higher than normal and only one emergency room (ER) visit per year, again, I think speaks to some of the care coordination efforts that PACE is able to put forth, as well as our decreased in hospitalizations which is significantly lower and the other dual-eligible beneficiaries as well.

So, again, fewer nursing home admissions and reduced hospitalizations, that's really what we're all about at the PACE Program. We found that our program participants will thrive in their communities, and we do our best to make sure that they stay there and

continue living the way they want to live.

So just an update how PACE changed with the development of COVID. In March of 2020, the Division of Aging Services put out a memo saying that we needed to take certain actions as PACE Programs. So essentially, all of our centers were closed for socialization, however, were still open for urgent appointments such as meeting with your primary care provider and/or physical therapy, that sort of thing.So we really as a community and as a group of programs ramped up our efforts in terms of using telehealth technology instead of doing face-to-face interactions.That continues to be in place now. And really, we shifted to providing all of our care in the homes instead of in the centers. So instead of having 50, 60, 80, or 100 seniors in a PACE center during the day, we had to provide care for them in their homes, which logistically was quite complex, but I'm really proud of the way that PACE rose to the challenge to meet the needs of our program participants and keeping them safe.

I know that a lot of PACE centers really turned into assembly lines for things like meal kits and medications and just daily supplies and toiletries and those sort of things so our participants didn't

have to go out anywhere and remain safe within their homes. So we really had kind of an assembly line set up at many of the PACE centers to be able put those supplies together, and then they were delivered by our transportation staff as well.

Fortunately, we've been able to reopen and have program participants come back for socialization to the centers, so we're no longer in that assembly line setup. However, we are taking all the recommended precautions and then some to make sure that we're keeping everybody safe and maintaining all appropriate infection prevention protocols as well.

So really, when you look at PACE and our response to COVID, relative to some of the things that we saw with other health care facilities, we're really proud of the way that we responded. We've maintained low COVID case rates and deaths and low hospitalizations as well. We really worked closely with hospitals, qualified health centers, and other different health care organizations to provide COVID vaccines very early in the release of the vaccines. All that organization and coordination to get the seniors the vaccines that they needed, that was all driven by the PACE Program in concert with some of the other organizations that I mentioned.

So just kind of looking forward and talking about the future of PACE a bit in New Jersey, the next two slides are just some remarks about the way the PACE operates. And I think we're really looking to expand in PACE in New Jersey, as I mentioned earlier, with the expansion into different counties and the existing programs really starting to grow.There is also federal legislation that's pending that could make accessibility to PACE significantly easier.That seems to be in the works right now in Congress and hopefully that will get passed in the not-too-distant future so we can really provide more access to PACE services for people across the country.

One thing that I think is pretty exciting about the State of New Jersey, though, we've been working closely with the Division of Aging Services to come up with a new initiative for self-directed caregivers where our program participants can appoint their own caregiver to help provide them services, specifically more things like what a home health aide would do, generally speaking. So we're looking to get that program up and running. We're working closely, like I said, with the Division of Aging Services as well. That will give our participants more choice and more options in terms of where they get their care.

So just some information there about Altarum, and talk about how PACE can handle the age wave, the silver tsunami, what's coming down the pike as the baby boomer population continues to age.

So here is some contact information for the different PACE Programs that are operational currently in the State of New Jersey. I really appreciate the opportunity to talk to everyone about PACE. I think it's a great model of care. The flexibility that the program is able to provide its participants really sets it apart from some of the other care options that are out there. Really, it's that insurance instrument and the provider all at the same time that I think really produce some terrific outcomes for our communities.

DR. SPITALNIK: Michael, thank you so much for this excellent presentation. It's much appreciated.

And I will remind stakeholders that the PowerPoint for the whole meeting is posted on the Division of Medical Assistance and Health Services (DMAHS) website, and we're going to add that link to the Q&A box right now. Typically, we do that after the meeting.

And with that, I want to turn to members of the MAAC and then I will also bring some questions to you that have been raised by stakeholders.

Theresa, let me start with you, if you would like to make any comment or ask any questions, given your involvement with PACE.

MS. EDELSTEIN: Thanks very much, Dr. Spitalnik.

So first of all, I would just echo Mike's comments about just the flexibility and can-do attitude of the PACE organizations throughout these last 18 months. It's been remarkable to watch here in New Jersey but also across the country.

One other thing I just want to mention is New Jersey, the Division of Aging Services, (specifically, has been part of a part of a National Academy of State Health Policy Initiative on PACE which members of the PACE organizations in New Jersey have had the privilege to be a part of as part of the State's workgroup. We are really excited about some of the initiatives that we'll undertake together on enrollment that will help us grow PACE in New Jersey. So there's a lot of good things to look forward to in our state with respect to PACE implementation and expansion, and we look forward to the continuing partnership. Thank you very much.

DR. SPITALNIK: Thank you very much.

Beverly, you have a question?

MS. ROBERTS:Yes, I do.

And thanks so much. This was a wonderful presentation.I had heard about PACE before but really didn't know much about it.

So my questions have to do with individuals who have an intellectual or developmental disability. My first question, I'm not sure if the presenter can answer, but I am aware that if somebody with Intellectual/Developmental Disabilities (I/DD) wanted to get Managed Long Term Services and Supports (MLTSS) services, they could not have MLTSS and Division of Developmental Disabilities (DDD)services at the same time. So I don't know if that also applies to somebody getting DDD services, could they have PACE services if they meet the other criteria, including having the nursing facility level of care. So that's my first question.

And the second question is, we do sometimes get contacted by people who are much older, never had DDD services, maybe they're being cared for at this point by a sibling, they could be in their 50s or older, parents passed away, and it's very hard for them -- for the sibling, let's say, to get the documentation that this disability occurred before the age of 22, which is what would be required for them to have DDD

services. So I'm wondering in a situation like with, would somebody with I/DD who, if they had a documentations could be served by DDD, but it's really difficult sometimes to get that documentation. Would they be able to enroll, again, with nursing facility level of care requirement, could they enroll in PACE?

MR. DIBIASE:I don't believe that you can get DDD services and PACE at the same time. Theresa maybe has a better answer on that than I do.

In terms of documentation that's required, if they don't have the DDD services and meet those other eligibility requirements, I would think that they would be eligible for PACE.

Theresa, do you have any insight on that?

MS. EDELSTEIN: So, Michael, I think the answer to the first question was correct, that you can't be on the DDD waiver services and also in PACE. But we can delve into that a little bit more.

On the second question, I agree that if they don't have the documentation to satisfy eligibility for the DDD waiver services and they meet PACE criteria, yes. I think the other important piece is the federal legislation that Mike mentioned that is pending would also expand the types of populations PACE could serve, and that would include more individuals with

intellectual and developmental disabilities. So these are things we're working on from a policy perspective at the national level with the National PACE Association.

MS. ROBERTS:Thank you very much.And then hopefully, we can get updated as that additional federal legislation goes through. Thanks so much.

DR. SPITALNIK: Thank you, Beverly.

Mary Pat Angelini, please.

MS. ANGELINI: I'm very familiar with the Beacon of Life in Monmouth County on the grounds of Fort Monmouth. It's a beautiful facility.

I had two short questions, one about marketing. Is there a concerted marketing effort? Or is it just a matter of reaching out to different physicians and practices?

And then my second question is, Michael, you mentioned there was federal legislation that will make it easier to access. What do you see as the barriers currently to access PACE?

MR. DIBIASE:So I think in terms of your first question, in terms of marketing, we don't really do much direct consumer marketing, but we do a lot of educational sessions for the community, and also, we work with professional referral services as well.

That's really what most of our marketing efforts are focused.

In terms of barriers to enrollment, that legislation, I think, really tries to address some of the expense that you might incur if you wanted to join a PACE program but weren't necessarily Medicaid eligible. That's really, I think, the focus in addition to serving other populations.But in terms of barriers, I think that's one of the main barriers that's out there preventing PACE from really kind of expanding out across the state and country.

MS. ANGELINI: Thank you.

DR. SPITALNIK: Thank you.

Wayne Vivian has a question, please.

MR. VIVIAN: Yes. My question is regarding behavioral health services. I know MLTSS hasn't had that much success with providing seniors or people who have MLTSS with behavioral health services. How does PACE intend to provide key behavioral health services to your members?

MR. DIBIASE:There's really several different mechanisms we use for behavioral health services. I mentioned the psychiatric clinics that often go on inside the PACE Program. So those clinics are all organized by PACE staff who provide transportation to

and from those clinics, we provide the home health aide in the morning, perhaps to help one of those program participants get ready to be able to make sure they attend their visit. We also had -- I'll speak specifically for my PACE organization. The psychiatrists do home visits as well, and we've also had our licensed clinical social workers do therapy sessions in the home. So wherever our participants are, that's where we go to meet their needs, whether that's in the center, that's in the home, they're at a relative's house. We are out in the community as well as our centers to meet those needs. And I think also just in terms of medication compliance and the oversight that we provide with our home health nurses and some of the tools that we use for medication compliance also really help specifically some behavioral health diagnoses as well.

MR. VIVIAN: Are your caseworkers that actually see your participants, are they trained to spot mental health issues?

MR. DIBIASE: Absolutely, yes.

MR. VIVIAN: How do the participants get to the attention of a psychiatrist?

MR. DIBIASE: So we have licensed social workers as part of our interdisciplinary team. We also

have several LCSWs as well. Most PACE staff go through mental health first aid training as well just to kind of be able to notice some of the indicators that may result in pulling in a social worker. And I think it's the number of touches that we have with our program participants.So they might come in the center five days a week and also get home care from us.So there's a lot of interaction as well.So those frequent interactions as well, someone that's having some issues or concerns will get attention pretty quickly.

MR. VIVIAN: Thank you.

DR. SPITALNIK: Very briefly, a few questions from stakeholders.One question was about dental care which was listed in one of your slides about covered services. The question, concretely, do we have a sense of timeline for expanding PACE in New Jersey? And then I would ask you also the Division of Medical Assistance and Health Services. And then there are questions about the relationship between Managed Long Termed Services and Supports and PACE. So that seems to be a recurring set of questions about MLTSS.

MR. DIBIASE:So the dental care piece, we do provide dental care all the way from things like regular cleanings to dentures to oral surgery, if the

need be. That's all within the PACE package of services that we do offer to our program participants. Expansion-wise, I think we had the dates for the Burlington County expansion there. I believe the other counties are potentially being considered.

Theresa, I want to say it's within the next year or two. I don't know that an official timeline has been put out by the State just yet.

MS. EDELSTEIN: You're accurate, Mike. There's definitely a timeline in mind for bringing PACE to all of the remaining counties.Demographic data will definitely help shape which counties come next in the cue. The RFA process is detailed, and we want to make sure as a State we get this right. But I think over the next two years we anticipate we'll see many more PACE organizations coming online and more RFAs to be responded to.

DR. SPITALNIK: Great. Thank you. Before we close out this segment, Greg Woods, did you have a comment from DMAHS's perspective to share with us about this, please?

MR. WOODS: Thanks, Dr. Spitalnik.

The only thing I just wanted to quickly say -- first of all, thank you for this great presentation. I did want to just, before the moment pass by, I know,

Wayne, you had mentioned some concerns about the integration of behavioral health into MLTSS. And I did just want to mention that's a concern we've heard a lot. It's a concern we've heard a lot historically. It's also a concern we've heard a lot just in response to our Draft 1115 Proposal. In particular, we've had some requests in some of the comments we received on the 1115 Proposal to delve more deeply into what the picture looks like for behavioral health with MLTSS and also with populations in our Division of Development Disabilities Waiver Program.So I did want to mention we've heard that request. We are looking at that data now and we intend to share for this group and I think in other forums in the pretty near future what that looks like from a data perspective. So that's something our team is working on intensively. I did just want to mention that. I will say I think, as we delve into this data, I think it's a complicated picture and we look forward to having that conversation. I did just want to mention that.

DR. SPITALNIK: Thank you very much, Greg, for that. And you've anticipated one of my agenda items for our next meetings going forward.

With that, I want to thank Michael DiBiase both for the presentation you've given us and for the

work you do day in and day out and especially the challenges of COVID and how PACE just met that. Thanks for being with us.

Theresa, thank you for your work in this. We'll now turn to NJ FamilyCare enrollment. And as I remind people, the slides are posted if that's helpful for participation.

Greg, I will turn to you more formally. Greg Woods is the Chief Innovation Officer, the Division of Medical Assistance and Health Services. Greg, thank you.

MR. WOODS: Thank you, Dr. Spitalnik.

We wanted to give a quick update, as we've done for this group a couple of times in the past, on where we are in overall NJ FamilyCare enrollment. As you can see on this slide, as of September, which is the most recent month we have data for, our total enrollment was a bit above 2 million across all of our populations. This represents an increase of around 350,000 since our pre-pandemic level. To put another way, a bit over a 20 percent increase in our total enrollments. That's quite significant.And this continues the trend that we've seen since spring of 2020 of barely consistently increasing enrollment.

As we've discussed with this group before,

can be somewhat challenging to disentangle the causes of this change. In particular, it's not possible to precisely isolate the impact of the ongoing Public Health Emergency and some of the continuous enrollment policies that go with that versus other changes that are happening in the State, including demographic and economic changes. So I don't have any precise way -- I know the question has arisen before. I don't have a precise way to say how much of it is driven by the fact that we have continuous enrollment in place versus how much of this is driven by other factors. That said, we continue to believe that the largest driver is that continuous enrollment phase.Just as a reminder, this is a policy that during the federal Public Health Emergency, which is ongoing, members are only dis-enrolled from our program in very limited circumstances, voluntarily or in the case of death or moving out of state. Looking at the totality of the information we have, we continue to believe that that's the primary driver.

I will note that recently in the past week, the federal government formally extended the Public Health Emergency for another 90-day period. So that takes from this month into the middle of January. It's always possible, though it's not likely, that they

could end sooner than that, but they have made it clear that there will be significant notice, at least a couple months notice, before that happens. So I think until we hear otherwise, we are assuming we are continuing to operate in that Public Health Emergency and with the policies that go with that.

That's probably a good transition to Jen who I think, among other things, is going to talk about some of our planning for when the Public Health Emergency ends and also some of our broader work on eligibility determination and re-determination.

MS. JACOBS: Thank you, Greg.

So we wanted to talk to you a little bit about that work that is going on right now at the counties and at our health benefits coordinator conduit. The information we've got for you here in black on this page is information we've provided to you at past MAAC meetings. The blue is where we're giving you a little bit of an update from recent times.

So the eligibility determining agencies are continuing to renew eligibility even while no one is being terminated from the program during the Public Health Emergency. When they find a case that appears to be ineligible, and that can include people who did not respond to the mailing at all, but also people who

report a higher income, those cases are getting a special flag so that we can revisit them at the end of the Public Health Emergency.So as Greg said, no one is being terminated from the program during the Public Health Emergency except for voluntary cases, people who have moved out of state, et cetera.

What's new now, which we wouldn't have shared with you before, because the Centers for Medicare & Medicaid Services (CMS) put out this new guidance in August, is a little bit of a timeline change. So for cases where we put that flag in the system -- we believe this case is ineligible, we've done the renewal, we're flagging it as ineligible -- we will conduct another redetermination at the end of the PHE. Every state will follow this policy. And we will have 12 months to catch up on all those redeterminations. So this is an expanded timeline from what we were looking at with previous guidance. That is a sigh of relief for all of us, I think, on all sides. And our intention here in New Jersey is to align that redetermination activity to the preexisting renewal dates for each case. So that spreads the work over the 12 months that we have as much as possible, maintaining that cadence that was already in place. So a little bit of new information there from CMS, but as

Greg said, we're still in the Public Health Emergency, so that effort applies.

The other thing we wanted to talk to you about today was system improvements that we have been making over the course of the Public Health Emergency. We had wheels in motion on a bunch of changes when the pandemic surprised us all with new priorities, and we've kept those wheels in motion. So we're now benefiting from system improvements that have phased in over the course of the last couple of years. I wanted to give you a little bit of an update on that.

Our theme around all of this, which has been prominent in our work, and so we wanted to make it prominent in this discussion, is energy follows focus. So we really need to work closely with our county partners to make sure that we were all focused on the same things and really trying to move the needle together in very consistent ways.So one thing we have done is move all the county welfare agencies to a single shared platform that we can now use for intake, processing, and tracking of applications. That is a huge technical lift on the part of our systems teams and everyone from eligibility policy here at DMAHS to frontline workers at the counties who are entering applications that may have been received on paper from

members or who are looking at applications that came in online.

So those enhancements to our system have let us standardize work processes that varied across 21 counties and have simplified eligibility determination overall. The team has new system enhancements in the works, so there's still more to come there, but we're already seeing the benefit of the work we've done.

And one of the things I thought might be interesting to you is we are tracking -- it is important that we track -- the effective efficient turnaround of eligibility processing so we don't end up with backlogs. It's also important that we work closely with families who are potentially trying to collect information that is needed to process their application. So if the family is working with us and they say, "We need a little more time," we've established a good cause indicator that lets the county tells us, this is a case we are working directly with the family, so we're keeping an eye on that to make sure that it doesn't go on forever, but it stops the clock on that case so that we're really watching effective, efficient turnaround times and also accounting for -- look, sometimes there are extenuating circumstances, and we recognize that people focus is

really important.

Another thing that we have done during this time, really very quickly -- actually, at the start of the Public Health Emergency, we established what I think of as a cadence of accountability with our counties where we were getting together to be accountable to one another on a weekly basis to make sure that we would not lose ground during the Public Health Emergency.

As you know, every workplace in America has been impacted by the Public Health Emergency, and the counties are no exception to that and certainly DMAHS is no exception either.What we needed was to make sure that as we were finding new ways of working and keeping the wheels in motion on the system improvements, we really needed to be talking to each other a lot. So we set up this cadence of meetings. It's now biweekly, but initially it was weekly. And we look at what I call a compelling scoreboard. If anyone has read The Four Disciplines of Execution, it's a phenomenal book for trying to track a project like this. And you can also Google that. I like the compelling scoreboard because it says to me we've got so much data, here is what we need to pay attention to, and this is going to tell us the story, then we can use the rest of the data to dig

into the details. So that goes along with energy follows focus.

Then we have really candid discussion in those conversations so that we're helping counties sort of address some of the challenges they're running into either on their end or on ours. And that has resulted in efficiency improvements and turnaround time improvements. I'm about to talk to you about that. But really what it means at the bottom line is we're getting coverage in place for people faster. You will see that in the data I'm going to show you in a moment. But we have knocked out backlogs. Turnaround times have improved. The counties have really worked very closely with us on this. The progress is tremendous. We have new dashboards on the way. And as I mentioned before, the technical team is working hard on continuing updates in the system that will make us more efficient and improve performance of the system overall.

So let's dig in for just a minute. I'm going to give you a little bit of data. Bear with me. These couple of bars or this bar chart represents processing volume.These are Modified Adjusted Gross Income (MAGI) cases, so not our Aged, Blind, and Disabled (ABD) cases, but the ones that process in this

format called MAGI which you don't have an hour to talk about, but these are the non-ABD cases. This is all counties. And what you're seeing here is processing volume. Left and right is July of 2020 and July of 2021. You see the colors are representing the amount of time it took for those cases to process.And so there's a lot behind the numbers here, but a couple of things that we really wanted to point out to you.

For one thing, if you look at the top, the yellow and blue rows, those are cases that waited too long. And we really want to reduce wait time. There are sometimes reasons why cases end up waiting, but they shouldn't be waiting a long time especially in the MAGI zone.

So what you see in the difference between July of 2020 and 2021 is a reduction in that yellow and blue zone, a pretty noticeable reduction. And that really is counties being more aware when they have a backlog, tracking the data. Like I said, those compelling scoreboards are telling us here is where we need action. The directors are all over that, and it is reducing delays in folks getting that Medicaid card in their hand or that NJ FamilyCare card in their hand.

And then at the bottom on the 2021 side, you see quicker turnaround times where that beige row and

the blue row at the bottom grow. Those are the cases that are turning around faster; more cases turning around faster, less cases backlogged or delayed.And more work to come on that, but really significant progress.

Here, we are looking at the ABD cases, Aged, Blind, and Disabled. These cases take longer to process.There are more steps involved. But also, it's really important to mention to you when we look at July of 2020 versus '21 for this group, we were adopting the new system here over the course of that period. So you see the volume increasing because more cases were being entered into that new system. And that's important to point out because we didn't have some significant jump in applications with our ABD group. That increased volume in this report represents folks moving ABD processing activity into the new system. Hopefully, that makes sense.

But then also what you see here is that yellow bar growing where the efficiency of the new system, the standardization of some of this process, watching those key metrics, is helping us also have quicker turnaround times on this side of the house.

So always more work to do, more work to come, but we're feeling good about the progress that we

see here.

DR. SPITALNIK: Thank you so much. Thank you for that wonderful walkthrough of data which is so difficult to process when we're first seeing it.

At this juncture, I will ask members of the MAAC if you have questions for Assistant Commissioner Jacobs or Chief Innovation Officer Woods, any questions about enrollment, maintenance of effort, and the redetermination and eligibility process?

MS. ANGELINI: I would just say a comment, not a question. Regarding getting all 21 counties on the same platform, I just cannot imagine what a herculean task that was. So congratulations.

MS. JACOBS: Thank you. Heidi Smith and the team worked really hard with the county directors to make that happen. We're excited.

DR. SPITALNIK: Anyone else from the MAAC, questions or comments?

MS. ROBERTS: Yes, I have a question.

DR. SPITALNIK: Beverly, please.

MS. ROBERTS: Thanks very much.

Thank you so much, and it's absolutely wonderful news about the improved turnaround time for the applications for MAGI and ABD. So thank you. That is absolutely fabulous news.

I have a very quick question about what's going to happen again after the PHE is over. And there are different kinds of situations, of course, that are going to occur. But one thing that I'm quite concerned about is people who were enrolled in non-Aged, Blind, Disabled programs they didn't have Medicare at the time, and that's not just the I/DD folks, that's maybe quite a few people, but they did start to get Medicare during the period of the PHE. What is going to happen with those folks when it's clear that they are not eligible for that category any longer, but at least for the I/DD folks there's a very good chance that they would be eligible for a different type of Medicaid, including Medicaid through the DDD system?

MS. JACOBS: Good question.

Heidi, I think you and your team have spent some time on this topic. Would you like to take the answer there?

MS. SMITH: I think the key is to get people to respond to the renewal so that we can see the best program that they're eligible for. During the PHE, because of the MOE, the Maintenance of Effort, and not terminating anyone, we have been putting people in categories to save their eligibility. So it's critical

at this juncture that people respond to their renewal so that we can put them into the correct program and not lose anybody who is truly eligible.

MS. ROBERTS: Thank you. So if somebody is getting DDD services, is that something you all would know? This population is probably a relatively small percentage of your overall numbers of folks who have started to get Medicare. How will it be known that a particular person who did start to get Medicare is getting DDD services?

MS. SMITH: So we have reports that come through that let us know who is now getting Medicare. We work very closely with DDD and Brian Brennan's group. And it's important when applications come through that door that we help shepherd them to where they need to be. That's another population also that sometimes needs - when we renew them realize they need to move on to MLTSS program from the DDD program.

MS. ROBERTS: Okay. There are probably relatively small numbers of that, but anything is possible.

MS. SMITH: We don't want to want to lose anybody that is supposed to be on the program.

MS. ROBERTS: Okay. Thank you very much, Heidi.

DR. SPITALNIK: Any other questions or comments from the MAAC at this point?

Assistant Commissioner, we have a couple of questions about good cause indicators and trying to take a deeper dive into understanding why people haven't been able to respond.

MS. JACOBS: So one of the challenges with eligibility work is that it requires a one-on-one interaction. And so we have made the good cause indicator available. The directors know that. Supervisors know that. Making sure that we're always communicating with the eligibility workers who are doing this work is important. We've had those conversations. So we feel like we have prepped folks for always offering that extension when it's appropriate. And sometimes we get individual cases where a worker made a mistake and didn't offer the extension or didn't approve the extension. Sometimes it's not appropriate. So what's helpful to us when folks feel that they're seeing a pattern of that is to get a few examples so that we can look at what county did it come from, was that about the policy at the county, the way that the county is handling extensions, or was it about the way a particular worker handled an extension request? And then we can work with the

counties directly. It always depends on the scale of the issue. Sometimes it is the county, sometimes it's the worker, sometimes we see a problem across many counties and we end up having that conversation on our biweekly calls. So it is helpful if folks are able to provide us with any examples where they felt like an extension was appropriate and not provided.

DR. SPITALNIK: Thank you so much for that response. As I ask Assistant Commissioner and Greg Woods to stay at the virtual podium, I will also want to thank Heidi Smith and her team for all their efforts that have made such a productive difference.

In conclusion of our updates, we'll now move to some policy implementation issues, and we'll start off with the 1115 Comprehensive Waiver Demonstration Renewal (Waiver, Renewal). And I turn to Greg Woods again. Thank you, Greg.

MR. WOODS: Thank you.So I wanted to give a quick status update on our 1115 Renewal process.And I will plan to be very brief here since we discussed this topic at length during the special MAAC meeting last month. We don't have major substantive updates since that meeting, but did want to give everyone an update where we stand with the process.

So just a reminder about what we're talking

about, our 1115 Demonstration is how the federal government gives us authority to run various critical parts of our program, our managed care delivery system, our home and community-based services programs, and is also a vehicle that allows us to work with the federal government to test various innovative approaches to running the Medicaid programs.

Our current demonstration periods, our current authorization, is approved through next June and so, therefore, we're at the time when we need to negotiate a renewal with our federal partners at the Centers of Medicare or Medicare services. So as part of that process, we posted a draft proposal, a draft renewal proposal, on our website last month on September 10th and we requested public comment. And that state public comment period was 30 days or maybe 31 days, and it ended on October 11th, so a little over a week ago. We received more than a hundred comments from the public and from stakeholders.So first, we want to say thank you for all that input. It's incredibly helpful to us and an incredibly important part of the process.Right now, my team is very intensively reviewing those comments and working on identifying where there are opportunities potentially to modify our proposal, whether there are updates, whether there are

just areas where we need to make some clarifications because our intent or our meeting may not have been clear based on some of the comments that we received.So that's where we are right now.

Once that process is complete, once we have reviewed all of the comments and assessed what changes we want to make moving forward, we will then submit an updated final proposal to CMS for their review. I will note that proposal will include summaries of the comments we received and responses, where appropriate, to those comments.So we'll submit that to CMS. CMS takes a couple of weeks to review that proposal and determine whether it has all the required elements and is complete.

Once they've done that, they will post it publicly on their website, on Medicaid.gov, and then there will be another public comment period, which is called federal public comment period which will allow the public and stakeholders to comment to CMS about the final version that we submitted. Once that public comment period is over, then we work with CMS to negotiate the final approved version.

So that's all to say we're continuing to move forward in the process.As we move forward, we will continue to update the MAAC and continue to provide the

public with information on where we are. So please do stay tuned. So more to come on this.

DR. SPITALNIK: Thank you.

Let's move to the American Rescue Plan Enhanced Federal Match for Home and Community Based Services (HCBS). And, again, Greg, thank you. We rely on you for this.

MR. WOODS: Thank you.So now we're going to turn to a different topic. As Dr. Spitalnik said, this is the Enhanced Federal Funding for Home and Community Based Services that was provided as part the American Rescue Plan (ARP).

Just to remind everyone, as part of the American Rescue Plan, Congress provided a 10 percent increase in the Medicaid Federal Medical Assistance Percentage (FMAP) rate for HCBS. So to put that in less technical terms, Congress has effectively said that the federal government would temporarily, so for one year, from April of this year to March of next year, assume responsibility for an additional 10 percent of Medicaid expenditures on long-term care services provided through the community above and beyond what the federal government is ordinarily responsible for. So in essence, the share of those expenditures that the federal assumes responsibility for went up; and at the

same time, therefore, the state responsibility goes down. Now, those enhanced federal dollars came with some significant requirements attached. Specifically, in order to claim those dollars, all states were required to demonstrate that we were taking those additional dollars and reinvesting them specifically into home and community-based services. So this wasn't something that states could take those dollars and fund an unrelated budget hole. It really needed to be reinvested in those services. And we were given three years to make those reinvestments. So the enhanced dollars are for one year, but then with those dollars, you have three years, through the spring of 2024, to make those reinvestments.

In order to demonstrate compliance of that requirement, New Jersey and all states, we were required to submit a spend plan to our federal partners at CMS, showing how we plan to reinvest those dollars. So what specific purposes related to home and community-based services were we planning to put those dollars to? And many of you may remember back in May or June, we ran a very accelerated process in the summer to seek public and stakeholder input on that spend plan. And it was a very accelerated process because there was a very quick deadline. CMS, I think,

originally gave us a month to turn that around, and if I'm remembering correctly, we maybe got a couple of additional weeks, but it was very brief, and we had to come up with a plan. We ended up submitting a spend plan to the federal government, to CMS, on July 12th. That plan is posted on our website and the link is here on the slide.

After submitting that plan, the next step in the process is for our federal partners at CMS to review it and send us their responses.

So at the end of last month on September 29th, we received a partial approval from CMS on our spend plan. So what does partial approval mean? It means that CMS approved most of the items in our spend plan and gave us the go-ahead to start implementation. For a smaller number of items in the spend plan, CMS has some additional clarifying questions for us that needed responses to before it could approve those items.

I just want to note here partial approval is not at all unique to New Jersey. I don't think CMS has published any comprehensive list of where all of the states stand, but our understanding, talking to other states, is partial approval is, by far, the most common outcome of CMS's review of state spend plans. So

we're not at all unique here.

So as I said, CMS sends us that partial approval. And what I'd like to do now is just take a minute walk true the specific items in our spend plan and do a very brief tour of the world about where we stand with each of them.

So first, this slide shows all of the items that CMS has that were approved and we were given the go-ahead to begin implementing as part of that partial approval.

Before I talk to the specifics, I do just want to briefly note that broadly speaking the things on this slide fall into a couple of buckets. I would say some of the things on this list, particularly rate increases, they're fairly straightforward and relatively simple for us to implement.And so for those items, we're moving ahead rapidly. You'll see there are generally in most cases there are specific target implementation dates included here. So that's one bucket of items.

There are other items where we propose more innovative or novel approaches supporting Home and Community Based Services. We had to put that proposal together, as I said, very quickly. Now that we have CMS approval, we're really focused on flushing out our

proposal and nailing down some of the operational details that, in many cases, we didn't have time to work through when we submitted the initial spend plan. So you'll see for some of these items we have TBD listed as an implementation date. The reason for that is we are right now very focused on working through what will the details look like. As we complete that work and as we fill in more details, we will certainly share more information with the MAAC and with stakeholders generally on what the timeline looks like for implementing those items.

So with all that said, I'll quickly walk through the things that are listed on this table. First of all, there are actually a couple of lines here around personal care assistance (PCA) rate increases. So the first one is an increase of the hourly PCA rate that Medicaid pays to agencies, the $22 an hour.This was actually part of the enacted Fiscal Year 2022 budget so it has already gone into effect. It went into effect back in July. Now that we have CMS approval, we will have funding to sustain that rate increase through the period through 2024. So that's already in place, and we have the funding that we'll be able to continue that. In addition, now that we have the approval from CMS, we are planning an additional rate increase of

further $1, so that will take us to $23 an hour for the personal care assistant services.We are targeting an implementation of that for January 1, 2022, so coming up in a couple of months. So at the moment, we're at $22. We expect to go to $23 on January 1st.

Next, moving down that table, the PPP rate increase, this is our self-directed service program for individuals in MLTSS. The change here is to increase the budgeted rate for personal care assistance services that are administered through the Personal Preference Program (PPP) that are self-directed by the beneficiary. That rate -- and this is the rate that is used to determine the budgets that are available for members, and that program will be increased to $19 an hour. That also, we are looking to make that effective on January 1st coming up.

Then turning to assisted living, there are a couple of assisted living items here. First, there is the rate increase that was included as part of the enacted budget for this fiscal year. That was a $10 rate increase. That was effective July 1st. And similar to what I said about PCA, by having approval for CMS for that funding to be included moving forward, that allows us to sustain that rate increase through the time period through 2024.

In addition, we proposed as part of our spend plan an additional tier rate increase which specifically increase expenditures on assisted living facilities serving a high percentage of NJ FamilyCare beneficiaries. For that one, implementation planning is still ongoing, so we don't have a targeted effective date yet, but that's something we are working actively on and hope to have more information on soon.

Moving down the list, we have in our spend plan some dollars devoted to encouraging nursing facility transitions to community settings. These dollars are intended to encourage increased and accelerated transitions of NJ FamilyCare beneficiaries from custodial nursing facilities back to the community which is one of the goals of our Managed Long Term Services and Supports Program. Exactly how these dollars will be targeted, we're still working through some of the details there. I think we expect to work closely with our managed care organizations. On that one, we don't have a target date yet, so more to come on that.

Going to the next item, enhancements to the "No Wrong Door" system.This is funding that's intended to support and enhance the existing community-based resources that are available, to make sure working in a

coordinated way, to educate and make sure information is available to all members or potential members about their options, their long-term care options. This one, we're working with our partners in the Division of Aging Services. And, again, the implementation plan is ongoing. I don't think we have a target rollout date yet, but we hope to have more information soon.

Also approved as part of our spend plan was a one-time payment to providers of services for individuals with traumatic brain injury. This is intended as a one-time funding to offset some of the costs associated for those providers with Public Health Emergency. Again, we're working through some of the implementation details and hope to have more information soon.

The next item is support coordinator rate increase. This is for support coordinators under our HCBS waiver program administered by the Division of Developmental Disabilities who function as case managers within those programs. This funding will increase the rate for those providers.We have be working with our partners at the Division of Developmental Disabilities. They are targeting implementation of November 1st, so coming up very soon. I do want to caveat that that's a target

date. I know they are working very intensively to do all of the operational steps and legal steps we need to do to make that a reality. So I think November 1st is a target date. If there are updates to that, we'll be sure to communicate that with stakeholders.

Lastly, on our approved list, there are some dollars for home health workforce development, which is something we heard clearly from stakeholders during the process we ran in the summer. The goal of this funding is to enable new and expansive initiatives around recruitment and retention of the home health workforce. We're working with our partners across our department. Implementation planning is ongoing and we expect to have more details on that both in terms of what we're going to do and when very shortly.

I want to go to the next slide. I do want to turn to the shorter list of items where we don't yet have full CMS approval, where we have some outstanding questions that we still need to respond to from our federal partners. Just as a rough timeline update, we are working actively on getting that additional information for our federal partners and expect to send them responses to their questions in the next few weeks. And we're hopeful that we will receive full approval for these items relatively quickly

thereafter. I don't want to go into all of the details for this group today about every question that CMS has asked. I will say in general the kinds of questions they have asked tend to be fairly technical and seem to be oriented towards confirming that these proposals really fit within their legal redlines and are compliant with the guidance and that, in particular, that some of these things that we are proposing fit within the definition of admissible home and community-based service, as defined for this purpose. So we're very focused on getting that information to them. I would say in general, we certainly don't view approval as guaranteed, but we are cautiously optimistic that we will ultimately have approval for all or at least most of these remaining items. We're going to continue that conversation with CMS.

With that conversation, I will go quickly and just run through what these items are where we're still awaiting approval. There's funding that we proposed around Person-Centered Planning. Our goal here would be to enhance and expand training for the various folks who work, including in our managed care organizations, on our the MLTSS Program and make sure we are really mindful and well trained on the principles of Person-Centered Planning. So more to

come on that.

The next item here is what we are calling Healthy Homes. This is a particularly innovative and new thing for us where we are looking to use some of these dollars to actually develop affordable housing units for NJ FamilyCare members where either a housing situation is affecting their ability to live and thrive in the community. This is separate from but aligned to some of the proposals we included in our draft 1115 Renewal around housing-related services. This is all part of a broader.Strategy and in this case, referencing what I said earlier, we're working, in particular, to make CMS comfortable and figure out a way to move forward with that complies with some of the statutory prohibitions that exist in the law for Medicaid funding room and board. So we're working that through with our federal partners and also, I should say, with various other partners around the state to work on housing issues have been really critical on this project.

The next item is enhanced rates for Applied Behavioral Analysis, ABA, services for children on the autism spectrum disorders. The proposal here would be to increase the rate there to $15 per 15-minute unit, which we're still working through with CMS, some of the

details there.

Moving on, we also proposed a rate increase for the Jersey Assistance for Community Caregiving (JACC) Program which is run by our partners at the Division of Aging Services and which enables non-Medicaid eligible individuals at risk of placement in a nursing facility to receive services and remain in the community. This is broadly aligned with the item that is in our approved list around increased rates for personal care assistant services.

Moving down the list, we also had a proposal that we developed in partnership with our partners at Department of Children and Families around intensive mobile services for the I/DD population. And the proposal here would be to establish a mobile treatment team to deliver interventions and support to youth with I/DD and with co-occurring needs within their home and community. We are working through with CMS to get them some additional information about how that program would function.

And then the last item on the list is the Behavioral Health Promoting Interoperability Program. Just as a reminder, previously, we had run a Promoting Interoperability Program using state dollars focused on connecting providers with Substance Use Disorder (SUD)

services through the implementation and upgrade of our systems. This funding is intended to extend a expand that, in particular to expand it to other behavioral health providers who weren't eligible for the previous program.This one, I will note, was also part of our 1115 Renewal proposal. There are a couple of different CMS approvals that are working together here. So we're continuing to work through our federal partners on that.

So that's my summary of where we stand on the enhanced federal match for HCBS services.

Dr. Spitalnik, I don't know if you want to pause or you would like me to keep going to the next topic.

DR. SPITALNIK: I do.And thank you for that. One concrete question before I open this to the members of the MAAC is do you have an approximate date for submitting the waiver to CMS?

MR. WOODS: I don't have a specific date to share at this moment. I think we would hope that -- I think we would hope to be submitting that final proposal in the next few weeks or month, but I don't have a specific date. I think it will depend on as we work through some of the substantive issues.

DR. SPITALNIK: Thank you for that. With

that, if members of the MAAC have questions or comments about either the waiver renewal or the FMAP increase, this would be the time to raise them. Any questions?

MS. ROBERTS:Yes. Thank you very much.

Greg, thank you. This was great, great information, a lot of information. I'm particularly excited about what you said about the intensive mobile services for children with I/DD and certainly hope that the remaining issues with CMS can be resolved as soon as possible.

I have a very quick question because you provided so much information. When you talked about the increase in the rate for PPP being increased to $19 an hour, I'm not sure if I heard you say that was specific to people in MLTSS.I believe it should be for everybody who receives Medicaid on that PPP increase, but I just wanted to confirm with you that it's for everybody who is receiving Medicaid and who receives PPP services.

MR. WOODS: Thanks, Bev. I think I misspoke. Thank you for correcting me. It's certainly individuals with MLTSS but it's anyone in the PPP program, any Medicaid, really. So I apologize.

MS. ROBERTS: Thank you. Thank you very much.

DR. SPITALNIK: Thank you, Bev and Greg.

Any other questions for Greg at this juncture?

I will just share a comment from stakeholders which is, as these be opportunities are being implemented, are there junctures or opportunities for stakeholders to work collaboratively in implementing these initiatives for stakeholder input, not only in the choices that have been made and approved, but in the actual implementation?

MR. WOODS: I think the answer to that is certainly yes. I think what that will look like will depend a little bit on the specific initiative. There are going to different, I think, stakeholder communities involved in different initiatives. Our intention is very much to work with the relevant stakeholders on each of these and reach out. So, yes, please stay tuned. I would say if anyone who is listening to this meeting, if there's a specific initiative you want to be more involved with, please do feel free to reach out to us. We really welcome that and we can make sure to get you connected. I think we also intend, as before, with the various items on this plan to reach out to various members of the community.

Jen, I don't if there's anything you want to

add.

MS. JACOBS: I agree with you, Greg. Absolutely. It's been part of the process all along, so we'll keep it that way.

DR. SPITALNIK: Thank you. And we'll certainly add that as a forward agenda item to keep track of that. Thank you so much.

We will now look to the provider relief funds information. And again, Greg, we're not letting take a breath. Thank you for this.

MR. WOODS: Thank you. So I do want to turn now to give some very high-level updates on the COVID-19 provider relief funding that is currently being offered by the federal government. Before I dive into this, I do want to emphasize this is a federal program. It's not administered by DMAHS or any other part of the state government, and we are not the subject matter experts on every detail of implementation, which can get quite technical. This program is administered by the Health Resources and Services Administration (HRSA), which is a federal agency within the U.S. Health and Human Services (HHS)federal agency. So I will say if you have questions, we do strongly recommend that you go to HRSA to get them answered. That said, we did want to spend

a few minutes today on this since it is an important opportunity for providers in New Jersey and also because while the program is not administered by Medicaid or by the State, providers may qualify for funding under this program, partially at least by virtue of having participated in NJ FamilyCare. So we wanted to talk about it to make sure people are aware. I do want to emphasize this is a federal program and that's probably, in general, the best place to go for specific or detailed questions.

So without going into a ton of detail -- there's more on this slide -- I did just want to note there have been three previous phases of the provider relief fund that the federal government has administered I think should be familiar to many of you. Across those three phases, they distributed somewhere north of $75 billion to providers nationally. There's a lot of complexity. Those dollars, they were distributed on a range of factors, including lost revenue during the pandemic as well some of it was distributed based on total historical Medicaid reimbursement, so those three stages were in the past. Now HRSA has announced a fourth phase.

I just want to say really loudly and clearly upfront, the deadline to apply for that fourth phase

for providers is October 26th, which is just five days away. And the application does require some significant documentation, so I am hopeful that most of the providers on this call are already aware of this opportunity and have assessed whether this is something they want to pursue. But if you have not, I would really encourage you to drop everything and take a look.

Because it might take you a few days to pull all the documentation together that you would need to apply. Again, it is only five days away, that deadline.

Go to the next slide. Quickly, a couple of points about this funding that's available.The fourth phase, the phase that they're currently accepting applications for, it includes 8 and a half billion dollars that they're planning to make available for rural providers. I do want to note that most of the time when we talk to the federal government, they don't consider any part of New Jersey to be rural. The Census Department has ways of defining rural, and none of New Jersey qualifies. However, my understanding is that HRSA is using an alternative definition of rural for this purpose and that it may include some limited areas of New Jersey.So I would just flag that

for providers that I would not assume that you're not eligible for that. So there's 8 and a half billion for rural providers. And then on top of that 8 and half billion, there's an additional 17 billion which is available for providers regardless of geography.And in order to qualify, providers need to document that they have revenue losses in the period from July 2020 to March of 2021.

The formula that HRSA is planning to use to distribute these funds is quite complex, and I am not going to attempt to summarize it.I will just say at a high level that there are various inputs into that formula. It includes revenue losses that providers may have experienced, changes in expenses due to the pandemic. There are different pools of money available for different providers based on their size. And then total Medicare, Medicaid, and CHIP billing also is a factor in calculating the payments that are available to each individual provider. On top of that, my understanding is that the final details of the formula that HRSA will use won't be finalized until after applications are received so that HRSA can make sure that whatever formula they're using, the amount of money they have, corresponds to the number of providers who have applied for support. So a lot of complexity

here. More detail to come. There is a lot more information on the HRSA website if you're interested in looking more closely.

We can go to the next slide. As I mentioned this is not a simple application.I just wanted to quickly flag some of what's needed. If you are going to apply, providers who apply for this funding are expected to provide significant documentation. This includes a list of billing numbers, internal financial documentation around changes due to the pandemic and tax returns. My understanding is that HRSA will then combine that data with the data that the federal government already has access to around Medicaid and Medicare reimbursement when calculating the amount of funding that each provider qualifies for, and they have been in contact with all state Medicaid agencies and they are having a challenge with identifying the correct data for a provider around Medicaid reimbursement.

So again, like I said, it's not a simple application. There is a lot of documentation that's required, and the deadline is coming up very, very soon on October 26th. So we would strongly encourage any provider who think they may qualify to really look at that right away. And if you do have any questions, I

recommend following up with HRSA.We're, of course, happy to help however we can, but we're really not the subject matter experts on this. And I think there was a link on one of the earlier slides to the website that has all of the information around this program.

DR. SPITALNIK: Thank you so much, and thank you for, not all the work you do, but the clarity you bring to it and in helping make it accessible to all of us.

Jenn, or any members of the MAAC, any comments or questions around provider relief funding?

Hearing or seeing none, with great thanks again to Greg for all these efforts. We'll now move to have social drivers of health. And Medicaid has always had a public health perspective and more and more in the larger world we're understanding that many of the factors that affect our health and well-being and services come out of the social environment.So it's very exciting to hear both about the housing that's proposed in FMAP relief and now to turn to this section. And I'll turn to Jennifer Jacobs to talk more about social drivers specifically, the Lifeline free smartphone, and the Emergency Broadband Benefit.

Assistant Commissioner.

MS. JACOBS: Thanks, Dr. Spitalnik.

We started this conversation a little bit at our last MAAC meeting, sort of mentioned it as an aside and said that we would come back to the Lifeline free smartphone. We really wanted to share some good information with you today. Also during the Public Health Emergency, there's something called the Emergency Broadband Benefit, so this is new and it is temporary during the federal Public Health Emergency, but important for you to know about.

The pandemic itself has given us -- everyone was already talking about social determinants or social drivers of health. We've been having this conversation, planning to build it into our 1115 Renewal, building it in lots of other ways separate from the 1115, making sure that it was always on the table and part of our discussions. But I will say that the pandemic brought that into sharp focus.And in a couple of specific ways, really upfront at the very beginning, as you know, shelves were emptying out and stores were sometimes closing altogether. Congregate dining spaces were closing. We saw food insecurity happening in a very serious way for our members.And that was something that that we jumped on with our health plans as we were doing high-risk outreach work. Another thing that kicked up very early in the

pandemic was telehealth. So the plans have been publicizing this free smartphone benefits through their websites and through care management, but the State -- because it's a federal benefit, the State hadn't yet created a state-based resource for this. And we now have, but I want to walk you through the benefit itself so that you can see what it's all about and then we're excited to share the new website with you.

So the free smartphone benefit is available broadly in the community. But every NJ FamilyCare household qualifies for this free smartphone through the federal program just on the basis of they qualify for NJ FamilyCare, they qualify for this smartphone. But I want to put it on your radar that it's not only our members who qualify. It is worth getting to know the program if you're a community-based organization or advocacy group that might not have been familiar with this already, just broadly for the people you serve.

So this is a program that provides low-income households with a free smartphone and the wireless phone service you need to use that smartphone. So that really means some free data, monthly minutes, and texting. And we see that as important for improving access to telehealth and care coordination, but also for being connected to providers

and to natural supports, having that cell phone and, in particular, a smartphone can be really important.

I think many of you are familiar with the relaxation of the telehealth rules during the Public Health Emergency. We don't know what will happen next with that at the federal level. We're trying to make sure that we're at the table to hear what's going on at the state level. But previously, you really needed to have an encrypted platform for a telehealth visit. And we didn't want to be in a place where our members don't have access to telehealth because they don't have a cell phone. So hopefully, a lot of those relaxations of rules during the pandemic will continue forward into the future. But in the meantime, we want to make sure that we're putting cell phones into as many people's hands as we possibly can.

There are a couple of ways that people access this program. You can go to the federal website. I'm not sure I would highly recommend that you do that and that's why it's not on this page. The federal website is really hard to follow. But there are two providers who offer the wireless service here in New Jersey, and that's how somebody can sign up for the free smartphone. They are Assurance and SafeLink. So we've given you those websites because

it's a little bit of quicker path, if that makes sense, to getting to that cell phone.

It's important to note that the Public Health Emergency has led to this Emergency Broadband Benefit which I will talk about in a minute. And someone who has a smartphone can access that Emergency Broadband Benefit a little bit differently than somebody who doesn't. So we'll come back to that in just a moment.

The other thing I wanted to point out to you is the health plans have partnerships with these providers, so everyone can get a free smartphone through either of these providers. But if they have a particular health plan through NJ FamilyCare, they may want to check in with each provider to see if there's some additional benefits that they may be able to access because of the particular plan. You can see here, we've tried to give you the information that is current today for the partnerships that exist between the plans and the wireless service. But as you know, these things can change. So we wanted to make that information available to you.

This is the free smartphone benefit that I've been talking about for a moment. It gets a little confusing, so stay with me as I go to the next page,

and you're going to see that same diagram on the next page. There's Assurance and SafeLink again on the right, but now we're talking about the Emergency Broadband Benefit. And this, as I said, is being provided during the Federal Public Health Emergency and it is meant to support households accessing Internet service.

As you know many, many aspects of society shifted from face-to-face experience to online platforms, just as we did here with the MAAC meeting. And so that is recognized here, that people need access to broadband. And there are a couple different ways that households can access the Emergency Broadband Benefit. One way is through that free cell phone we talked about a minute ago. Households that have that free Lifeline cell phone can get unlimited talk, text, and data on their Lifeline phone through the Emergency Broadband Benefit.And households that don't want to access the broadband benefit that way could also choose to receive a discount on broadband service up to $50 a month, which is not small dollars. So we want people to be aware of both options.It's your option. Each household can choose which one to go with. So, for example, if you had a Lifeline phone but you didn't want the unlimited talk, text, and data and you really

needed the emergency broadband, the $50 discount at home because of kids doing online after-school activity or whatever, and certainly if schools closed again -- every parent in the room is saying, "Please don't let that happen" -- you could elect the discount instead of the unlimited talk, text, and data.

We are really excited about the unlimited talk, text, and data because we just feel like it opens up telehealth options for folks, and that feels really important.

So a couple of ways to access the emergency benefit. If a household wanted to go with that unlimited talk, text, and data through the Lifeline smartphone, they can talk to their service provider, Assurance or SafeLink. You see why we included that same diagram on the second page. And if they wanted the broadband discount, we've provided information here on how to access that broadband discount.

At the bottom of this page, you see the website that we've developed, digital access for all, and you can go to that site to get essentially the same information I've provided here, but it lets you sort of forward the link rather than forwarding our giant MAAC slide deck. And we're going to continue to build that site out over time. It is simple because it is not

to confuse people, just give people the simplest path to the program. It is a federal program. But we're really trying to just support access, and we're going to continue to work with our managed care organizations to make sure that our NJ FamilyCare households are aware of this benefit.

Dr. Spitalnik, the last time we got together, folks had interest in this. We wanted to give you everything we've got on it. As Greg said, it's a federal program so we're not the subject matter experts, per se, but we have done a deep dive here to try to make sure that we're giving people access to this program as much as possible.

And last thought, there is a New Jersey program called Lifeline that is utility assistance. It's unfortunate that we have a federal Lifeline and a New Jersey Lifeline. Those are two different programs that actually have a lot of overlap in terms of eligible populations. But we are excited to continue to promote this benefit so we're making sure people have access to services, including and especially telehealth.

DR. SPITALNIK: Thank you so much for the clarity of this.

I will call everyone's attention to the fact

that in the chat you can copy the link for this program.

And at this juncture, I will ask if there are any comments or questions from the members of the MAAC about this program, understanding that you're transferring application information to all of us. Any comments or questions?

At this point, let me add, and I'll thank one of our stakeholders for saying that in addition to having a paper application there is a toll-free number for assistance in filling out the application. And also note that Comcast has Comcast Essentials that is also a program for Internet access.

So that concludes our agenda except for our forward look.And we wanted to be visible on the screen as we look towards the planning for our next meeting, which is January 27, 2022. So far in my notes, there is interest in the implementation around the FMAP opportunities and stakeholder involvement. There's a request for information about behavioral health integration and specifically behavioral health services for the intellectual and developmental disabled population. We will also be requesting an update on the progress of the comprehensive waiver, both submission and any response that there's been for CMS.

Beyond being able to read my own handwriting, what other things would MAAC members or DMAHS suggest for our next agenda?

MS. ANGELINI: It's not an agenda item, but I thought I saw on one of the slides that we have to meet to approve something. I saw September 13th. Did I misread that?

MS. JACOBS: Maybe it was the 1115 thing, Greg?

MR. WOODS: Mary Pat, I think September 13th may have been the date we held a special MAAC meeting on the 1115 review.

MS. ANGELINI: Oh, it passed. I'm sorry.

DR. SPITALNIK: Just from a process point, let me clarify that we did not have minutes from that meeting because of the nature of that is a special meeting, and miraculously we are up to date with the approval of our minutes. But thank you for keeping us on track.

Beverly, what would you like to say at this juncture?

MS. ROBERTS:I guess it would be great for Greg to be able to give us an update on the increased spend plan items that are still being discussed with CMS, which he probably would be doing anyway, to just

sort of see where things are.

DR. SPITALNIK: Thank you.

From Theresa or Wayne, any other agenda items?

Seeing none from Theresa, hearing none from Wayne, we have -- well, first let me again express our thanks and admiration to the Division of Medical Assistance and Health Services and Jen Langer Jacobs' leadership and Greg Woods' leadership in policy to have been responding to the need of beneficiaries in the Public Health Emergency, to keep the program on a forward roll, and to not losing the initiatives that are so important as the extraordinary demands upon NJ FamilyCare and all of the programs of the Department of Human Services.

I also want to reflect on the attention to detail that the Division puts into the MAAC meetings to ensure that there is clarity and transparency and opportunities for participation. We are struggling with both, of course, responding to state policy, but the challenge in assuring participation, which are virtual mode, has increased missing the close interpersonal action, but looking forward to the next year.

At this juncture, we've made the

determination that at least at the start of the year that our meetings will be continued to be remote, and we continue to try to find ways to ensure through question and answer function that we fulfill both our requirement and our shared commitment to stakeholder input.

So at this juncture, we are scheduled to meet virtually all of these meetings for the next calendar year are 10 a.m. to 12 noon for Thursday, January 27, 2022; April 28, 2022; July 28, 2022; and a year from now October 27, 2022. And so with the hope of giving everyone back six minutes in their life, per our schedule, do I have a motion to adjourn?

MS. ROBERTS:Motion to adjourn.

DR. SPITALNIK: Second.

MS. ANGELINI: Second.

DR. SPITALNIK: Adjournment doesn't require a vote, so I thank everyone again for their participation, and with wishes for good health, good holidays, well-being, and enjoying this beautiful fall. Thank you all, and we look forward to seeing you in the new year.

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

CERTIFICATION

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

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Lisa C. Bradley, CCR

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