MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Videoconference
July 22, 2021
10:00 a.m.
FINAL
MEETING SUMMARY

MEMBERS PRESENT:
Deborah Spitalnik, Ph.D., Chair
Mary Pat Angelini
Chrissy Buteas, via audience phone line
Mary Coogan
Theresa Edelstein
Beverly Roberts
Wayne Vivian

MEMBERS NOT PRESENT:
Sherl Brand
Dorothea Libman

ALSO PRESENT:
Sarah Adelman, Deputy Commissioner
Jennifer Langer Jacobs, Acting Commissioner
Heidi Smith, Chief of Operations,
Division of Medical Assistance & Health Services
Greg Woods, Chief Innovation Officer,
Division of Medical Assistance & Health Services

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

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, and as Chair of the NJ FamilyCare Medical Assistance Advisory Council (MAAC), it's my pleasure to welcome you to the July 22, 2021 meeting. In compliance with state restrictions, we are meeting virtually.

Let me share that this meeting has been advertised in accordance with the New Jersey Public Meetings Act, and I will review our processes in this format. In a moment, I will review the agenda and we will have introductions from the MAAC members and the Department of Human Services and the Division. MAAC members will be able to speak or put questions in the chat or comments. As always, we ask everyone to defer to the MAAC membership after each subject area. Members of the public and stakeholders are welcome to put questions and comments in the Question and Answer (Q&A) box at the bottom of your screen, and we will do our earnest best to get to those questions. If we are unable to respond to them or raise them on the screen, they will be brought back to the Division of Medical Assistance and Health Services (DMAHS).

So today, our agenda is that we will review the minutes from our previous meeting. We will welcome Acting Commissioner Sarah Adelman who will provide an

update from the Department. There will be NJ FamilyCare updates by Greg Woods and Heidi Smith. And, then there will be policy implementation presentations and the opportunity for discussion with Assistant Commissioner Jennifer Jacobs and Greg Woods. Then, as always, we'll collect our agenda items for the next meeting, and we will end promptly at noon.

So with that, let me ask the members of the MAAC to unmute. And, Beverly, Mary Pat, please introduce yourselves.

MS. ROBERTS: Thank you so much, Deborah. My name is Bev Roberts, with the Arc of New Jersey.

DR. SPITALNIK: Thank you. Mary Pat, and then Theresa and Mary.

MS. ANGELINI: Hi, everybody. My name is Mary Pat Angelini. I'm the CEO of Preferred Behavioral Health Group.

DR. SPITALNIK: Thank you.

Theresa, please.

MS. EDELSTEIN: Good morning, everyone. I'm Theresa Edelstein, Senior Vice President of Partnerships Transforming Health at the New Jersey Hospital Association.

DR. SPITALNIK: Thank you.

Wayne.

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

DR. SPITALNIK: Thank you.

And Mary.

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

DR. SPITALNIK: Thank you.

And from the Department, Commissioner.

MS. ADELMAN: Good morning, Sarah Adelman, Acting Commissioner at DHS.

DR. SPITALNIK: Thank you.

From the Division, Jen.

MS. JACOBS: Good morning, Jennifer Jacobs, Medicaid Director.

DR. SPITALNIK: Thank you.

Greg and then Heidi.

MR. WOODS: Greg Woods, Chief Innovation Officer for Medicaid.

MS. SMITH: Good morning, Heidi Smith, Chief of Operations for Medicaid.

DR. SPITALNIK: Thank you.

And right now, 162 of us are together within this virtual space.

I will turn to the approval of the draft

minutes from our last meeting, which was April 22nd of this year. An earlier version had the incorrect date, but that has been updated.

Are there any additions or corrections to the minutes from the members of the MAAC?

MS. ANGELINI: Move to accept the minutes, as presented.

DR. SPITALNIK: Thank you. Second?

MR. VIVIAN: Yes, I'll second it.

DR. SPITALNIK: Thank you.

Do I have a motion for approval?

MS. ROBERTS: Motion to approve.

DR. SPITALNIK: Thank you. If you can unmute, do you approve the minutes?

MAAC MEMBERS: Aye.

Any abstentions?

DR. SPITALNIK: The minutes of April 22nd are approved.

And again, our thanks to Phyllis Melendez and Lisa Bradley for producing these.

I now have the pleasure of turning to Acting Commissioner Sarah Adelman for an update from the Department of Human Services. Commissioner.

MS. ADELMAN: Thank you, Dr. Spitalnik. And good morning, everyone. As you saw in the last slide,

there's a very packed agenda for our morning today. And I just want to take an opportunity, as you'll hear from our team today, about all of the many things going on to thank Assistant Commissioner Jacobs and the entire team at Medicaid for the extraordinary work and commitment of the Division over the last many months. I think you will see just how much is going on, and we're just very grateful for the dedication of our team.

I am going to just talk a bit about the Fiscal Year 2022 budget and highlight a few initiatives at the Department of Human Services.

As many of you have likely followed closely, a few weeks ago, Governor Murphy did sign the Fiscal Year (FY) 2022 State Budget, which is a responsible and bold budget that meets the State's current and future obligations, making New Jersey more affordable for working and middle-class families, providing record investments in education and health care, supporting pandemic recovery, and investing in small businesses and long-term economic growth. It is a true statement of values that prioritizes initiatives at our Department to support New Jerseyians in every stage of life. And I'll just take a few moments to highlight just solve those initiatives for New Jersey Human

Services.

Starting in our Division of Aging Services (DoAS), we are raising the income limits for our prescription assistance programs, PAAD and Senior Gold, by $10,000 each. Those programs help older adults pay for prescriptions and premiums and Medicare. And we anticipate many thousands of New Jerseyians becoming eligible as part of this increase for the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program and Senior Gold.

We've also, with AARP and a number of advocates here today and across New Jersey, recently launched an Age Friendly New Jersey Initiative, which is going to work in partnership with communities across New Jersey to help make our State a more accessible and inclusive place to live at any age for individuals with disabilities and individuals through their lifespan as they age.

And we are maintaining a 10 percent rate increase for Medicaid rates for nursing facilities, which has allowed facilities to make significant investments in frontline worker wages and in infection control and response to the pandemic. The investment this year also adds some additional funds on top of that 10 percent increase to maintain compliance with

the progressive minimum wage. So we have a total of $174 million in new funding going to nursing facilities this year using state and federal funds.

This is also a bill full of tax relief for so many New Jerseyians who will benefit from these initiatives. I wanted to highlight, in particular, the Homestead Benefit which will increase tax benefits for older adults over age 65 who are homeowners. And we have also made some changes to the Earned Income Tax Credit (EITC) to expand to residents 65 years and older without dependents. Last budget cycle we made some increases for younger adults, and this year we're continuing those with older adults.

Our budget also continues to build on increases that we've made for several years in the developmental disability community, increasing DSP wages by an additional $42 million in this budget; increasing rates for residential providers, which is something that began during the pandemic that we're continuing for the first part of this fiscal year to help providers who have individuals at home in their residence while day programs are closed or partially closed; and an increase for our day program providers as they work to reopen, bring back staff, and meet all of the various health and safety requirements.

We're also going to hear a bit later in our presentation about our groundbreaking investments to cover all children in New Jersey in health insurance. There are about 90,000 kids in New Jersey without health insurance today, many of them eligible for our Medicaid program and others that aren't because of immigration status or income ineligibility. So we have introduced a proposal over the next two years to make affordable, accessible health care available for every child across New Jersey. This is something that the Governor and our Department will be working on very closely and is a huge tenant of his budget this year, and we're very excited to be moving it forward across our administration and with the many advocates who have helped us get here.

We are also continuing to make investments in our Department across government in an all-government approach in the First Lady's Nurture New Jersey Initiative. We'll talk more today about some of the things that we're doing as part of Nurture NJ in our Department. But one of the things that I think we've all followed closely over the last couple of years is our ability to expand coverage for moms after they deliver. We have 60 days of coverage for new moms after delivery as part of our Medicaid program. Under

the last federal administration, we had attempted to extend that to 180 days, and President Trump's administration did not approve that plan. But now in partnership with the new administration in Washington, we are moving forward with a plan to expand coverage for new moms for a full year postpartum. We're very excited about this. And we know that from data it will improve outcomes for both maternal and infant health.

We are also adding $19 million to support reproductive health. We have a small fund that has been funded in the budget in our Department for many years to provide prenatal services to women who are not eligible for Medicaid, even when they become pregnant. This fund usually runs out of money within the first couple of months of the fiscal year, so we have made some significant investments in this budget to ensure that we have funding throughout the fiscal year for prenatal services for new moms ineligible for Medicaid.

We are also making continued investments in our regional health hubs and in personal care assistance, assisted living rates, and adult medical day services. We know all of these services and providers have been on the frontline of providing care for individuals throughout the last year and a half, and we're very excited to reflect the important work

that they've been doing through continued increased wages and rates in this fiscal year.

We're also making significant continued investments in child care through our child care subsidy program to provide subsidies to low-income families who need assistance with child care. And we know, especially after the last year and a half, that child care is essential to economic recovery. And so we are adding an additional 60 million in our state budget to help support these investments and infant rates and child care subsidies. We'll also be working with the Economic Development Authority on grants for child care providers to help continue to increase their infrastructure and become quality-rated providers in our Grow NJ Kid system. And these investments, like many others, build on significant federal funding we're receiving through the Corona Relief Fund and the American Rescue Plan. So we will be spending nearly a billion dollars on child care throughout the pandemic period in New Jersey.

We're also continuing to make new investments and grow our staff in our new Office of New Americans at the Department. Earlier in Governor Murphy's administration, we created this office to ensure that New Jersey is a welcoming state and that

there are partners and state agencies to work with community providers to ensure that new Americans in our state feel welcome and have all of the resources at their disposal they may need. So we are increasing funding for removal defense funding and we are increasing funds for young immigrant children living in New Jersey.

We're also continuing to make investments for counties to operate Code Blue placements and Cold Blue shelters for very cold and very hot days. And we are increasing shelter rates to our shelter providers across New Jersey so they also can continue to increase rates with the progressive minimum wage.

One of the things not noted here I wanted to also mention is that the budget is also investing in a new program in our Department in partnership with the Rutgers School of Social Work and the Hudson Pride Center to provide training to shelters across New Jersey in LGBTQ issues and making our shelters a safe and inclusive place where workers have things like cultural competency and implicit bias training and some training in the experience of LGBTQ+ homeless individuals who make that experience more successful.

Also making some ongoing investments in our Division of Mental Health and Addiction Services

(DMHAS), we are increasing our rental subsidies for individuals receiving supportive housing funds through our Division of Mental Health and Addiction Services to increase our subsidy rates with new fair market rent standards. And one of the new programs we're very excited to launch this year is a new program to fund psychiatric residencies to begin to build a pipeline of psychiatrists who specialize in the myriad of issues that individuals interacting with our Department are facing. So we will be funding 10 new residency slots across New Jersey for a full four years, and we hope to continue to build on this program in future years. This is a very exciting new initiative to build our pipeline.

And finally, I wanted to highlight the extension of our Early Intervention Support Services (EISS). We have EISS response in 11 counties in New Jersey today, but this budget will fund our Division to be able to expand these services to every county across New Jersey.

We are also making some important changes in benefits that are available to individuals after incarceration. There have been some historic rules that prevent individuals with certain drug convictions to receive benefits upon release. We know that that

extends cycles of recidivism and challenges for individuals upon reentry. So we're excited to be able to change these rules so that any individual leaving incarceration is able to access our programs if they're eligible.

Another exciting initiative, for more than 30 years, our reimbursement rates to help support individuals needing financial assistance to purchase hearing aids has remained the same. So after 30 years of no rate increases, we've been able to significantly increase our hearing aid reimbursement for individuals needing to buy one or two hearing aids from $100 each to a total of $1,000 in reimbursement. So this is a significant increase to this benefit and one that has been a long time coming. And we're very excited about the possibility of helping additional individuals with reimbursement for these important and valuable hearing aids.

And finally, I wanted to point out that the budget also increases by one and a half million dollars funding to our Centers for Independent Living (CIL). These are often the first place in the community that individuals with disabilities access for services and support. So we're very excited to be able to continue to enhance the services and the funding for ourselves

across the state.

As I mentioned, these are just a few of the highlights. There's so much more, and I know that we'll be working in partnership with many of you over the coming years we implement these budget initiatives. I appreciate the opportunity to highlight a few of them for you all. And I want to thank each of you in the advocacy community for your work to continue to raise your voices and draw attention to human services issues. Without your partnership, we wouldn't be able to achieve all we have in this budget. So thank you. And I will now turn it back over to Dr. Spitalnik.

DR. SPITALNIK: Thank you so much, Commissioner. I know what your schedule is like. And thank you for this and a very heartening presentation about where we're moving forward as a state. My understanding is that you need to jump off the meeting. I didn't know if you had time or if there were comments from the MAAC. Let me know what works best in your schedule.

MS. ADELMAN: Of course. If there are questions, I'd be happy to try to help.

DR. SPITALNIK: Thank you. I'm setting aside the virtual gavel and just wanted to comment. My hope is that in the very timely and long-needed support

for psychiatry training that that also addresses co-occurring developmental disabilities and mental health conditions, also a very underserved area that needs to be built into curriculum.

Mary Pat, did you have a comment?

MS. ANGELINI: No. I was just going to agree with you a hundred percent. Thank you for raising that.

DR. SPITALNIK: I see Beverly.

MS. ROBERTS: Totally agreement. Total agreement with what Deborah just said. Thank you.

MS. ADELMAN: So two things. I mentioned that we don't have time to talk about all of the things in the budget, but I will note since you're raising this that the budget continues to fund with $9 million some funding for our Division of Developmental Disabilities (DDD) to make investments specifically in this area, individuals with Intellectual/Developmental Disabilities (I/DD), with co-occurring mental health conditions or individuals with I/DD who may not have a co-occurring condition but may have significant behavioral needs related to their underlying diagnosis. So, we are continuing to move forward with all of the initiatives that are part of that previous budget funding that continues to be funded in Fiscal Year

2022. And for the new initiative in partnership with some of our universities across the state for the pipeline program, we will be ensuring individuals in their rotations have training in all of the different areas that are top-of-mind for our Department from addiction to IDD. So absolutely top-of-mind, and our Department's divisions will be working together on all of these things.

DR. SPITALNIK: Thank you.

Beverly and then Wayne, please. Wayne, did you have a question or comment?

Anyone else from the MAAC?

MR. VIVIAN: No. I'm sorry. I couldn't unmute. No, I don't have any questions. Thank you.

Thank you, Assistant Commissioner. Thank you.

DR. SPITALNIK: Thank you.

Again, our thanks to you and the Governor and the Legislature for this.

We're now going to turn to a series of updates from NJ FamilyCare. Greg Woods, the Chief Innovation Officer; and Heidi Smith, Chief of Operations, we have two different topics, and I'll ask each of you to just sort yourself out. I'm not sure who's going to cover.

Heidi, are you covering enrollment?

MR. WOODS: I think I'm going to go first and then I'll hand off to Heidi.

DR. SPITALNIK: Yes.

MR. WOODS: Thanks, Dr. Spitalnik.

So just wanted to give a quick update on where we are with overall NJ FamilyCare enrollment across both Medicare and Children's Health Insurance Program (CHIP). What we're looking at now is an updated version of a slide that we presented to this group previously. It shows our overall enrollment trend. And I think what you'll see here is we're now just above 2 million total enrollees. It's essentially on-trend for where we've been throughout the Public Health Emergency, throughout the pandemic, with fairly steady growth. It represents about a 20 percent increase or several hundred thousand increase from the pre-pandemic low point back in February and March of last year. And as we've discussed at previous meetings, it's a little hard to disentangle exactly what is driving this increase. I think there are multiple factors. Our best guess is that the requirement for continuous enrollment, so the requirement we've discussed before that during the Public Health Emergency (PHE) that everyone is

maintaining coverage, that's probably the largest driver. But again, we think that this continued growth probably represents a mix of factors that can be a little bit tricky to disentangle.

We also did just want to contextualize this. The federal government has recently put out some additional numbers about national Medicaid and CHIP enrollment. And we thought we might quickly show a comparison between where we are in New Jersey and where the programs are nationally. These numbers, I'll note, are a bit out of date. The federal numbers, they only go through February of this year, so we're looking at a somewhat different time window than the previous slide. But with that said, if you look nationally, Medicaid and CHIP enrollment between December of 2019 and February of 2021 went up about 11 million, from over 70 million to slightly over 81 million. When you do the math, that is a 14.8 percent increase. When you look at New Jersey Medicaid and CHIP over the same time period, we're going from about 1.7 million to 1.95. And, again, this is through February, so that's why that number is a little lower than the final number we saw on the previous slide. That represents a 14.9 percent increase. So I think the basic takeaway here is that based on the data we have, New Jersey is pretty

much exactly on national trend. So what we're seeing here is not unique or specific to New Jersey Medicaid and CHIP programs. Nationwide, we see similar enrollment growth.

I think, with that, I'm going to hand over to Heidi for the next section of slides.

DR. SPITALNIK: Thank you, Greg.

Heidi.

MS. SMITH: Thank you, Greg.

I'm going to talk about the redetermination strategy for the conclusion of the federal Public Health Emergency.

Overall, we have a strategy on how we're going to be approaching the redetermination at the conclusion of the federal Public Health Emergency. So we came up with some questions and answers because these are the questions that we are getting. So thank you for the opportunity to have this as an agenda item on the MAAC meeting.

So what's the timeline for continuing eligibility due to the pandemic?

Eligible for Medicaid members continues through the end of the federal PHE, or Public Health Emergency. The estimated time that the Public Health Emergency will last is December of 2021. That's this

December. So we are anticipating that will be the end, but we have to wait for more guidance on that.

What is the Centers for Medicare & Medicaid Services (CMS) saying about the eligibility determinations? What are they telling us about how we are to handle the redeterminations?

So CMS has indicated that all redeterminations conducted within six months before the end of the PHE will be upheld. So we're anticipating that there will be additional guidance. We attend every meeting so that we are using the most up-to-date approach to redetermining our families.

So what's happening right now?

Right now, eligibility workers are conducting redeterminations, and we are noting any changes in someone's eligibility in our eligibility system. This is very important because redeterminations are going out right now and the eligibility workers are processing those eligibility determinations applications that are coming back in. But it's important to note that right now no one is losing coverage as long as the PHE remains in place. And, again, we're anticipating it's going to be December 2021, but we don't have that guidance now. So right now we are conducting redeterminations. We are

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sending out those applications. We need families to respond. And that's how you can help as a MAAC member connected with agencies, connected with the families that we all serve, and the families in our shared community. This is how we need your help to say to families, "Send the renewals back. Keep the agencies, keep the workers updated on any information or anything that's changed with you so our records are updated and current."

We want to help people to understand they may need to provide additional information for NJ FamilyCare eligibility, and we want to help them to move to whatever program or Medicaid option that we have to offer. So during this summer while we are starting to send out renewal applications, we want to be very clear with our noticing to families that if families are not eligible, that they know that they failed to submit something or they failed to return their application, so they will get a notice this summer telling them that, but they're going to maintain their eligibility until the end of the PHE.

So what will happen at the end of the PHE? If a member was found eligible in the redetermination, then their enrollment will continue seamlessly. If a member was found ineligible and a notice was previously

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sent that asked them for additional information or asked them to return their renewal application, then they will receive a final eligibility outcome notice and that will contain fair hearing rights.

After the PHE ends, redeterminations are going to return to normal. And something I can't talk on today, but I plan to talk on at another time, is that during this time of COVID, during this time that we are working through the COVID and all of the changes that we needed to do, we've also been working on streamlining and improving our redetermination processes, making important changes to our system so that we're ready with this new streamlined process when things return to normal. And normal will be after the PHE.

So what else is important to know? Medicaid members must respond to the redetermination notice timely. They must notify NJ FamilyCare when they have a change in their circumstances because, again, it's important that we have the most current information when we process. DMAHS, our Division, will be monitoring the timeliness to be sure that we meet the CMS requirements to renew and do redeterminations timely. So we will be watching this through our monitoring and our reporting.

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So Division of Developmental Disabilities (DDD)-focused redetermination strategy for the conclusion of the Federal Public Health Emergency. So what's happening specifically for the DDD population?

DMAHS shares a list of DDD beneficiaries that are losing Medicaid eligibility through SSI with the DDD care coordinators. We've always done this. This is ongoing. And this helps the DDD care coordinators be aware of which of their clients are going through the redetermination process or losing SSI so that they can help their clients transition to the best Medicaid program that's eligible for them. This is going on now. This has gone on before COVID. This will continue after the PHE. That's a standard practice that we have in place. DDD will be providing guidance to their stakeholders, their care coordinators, and their staff to ensure everyone is aware that we are redetermining eligibility right now. These renewal packets are going out right now, and they must be completed and returned timely.

DMAHS will provide DDD with a monthly report of all individuals that were ineligible after the redetermination that are receiving DDD services so that they know this is the group that did not respond to the renewal or they did not respond to any requested

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information or are no longer eligible. DDD will know that. These individuals also continue to receive benefits until the end of PHE. So this is sort of a heads-up to DDD about their clients that did not meet eligibility. Again, they're going to stay on the program until after the end of the PHE.

DDD can use that list to follow up with their consumers or their clients or their authorized rep to help the family get whatever information is needed so that they can maintain eligibility or transition them to another Medicaid assistance program.

When a DDD beneficiary is determined ineligible on the basis of income, the eligibility worker is expected to transfer the case to our Special Processing Unit that's at the state or CCP and Supports for waiver eligibility review. Our intent is to not have people lose eligibility when they can eligible for a different program. So we want to help with that, and we're asking you to help also by reminding anyone that you're involved with to return and be responsive to the renewals that are going out.

Thank you.

DR. SPITALNIK: Thank you so much, Heidi and Greg. I think there are questions and comments.

I recognize Beverly, please.

MS. ROBERTS: Thanks very much, Deborah.

And thanks, Heidi. That information was very, very helpful.

So I have a question specifically about the last bullet point. So if a DDD beneficiary is determined ineligible on the basis of income, so the case is going to be transferred to the Special Processing Unit. Could you just give me a little bit of information on what would happen in a situation like that.

MS. SMITH: Sure. The county processes cases up to certain income threshold. At the state, we have a special unit that works on the waiver programs, DDD waiver programs. So the plan and our expectation is that someone would not lose eligibility because of their income but they would just be considered for a different program through a seamless transitioning of the case to the special eligibility workers who work eligibility for the waiver programs.

MS. ROBERTS: Does that mean that they are not going to get a termination notice? In terms of the specifics that the county typically, if it wasn't for this, probably a termination notice would be sent out. So are you saying that's not going to happen?

MS. SMITH: That is our intent, Bev, is that

they're on a Medicaid program already. All we're doing is transitioning them to another Medicaid program. They don't get denied and have to do a fair hearing to get back on. We are just moving them from one program to another.

MS. ROBERTS: Okay. There are a lot of moving parts to this.

MS. SMITH: Yes, they are.

MS. ROBERTS: If it works the way you would like it to, it sounds like it's going to be very helpful. Thank you.

DR. SPITALNIK: Thank you, Beverly.

Theresa Edelstein.

MS. EDELSTEIN: Thanks very much, Heidi. Just a couple questions.

We've been on some national calls where the redetermination process has been discussed. And one of the issues that came up was the mobility of this population. Even under more normal circumstances, they're fairly mobile. So I just wondered if you could comment on what's going to happen with all the "return to senders" you're likely to get via the mail? Is there any e-mail contact that you will have with any of the beneficiaries? What's the plan for that?

MS. SMITH: Thank you for that question.

One of the things that we do have in place is our regular mail that goes out. We have one person in the Division assigned to updating addresses. We get updated addresses regularly also from the managed care organizations (MCOs). They do a lot of mailings, anticipatory guidance mailing, update mailing. And when they get mail back also, they let us know that the address has changed. So we are current with our address updates. It is important -- it's one of the criteria to be on the Medicaid program for the beneficiary to alert us when their address changes. We only know of an address change if the mail comes back or the mail is not deliverable. But a family who we don't have that address for, we don't use e-mail messaging to try to reach some via e-mail. That's not our current practice right now. We need their best address. So I think what's going to help us and help our families right now is this outreach that we're going to be doing this summer and that we started this summer. So they've got from now -- I'm saying December. We don't know when the end of the federal PHE is. They have now from to December to right their ship. So we're hoping with our advocacy community and our care coordinators that they can help us and help the family get their correct address and help us get

the correct information so that we can help them maintain eligibility. Our intent is not to do a disenrollment when someone is certainly eligible.

MS. EDELSTEIN: Let's just hypothetically say you get a return-to-sender envelope. Will there be a proactive outreach to the MCO they're enrolled in to see if they have new information or they can do an outreach? Is there some kind of coordination that can occur? And can hospitals and other health care providers help you in any way with that?

MS. SMITH: I'll have to take that back. I'll make a note of that and take that back on how we can best have the most current address. Right now, we take our address changes from the MCO when they provide that. And they send over new addresses every week because they're very good at mailing to their beneficiaries all the time to give them new information. So they send those to us. Our eligibility workers update the addresses so that we have the most current. But I'll take that back. Thank you for that.

MS. EDELSTEIN: And just one last comment. I really love the coordination on the DDD side. If there's something similar that can maybe happen with PACE or AL where there's some sharing of information

where they might be able to do targeted outreach, I think everyone would benefit. That's all. Thank you.

MS. SMITH: Thank you.

DR. SPITALNIK: I don't see any other questions from the MAAC. Let me reflect a comment and one question from the chat.

The issue has been raised that in terms of Social Security Income (SSI) terminations. Workability may be an issue because of the loss of work, employment, during COVID. That's just a comment.

And then one final question. Does October 15, 2020 guidance to MCOs about extending prior authorization for outpatient services which require face-to-face assessments require MCOs maintain existing levels of PCA, private duty nursing, and EPSDT, private duty home care services?

Could either of you speak, or Assistant Commission? Can anyone speak to that? Or is that something that can be responded to later.

MS. JACOBS: There are some details there that matter. And also, we are working on returning our Managed Care Organizations to the field. So we will have some updates on that topic which we're not prepared to discuss today.

DR. SPITALNIK: Okay. Thank you.

MS. COOGAN: Deborah, can I ask a question?

DR. SPITALNIK: Yes. Of course.

MS. COOGAN: Heidi, can I just get a clarification on when you're referring to timely? So given the discussion we've just had about people not keeping Medicaid or NJ FamilyCare updated with their current address, is timely going to be restrictive? Or as long as the information that NJ FamilyCare is requesting is to NJ FamilyCare before the end of the Public Health Emergency, is that going to be considered timely compliance?

MS. SMITH: That's a great question. Everybody knows, I think, that when we send out a renewal application, it says, "Please return this by X." So people have until X to get us back their information. Or as you process it and you need additional information, it always says, "Please return it by X." What is new about this process is we're starting six months ahead. So families are given a little bit extra time, right? If they're getting a notice in July, August they didn't respond, they still have more time because the PHE is still going on. So absolutely, if the renewal comes back or that piece of information comes back before the end of the PHE and we can update their information and satisfy that renewal

request, then they're golden. They're good.

MS. COOGAN: Okay. Thank you. I just wanted to make sure.

DR. SPITALNIK: Anyone else from MAAC.

I'll ask my MAAC colleagues in the next period to use the raise hand function at the bottom of the screen which will help us ensure that your questions get answered.

We now turn to a series of presentations about policy implementation. There are three topics. We will entertain comments or questions at the end of each specific topic. These are rich, robust areas for discussion and input. We will do our best with the virtual format, but I will also say in advance that we anticipate a special meeting of the MAAC sometime in the next month prior to the submission of the 1115 Comprehensive Waiver (Waiver). So I'm kind of going backward in terms of the agenda, but I wanted to reassure everyone of our commitment to stakeholder input.

So I turn to Jennifer Jacobs, the Assistant Commissioner for DMAHS; and again, to Greg Woods.

MS. JACOBS: Thanks, Dr. Spitalnik.

I will talk first just for a couple of minutes here about the Cover All Kids (CAK) Initiative,

which the Commissioner mentioned just a few moments ago. This initiative is an exciting one that includes the $20 million in the State Fiscal Year 2022 budget which the Commissioner mentioned. The intention here is to guarantee health care coverage with comprehensive benefits, meaning primary care, specialist care, dental, vision, mental health, and more, for all of our children in the State of New Jersey. And we expect to implement this over a couple of phases, a couple of years. And once we have done so -- to the point that Governor Murphy makes in the yellow box here, once we have done so, we'll have laid a foundation that offers access to quality health care that all kids deserve. And this feels like a critical initiative for us. We're going to talk to you about a lot of other things that are happening, but this one is important.

So we wanted to just give a high-level timeline for today so that you have a sense of what Medicaid will be working on in this regard over the course of State Fiscal Year 2022, so that means from now until next June, and then what really is a longer-term effort. So the work behind the scene starts now and then becomes much more visible beginning in July of 2022.

So our focus here in Phase 1, meaning for

the current fiscal year, is to reach the 53,000 children the Commissioner spoke about who are currently eligible for our program but are unenrolled. And they're unenrolled for some good reasons. We need to address the barriers we see for families wanting to access our program, so there are a couple of things we're doing.

We are eliminating the 90-day waiting period that exists for coverage for children who are newly enrolling in the program. That waiting period was put in place, I think, years ago with concern that people would drop their private coverage and enroll on CHIP, and there was a concern about what folks called crowd-out. We are eliminating that waiting period because we also recognize that what was set up there may create a barrier to folks enrolling their kids, and we want to make sure that all children have coverage right away.

And we are also removing the premiums that families have paid for their children enrolled in the CHIP program. So we did take that step during the Public Health Emergency. It will just continue beyond the Public Health Emergency. So those couple of barriers will be addressed.

And then this important piece in Phase 1

about supporting connection to coverage and really doing targeted outreach with community organizations to help New Jerseyians understand that this program is available for their children and to encourage them to sign those children up. In some cases, those are families, as the Commissioner has referenced, who were very concerned about signing their children up for benefits even though they were eligible maybe because of immigration status in that household. And we want families to understand that in New Jersey they are welcome to enroll and that this is a new era, a new chapter.

And then there are families who simply haven't been aware of the program or haven't been focused on signing their kids up for coverage. So doing a little bit of encouragement and education in the community, we think, will help us reach more of those 53,000 kids.

And then behind-the-scenes work happening now, but really with focus on outreach beginning in July of 2022, we want to reach about 36,000 children who are not eligible for our program today either because the household income is too high or because of their immigration status. And so there's a couple of ways we will get at that. One is we'll work with our

state-based exchange, which is called Get Covered New Jersey. And through that partnership, offer subsidized coverage for children whose household incomes put them above our CHIP income eligibility limit. And that's about 94,000 for a family of four. And then also develop coverage options for children who do not meet lawfully present status that is required for participation in our program. So we're working through the options and considerations for these 36,000 children behind the scenes right now, thinking about what are the best ways to cover these families and these children, and then really with focus on getting out in the street with it July of 2022.

So that is really at this moment the update for Cover All Kids. A lot of work in progress around Phase 1 in particular. And I'm happy to pause here, Dr. Spitalnik, and take any questions from the members of the MAAC before we move on to talk about home and community-based services.

DR. SPITALNIK: Thank you for anticipating my question about questions.

Beverly Roberts.

MS. ROBERTS: Thanks very much.

Thank you, Jen. This is really wonderful, wonderful information. So I have many questions, but

I'm only going to ask a couple and then maybe we can talk separately for more in-the-weeds kinds of things.

If there's a child with IDD who is going to be in need of Personal Care Assistant (PCA) services or the Personal Preference Program (PPP) services, would that child, meeting the income criteria, be able to get PCA or PPP through this type of NJ FamilyCare.

MS. JACOBS: There is a lot of nuance to that question because it comes down to the way the benefits get structured for higher-income children. So I think that's beyond the level of detail that we're able to speak to today, Bev. But I will definitely be interested in following up with you to sort of work through the details of that as we go forward.

MS. ROBERTS: That would be terrific. And then one very last question. So with the immigration status, so at present today, somebody that has a green card for five years, then they're eligible. Is the thinking that it would still have a green card but you don't have to have it five years? Or that potentially a green card would not be the requirement?

MS. JACOBS: The intention is to be able to cover all children. So there are restrictions today that exist within our programs. Those restrictions are based in federal rules, as you know. That leaves a

gap. These are the children we're looking at, the 36,000 children. A portion of those are due to that immigration status. Our intention is to fill the gap so that we have coverage available for all children. And so the policy questions we're working through behind the scenes right now are what does that mean for us operationally in terms of the way we set up the program? But at the bottom line, we'll cover all children. That's the intention.

MS. ROBERTS: Thank you. Thanks very much.

DR. SPITALNIK: Any other questions from the MAAC.

Thank you for this presentation and very exciting and comforting news for New Jersey's children. We'll now turn to the American Rescue Plan, the Enhanced Federal Match and Reinvestment For Home and Community Based Services. And we'll, in addition to the MAAC, do our best to field questions from the Q&A from the stakeholders in this regard.

MS. JACOBS: Thanks, Dr. Spitalnik.

It's true, talking through this at the MAAC is very different in person than over Zoom. We're learning new multitasking skills. So if you see us talking to you here and then turning to look over here, it's because we're trying to track the questions and

answers that are going on in real-time, which is not how it works when we're in real life. So Greg and I are going to tag-team this a little bit.

Greg, let me hand this slide over to you.

MR. WOODS: Thank you. As we move into this topic around this specific bucket, federal COVID relief funding, before we speak to the details of how New Jersey intends to use those additional federal funds, I do want to talk a little bit, because I think it's important, about exactly what Congress did in the section of the American Rescue Plan (ARP), which I acknowledge is a little bit complex and can be hard to follow, so I'm going to do my best to disentangle it, but welcome questions on this.

Congress did a couple of things in this provision of the Rescue Plan. First, Congress provided a temporary 10 percent enhanced match rate for Medicaid and home and community-based services provided for a year, between April of 2021 and March of 2022. So if, for instance, a service under ordinary circumstances would have been split up 50/50 between the state and federal government in terms of cost, under this provision for that year, the federal government will instead pick up 60 percent of the cost for that

temporary period. I should also note, though, when interpreting this provision, our federal partners at CMS were fairly generous. So they defined home and community-based services quite broadly for the purposes of the enhanced match. So we're not just talking about what we in New Jersey would call waiver services under our Home and Community Based Services (HCBS) programs, we're also talking about a broader set of community-based services offered under the state plan, so things like personal care assistance, things like behavioral health rehabilitative services. There was a broader definition of home and community-based services that were eligible for that enhanced federal funding.

So the federal government picks up a greater share of the cost of those services for one year. However, Congress attached an important and, I think, valuable string to that enhancement. In order to claim those additional federal dollars, all states -- states are not able to use it to balance their budgets or to make unrelated investments. Rather, states are required to reinvest those dollars back into home and community-based services to enhance, strengthen, and expand those services.

And in addition and along the same lines, Congress also said that those dollars had to supplement

and not supplant existing state investment. So in other words, you couldn't use those dollars just to backfill the cost of the things that you were already doing. It was a requirement that all states reinvest those in new or strengthen programs, additional spending that didn't exist prior to this provision being enacted.

Lastly, before we move on to the next slide, I just want to note that while the enhanced match on our home and community-based services only is available for one year, from April of this year to March of next year, the period that states have to then reinvest those dollars back into home and community-based services is actually longer. So we have three years for that reinvestment period, from this year through 2024. So we have a deadline of March of 2024 to spend those dollars, which I think is important context as we look through some of those specific investments that New Jersey is proposing.

And then, in terms of process, I will say CMS required that in order to receive the enhanced federal match, states had to demonstrate that they were meeting those requirements that I just described to reinvest those dollars back into home and community-based services and to supplement, not

supplant, existing investments. And the way that they operationalize that requirement is to require that each state submit a spend plan that shows how that state intends to reinvest those dollars. And that was due to the federal government last week, and so we submitted that last week.

I will emphasize that that's an initial spend plan. And just to be really clear -- because I know that many of you have reviewed that, that's now on our website -- that is subject to CMS review and approval. And so that process is still ongoing.

I will also note that we are expected and be required to update that spend plan quarterly. And we expect that it will evolve somewhat over time as we get more precision on exactly how many dollars are available as we move forward with implementation. So I think it's a good picture of what the State intends to do, but it is an initial spend plan. I would expect that it will evolve over time as we move forward. Again, I acknowledge a fairly complicated background. I welcome questions.

Before we get to the substance of the spend plan that we submitted last week, I did want to talk about the stakeholder process that brought us here. And I will just say this was a very accelerated

stakeholder process. There was a very brief window between when CMS gave us guidance on what the expectations were for states to submit and when they were actually due. And so we really did have to scramble over what was a very brief period to get stakeholder input. So it was certainly more accelerated than the way we would normally operationalize a process like this. And I do want to just give credit to John Tu who is on my team who really help pull this together very rapidly and worked with all OF the stakeholders to solicit that input.

So within the time constraints, we pursued a few strategies for stakeholder input. We had several targeted small group Zoom meetings, each with a specific focus on a particular subset of HCBS services or populations. We had an open public meeting that was open to everyone. That was attended by over 200 individuals. And then we also requested that stakeholders submit feedback in writing. And we received a really gratifying and robust response on that, on what we recognize was a really unreasonable and challenging deadline. And I believe we got over 90 submissions from stakeholders.

So first of all, I want to just thank everyone who provided that feedback. It was really

critical for our decision-making and for our ability to pull the spend plan together very quickly. And I think that's actually probably a good segue to the next slide where I think Jen is going to talk a little bit about some of the criteria that we applied as we were formulating the spend plan.

MS. JACOBS: Thanks, Greg.

So I want to echo Greg's appreciation for the responsiveness of our Medicaid community here under what was a completely unreasonable timeline and really the very thoughtful responses. We went into our stakeholder discussions really trying to be very intentional about our vision here. And what that was was we wanted to support independence, community options, and person-centered care through our system. And always, we focus on trying to make sure we're serving people the best way possible. And so that's how we asked folks to sort of frame their thinking with us as we sat in the stakeholder discussions. And really, the response of our community was exactly that. It was about independence. It was about making sure that people had options for living in a community. In a state like New Jersey, that's not always easy. And making sure that we were keeping the human side of this, that person-centered care. What are the very

specific goals and preferences of our members, top-of-mind all the way through.

So we really relied on our stakeholder input as we were taking the excellent template that was provided to us by our federal partners and determining what is the universe of potential investments based on all of that feedback that Greg just spoke to you about and then sort of determining what was the best way for us then to balance what we were looking at and consider the appropriate reinvestment of the HCBS funding.

Stakeholders talked to us in a lot of detail about different challenges that we face across our state. So in some ways, this task was inspiring to be able to work through what could these investments look like. In other ways, it was crushing because we knew we couldn't do everything that we wanted to. But the feedback we got came under the themes of workforce development, provider access where the workforce might be out there but it was challenging to get to those providers in one way or another, independent living, and transition support for people who were moving from an institutional setting to a community setting.

And then as we sort of balanced all of that feedback, here's all the need in the community, we had to put it into a little bit of a methodology or

calculus for thinking through how do we prioritize these needs, how do we make sure we're addressing everything in ways that make sense. That required a lot of collaboration with our sister agencies because, as you know, this Medicaid program crosses a number of different divisions and even crosses departments. So extensive discussion where we considered whether an investment had a short or a long-term horizon, that was important because the federal program requires us to spend the money in a particular period. And so if something had a very long-term horizon on the spend itself, that became challenging for us.

We talked about the number of beneficiaries that would be served by the investment. In some cases, you know, really focusing on making sure we were hitting a very broad population but also making sure that we recognized there are specialized populations here in New Jersey, and so sort of keeping an eye on both of those things. Sometimes a very broad population needs a certain level of attention. Sometimes a very specialized population needs a certain level of attention.

We also talked about other funding that was available in any given area. This wasn't the only funding on the table this year. And so we tried to be

very deliberate about having conversations across state agencies so that we knew what kind of funding was available for different needs and we could be strategic about how we deployed this particular fund.

And then finally and painfully really acknowledging that this funding is time-limited in addition to being obviously funding-limited; and that at the end of that time period, it would not be there anymore. There are certain investments that we were being asked to make and that we have proposed where a gap would remain after this enhanced funding is gone. And so this is a multidimensional effort, and we wanted you to understand some of the context and complexity of having walked through this conversation.

The next thing that Greg and I would like to do is share with you at a high level the details of what's in the spend plan. And as Greg alluded to, the spend plan itself at this moment does not go into great detail because we need to be having a conversation with our federal partners about what will be approvable under this plan and what the specific math will look like, what authorities will need to be requested. Our partners at CMS are really doing a great job working through this discussion with 56 Medicaid programs. And so we know that there's details to be worked out down

the road, but we wanted to talk to you today about what we have proposed.

DR. SPITALNIK: Jen, would you interject also that this was posted yesterday, the plan itself, and sent out broadly to the mailing list of stakeholders?

MS. JACOBS: That's right. And I believe just this second Phyllis has posted the link to that in the chat so that all attendees will be able to go there. Hopefully, you'll stick with me for the moment. But certainly, the details of what we've submitted to CMS are available to all of you.

So let me just talk briefly here about Personal Care Assistant Service. There was an increase recently enacted. Little by little, Personal Care Assistant Service, the rates have been increased. This is a critical service for us. It is being used by 55,000 people in New Jersey today. And so for agency services, the rate has been increased by the Legislature, and we are adding on to that increase. And so you see us proposing to CMS that we will increase that rate to $23 per hour. That is in response to real-life experience on the ground which is telling us that these workers have fordable skills and they are getting jobs in other industries, and that is

making challenging for us to staff cases to make sure that folks have the level of service that they need, that they have reliability, that they have well-trained aides who stick in that industry. And so this is really intended to make sure that this PCA service which so critical to so many of our members remaining in the community, living independently, that we are able to adequately staff those cases.

In the same way, we are increasing the Personal Preference Program rate. Now, this rate is a little bit lower because you don't have an agency involved with nurse oversight, and the member herself or himself is really taking over the role of employer. They work with a vendor that helps to administer our self-direction program, but that's why you see a difference between the PCA rate and PPP rate, the self-direction rate, because in this case, the member is taking on some of that administrative work of managing the aide. So we have increased that rate to $19 per hour.

And so those two pieces will be under discussion with CMS, as all the rest of these will.

The next rate we wanted to talk about was Assisted Living. So this rate, too, was increased in this state budget, the State Fiscal Year '22 budget.

What we have done is sustained it through the period of this program. And we have also proposed -- and I think this is important -- we have proposed to increase rates for facilities that serve a high percentage of Medicaid beneficiaries. We have assisted living facilities in the State of New Jersey who do not welcome participation with our program. And we have assisted living facilities in the State of New Jersey who welcome participation with our program and serve many of our members. So we wanted to recognize that and so we have proposed that in the document that we are discussing now.

The next item is the No Wrong Door System. This was a really valuable suggestion from one of our stakeholders who said, "Look, there are a lot of different community organizations that are involved in people accessing home and community-based services in New Jersey. Much of the home and community-based services we're talking about happens with Medicaid funding but not all of it. And these community organizations are really trying to give coordinated information about multiple programs to the people they serve in the community. And so it makes sense to spend some attention and some resources on better alignment of our programs in that sense, making sure that we're

supporting accessible processes for enrollment or for accessing services and also addressing the sort of unique cultural identities in New Jersey. The diversity of this state is something that we all value, and we want to make sure that across all of the different cultures that are represented here, people have access to the services that we provide. We really think that's part of serving people the best way possible. And so we have proposed to do some work in that area.

The next item Jersey Assistance for Community Caregiving, loving known as JACC, is not a Medicaid program. This is comparable to the personal care assistant services that we provide through the Medicaid program, but not a Medicaid program in the sense that you don't have to have Medicaid to access it. Once you do have Medicaid, we're covering through PCA. But this program is really important to Medicaid because as people are perhaps spending down to Medicaid eligibility in the community, they are accessing this program. And we want the program itself to be strong and to support the independent living of these individuals so that they don't find themselves in an institutional setting unnecessarily before they reach Medicaid eligibility and have access to our home and

community-based services. So if JACC is strong, we are strong. And our intention, our proposal, is to increase rates for this program as well.

Then we talked a great deal about workforce and creating incentives to recruit and retain home care workers. Those fall into a few categories. We talked about training for workers in the self-directed programs to make sure that people have the support and the skills that they need to support loved ones in the community or really just to be a worker. It may not be a family member that they're working for, but to feel that they have the skills they need to provide high-quality care and to feel strong about the work that they're doing, to feel confident and comfortable in that work.

We also talked about supporting recruitment and retention initiatives incentives and then taking a look at member satisfaction across the agencies who are serving our population. Some of you will be familiar with the member satisfaction survey that exists on the Medicare side of the world for skilled home care. And we envision a member satisfaction survey on the PCA side of things and sort of taking the opportunity to look at our provider agencies from that angle.

Then finally, for this section, we talked

about creating new mechanisms to help transition individuals from nursing homes to home and community-based settings. And there, we are looking to tap best practices from inside and outside New Jersey to put some new energy and initiative towards helping people move from a nursing home setting to community.

Let me hand off to Greg here to cover the second half of the plan.

MR. WOODS: Thanks, Jen.

Just to continue going through this list, and I think on this slide we're going to talk about some targeted investments that we thought really would have a high return in terms of the impact on beneficiaries consistent with the principles that Jen discussed earlier. And also, I think everything on this slide or nearly everything was suggested to us in some form by a stakeholder. So this very much reflects the input that we received from stakeholders through that accelerated process we talked about earlier.

So the plan we submitted to CMS includes an investment to build capacity and person-centered planning. This is a tool to ensure that members in our HCBS programs have a plan of care in place that makes sense that reflects their individual needs. Our vision is that this would apply to both the Managed Long Term

Services and Supports (MLTSS) and to the HCBS programs operated by the Division of Developmental Disabilities. And I think how it exactly would be operationalized is part of what we're continuing to work on, both to our managed care organizations likely for MLTSS and through providers on the DDD side.

Our plan also included an investment in applied behavioral analysis for children with autism spectrum disorders. I am not the subject matter expert here, but I know this is a topic we've discussed a number of times with this group before and so I'm not going to belabor the value of these services. But I think as we have transitioned these services from waiver services to state plan and as we were trying to build access to our members, as we were trying to build a robust network to ensure all children who require those services, who would benefit from those services, have access to them, this is an investment intended to really support that and to make sure that that's where we end up.

We also have heard from stakeholders, from providers who provide care to individuals with traumatic brain injury, that there have been very specific challenges they have faced during the COVID-19 Public Health Emergency. As part of our plan, we have

a one-time investment to address those challenges and some of the very specific costs that may not have been met elsewhere for that subset of providers. So that is a really targeted one-time investment that reflects some of the challenges of the pandemic.

We also, as part of our plan, are proposing to implement a new program to assist youth with intensive intellectual and developmental disabilities and co-occurring behavioral health needs. This is a proposal that was based on stakeholder input and was also developed in partnership with our partners at the Department of Children and Families as part of their Children System of Care. I think the vision here is to support multidisciplinary and flexible mobile treatment teams that will deliver interventions and fill gaps for youth with co-occurring intellectual developmental disabilities and behavioral health needs. So we're excited about that opportunity.

We also are proposing an investment in incentive pavements for behavioral health providers to adopt interoperability HR technology. This builds upon a program that we already have in place for SUD providers, the SUD Promoting Interoperability Program. We have heard repeatedly from stakeholders that they think there is an opportunity here, really, to go

beyond just SUD providers, but also to the broader universe of behavioral health providers, some of whom may not have qualified in the past for previous high tech or other EHR incentive programs. So the proposal here is to, in fact, expand the promoting interoperability program to target other categories of behavioral health providers. And while we haven't worked out all of the details of how this proposal will be implemented -- as Jen said, we're pending CMS approval -- I think we would expect there to be consistency with how the SUD Promoting Interoperability Program has been operationalized. We would expect there to be really close collaboration if we move forward with this between Medicaid, between the Department of Health, between NJHIN, and really importantly between providers and the stakeholder groups that represent providers. So we would expect to be a collaborative effort as we fill in the details moving forward on this.

As part of our proposal, we also are proposing an increased rate for support coordinators. For those who are not familiar, these are individuals who provide care management to beneficiaries in our DDD waiver programs. I think what we have heard consistently on this front is that there is a mismatch

or there have been challenges given on the educational requirements for these roles and the rates that are available, and we're trying to ensure that any workforce challenges that result from that are addressed. So this is really a targeted investment to make sure that support coordination services are available to our beneficiaries in the DDD waiver programs.

And then lastly, and something I want to talk to about a minute -- and, Jen, I know you're excited about this so you may also want to jump in on this one. We are proposing what we're calling the Healthy Homes Investment. I think this is a little bit far afield from what Medicaid has traditionally done, but it's something we're very excited about. As I think probably everyone or nearly everyone on this call is aware, housing is really a major challenge for many of the populations that are served by Medicaid, including older adults, the disabled, individuals with behavioral health needs, individuals with intellectual or developmental disabilities. And part of the problem is around making sure that all of those categories of beneficiaries have the supports that they need to be successful at remaining in housing in the community. And we're going to talk a little bit about that when we

talk about 1115 Renewal in the minute. But apart from just providing supports for individuals, there are also just challenges around there being a simple shortage of appropriate and affordable housing available. And we all know New Jersey is a high-cost state, that housing is not inexpensive, and that this is really a barrier for some of our beneficiaries. So this is not typically something that Medicaid can address directly under ordinary circumstances. But because we have this special pool of funding, we are proposing with these dollars to do just that, and specifically to support the development of new housing units that would specifically for Medicaid-eligible populations with housing challenges. This investment includes both the upfront development cost and also includes operating funds that will ensure that that housing remains affordable and dedicated to Medicaid beneficiaries for the 30-year life of the housing unit.

I will acknowledge that those of us representing DMAHS on this call today are not necessarily experts in housing development. But I think the good news is that those experts do exist elsewhere in state government who are really focused on developing affordable housing. And we have begun to collaborate and our intention to move forward with this

program, to collaborate closely with them on this project, assuming we can get CMS approval.

Jen, I don't know if there's anything you want to add either on Heathy Homes or anything else on this list.

MS. JACOBS: No. I would just reinforce your point that we have within the Department of Human Services and well beyond it expertise in state government to help us implement Healthy Homes. And it gives us pause, this particular proposal, because it is allowing us, in the absence of this HCBS program that we're talking to you about right now, this opportunity that we have, we would never be able to do Healthy Homes. And so we are excited about the opportunity. It will be a challenge for us as an organization, but it is a challenge that we are eager to undertake and where we feel supported by sister agencies and the Murphy administration. We think it's a bold proposal and we're really excited about it.

Dr. Spitalnik, I think that's the end of our formal slides on the HCBS proposal.

DR. SPITALNIK: Thank you so much. Again, I want to reiterate that this was posted yesterday and is available on DMAHS website and was also broadly e-blasted to our mailing list.

Anyone from the MAAC have comments or questions, please just indicate on the raise your hand icon, and we can call you. I'm not seeing any, due, I think, to the comprehensiveness of the proposal. And there were no questions from stakeholders, so I suggest that we move on to the preliminary discussion of the 1115 Comprehensive Waiver. And, again, I'll reiterate that this is preliminary and that we are anticipating a special meeting of the MAAC as one of the vehicles for stakeholder input to this proposal as the MAAC has functioned through previous waivers. So I'll turn back to you two.

MS. JACOBS: Thanks, Dr. Spitalnik. Greg is our 1115 wizard and has done an extraordinary amount of work on this to date in partnership with folks all over the Division. So Greg, please go ahead.

MR. WOODS: Thank you.

So as Dr. Spitalnik said, I'm going to give a brief update and a preliminary update on where we are in the process of renewing our 1115 Demonstration today. And as Dr. Spitalnik said, I would view this as a preview for much more detailed discussions to come in the not-too-distant future.

Just as a reminder for those who may not be familiar, our 1115 Demonstration is the vehicle that we

negotiate with the federal government and that really gives us authority to go beyond ordinary federal Medicaid rules and requirements and innovate within our program. We have a Comprehensive 1115 Demonstration. Some states have multiple 1115 demonstrations that cover different topics. In New Jersey, we have consolidated them all into a single demonstration, and it really does cover a wide range of policy areas, including but not limited to our managed care delivery system, our HCBS waiver programs, our SUD initiatives, and a broad range of other things.

The way 1115 Demonstrations work, they are renegotiated with our federal partners at CMS every five years. So you negotiate them for a five-year period and then you come back after five years and renegotiate them between the state and federal government. And our current approval period expires in about a year, in the middle of 2022. So that's really what we're gearing up towards, the renewal of our 1115 Demonstration for next year.

So those of you who have been following the process closely will know that we're a little bit behind in terms of where we thought we might be. The renewal application was initially due at the end of last month. We have requested an extension and

received an extension from our federal partners at CMS. And this was really to allow us some more time to work through what are some really fairly "weedy" challenging budgetary, legal and technical issues on the back end with CMS to make sure that when we move forward with our proposal that all of those issues have been sufficiently worked out, that we feel confident that we can move forward with all of the programmatic things that we want to do as part of our 1115 Renewal.

With that extension, we are now expecting to submit our application for the renewal to CMS at some point during the fall. Before we do that, and just to reinforce what Dr. Spitalnik was referring to earlier, there will be a full public notice and comment period that includes two public hearings, one of which will be a special meeting of the MAAC and both of which will be open to all members of the public. I think that MAAC meeting will likely be off of our normal schedule, so more details to come on that. And it will also include the opportunity to submit formal written comments. And as part of that process, we will post a very detailed draft proposal for all stakeholders and the public to respond to. So that's all coming up and that's sort of the process that we have to look forward to.

I think today, we did want to give a little

bit of a preview of some of the things that we expect will be part of our renewal proposal at a high level. And, again, I would treat this as sort of an early preview. I will just say, to emphasize, this is the things we want to highlight. This list is neither exhaustive nor final. This is where we are at the moment. We think it's a good snapshot that gives you a sense of the kinds of things that we're thinking about, but it is subject to change, so please do treat it as a preliminary snapshot. And as I said, it's not exhaustive. So if something is not on this list, that doesn't necessarily mean it wouldn't be part of our proposal. We're just aiming to give you a preview. But I know we've talked about the 1115 Renewal for several -- this is probably the third MAAC meeting that we're talking about it. And since we're not quite ready to share the full proposal, we did want to give a preview of some of what we think the substance is likely to be. So we wanted to flag a few big buckets of areas that we expect will be part of our renewal proposal.

First, consistent with the First Lady's Nurture NJ Initiative, we expect that there will be a significant focus on maternal and child health. I know at the beginning of this meeting, the Commissioner

talked about the 12 months of postpartum coverage. That's sort of a special case that we are both looking to include that in our Waiver Renewal but also, as the Commissioner discussed, get federal approval. We hope and expect to get federal approval for that sooner so that can sort of kick in over the next year before the current demonstration period ends, but we also expect that to be part of our renewal.

We are also looking at several other innovative or pilot programs targeted at mothers and children. This includes a potential pilot around medically indicated meals for women with gestational diabetes. It includes the integrated Care for Kids model, which I think some of you are familiar with and we have talked about previously. This is a model that is supported by a federal grant to several providers within New Jersey from the Center for Medicare and Medicaid Innovation. So this would, as part of our 1115 Renewal proposal, we expect to request authority to implement the Medicaid payment part of that program, working with those provider partners.

We also expect that a renewal proposal will include an expansion on some authority we received a couple of years ago around a home visiting pilot that we have been working closely with our partners at the

Department of Children and Families to stand up. So we expect that authority to request that authority to be extended and also potentially expanded to allow that to serve more families. And then we have also been working with our partners at DCF around some potential supportive visitation services for families who are in the child protection system and who have very specific needs. So that's one big bucket.

A second bucket that I want to flag is Social Determinants of Health. And I will say this ties very closely to some of the things we just talked about as part of the enhanced federal match spend plan, but we really view this as complementary.

So we just talked about the Healthy Homes Initiative that we're proposing. But I think in addition to the actual provision of housing, we recognize that there are real opportunities to promote housing-related services, so this includes both supports for individuals who are transitioning out of institutional settings and into community-based housing, and there's a set of services we think could be really valuable for those individuals, and also includes what we call tenancy support services for individuals who are in the community but may require some ongoing support to remain there. And so we are

looking to expand the availability of those services to Medicaid enrollees.

I think along with that, we recognize that to really successfully implement those services, to coordinate with the Healthy Homes Initiative, to make sure that we are well aligned with all of the different state actors and private sector actors who are working on housing issues in the state, that there will need to be additional infrastructure both here at DMAHS and also within our Managed Care Plan. So that's part of the proposal that we expect to move forward with.

We are also looking at some opportunities around pilots for community health workers. We know that there is already a lot of exciting activity within the state. And working with our partners at the Department of Health, we're looking at opportunities to better use community health workers within the Medicaid program.

And then we're also -- and I think the Commissioner referenced earlier to additional funding for regional health hubs that was part of their recently enacted budget. For those who don't know, there are four organizations around the state who partner closely with Medicaid and are really focused on addressing the needs in individual communities. As we

develop our 1115 Renewal Proposal, we're looking at opportunities for additional flexibility for those organizations. So not only to expand the dollars available, but what those dollars can be spent on to really address some of the social determinants of health and sort of broader community need.

I want to talk for a moment about behavioral health, which is another big bucket of some of the proposals that we're anticipating will be part of our 1115 Renewal. And I will say for everything on this list, this has been very much a collaborative effort with our partners at the Division of Mental Health and Addiction Services.

So a few things that are potentially on the list. One is continuing the stakeholder-driven process that we've had, to think through how we best can improve coordination of medical and behavioral health needs within our program. And I think that's a conversion that predates me, that has been ongoing between Medicaid, between Mental Health and Addiction, and between stakeholders and providers. And we expect that to continue as part of our renewal process.

We're also looking to update the Certified Community Behavioral Health Clinics Program, also known as CCBHC. For those who are unfamiliar, this is a

program that was a federal demonstration program as part of federal legislation and has been extended several times and has existed in New Jersey now for several years. We're looking for opportunities within our 1115 Renewal to sort of place that program on a more permanent footing and to build upon the lessons we've learned operating that program to date and sort of to continue to iterate and innovate in that space.

We're also looking at some opportunities to provide coverage of prerelease transitional behavioral health services for incarcerated Medicaid beneficiaries. In general, Medicaid is not able to cover services for individuals who are incarcerated in most instances. We will be looking for an exception to that rule to really focus on the transition as incarcerated individuals are going to be released to make sure that if they have either SUD or other behavioral health needs that there's a smooth transition out of incarceration and to make sure that they know where and how to seek care once they are released.

We're also looking to see if it's possible to receive enhanced federal support for diversion beds. I think many of the folks on this call will be familiar with that and the focus there on making sure that

members don't end up inappropriately in a state psychiatric hospital or in an acute inpatient hospital when they have a behavioral health crisis. So we're looking to see if there are opportunities to increase federal support for those diversion beds.

And then sort of aligned with what I was talking about a few minutes as part of the enhanced match exercise, we're looking for opportunities to increase the federal support for the HIT incentives for behavioral health providers. And this is both the existing program, the Promoting Interoperability Program for Substance Use Disorder (SUD) providers, but also, assuming it's approved, the extension to other behavioral health provider categories.

And then the last bucket I want to quickly talk about is focused on supporting independence community options and person-centered care for our members who are in the HCBS waiver programs that are authorized under our 1115 Demonstration. I think one thing we're looking at here within our MLTSS program is additional services intended to support nursing home diversion or transition out of nursing homes. Potential things we may propose here include benefits related to nutritional supports, benefits related to caregivers, specifically respite and other supports for

caregivers, to really make sure that we are putting in place the structure that our beneficiaries need to be able to remain in the community and not need to transition to an institution.

We're also working with our partners at DCF around whether there are opportunities to enhance access to certain Medicaid services for certain pediatric populations. That's an ongoing conversation, but it is something we've heard from stakeholders and something we're continuing to work on.

We're also looking at program changes to reduce churning between our DDD waiver programs. This is a situation that can arise when a member who is in one of the DDD waiver programs requires a rehab or post-acute or nonpermanent placement in a nursing facility depending on the situation that sometimes requires, if they remain in that facility for a long time, a transition to MLTSS. Currently, we know that that can sometimes be quite disruptive in terms of care management and continuity of care. And so we're looking for opportunities to reduce that churn and expanding our authority to allow more flexibility in terms of which programs that a person remains in in that situation.

And then lastly, we have been working very

closely with our partners in the Division of Development Disabilities to think through a number of updates and fixes to our existing authorities for those waiver programs. And so more detail to come on that.

So, again, I would treat this as a preliminary preview. This is neither final nor complete, but we did want to -- since we've been talking in fairly high-level terms about our 1115 Renewal, wanted to give a preview of some of the things that we're thinking about. As Dr. Spitalnik said, we expect to have a dedicated session where we will go into each of these things and everything else that ends up ultimately being included in our proposal in quite a bit of detail and to talk through the weeds there. So we may defer some questions to that session. But with that, I will stop. I see there are already a couple of virtual hands up.

DR. SPITALNIK: Well, I think I'm not seeing the same thing, Greg. But as I ask the MAAC members to raise their hand and also look at the Q&A, I also want to point out that the opportunity for the increase took precedent and in some ways interfered with the continued development so that it was not in any way ignored, but rather to respond to the immediate opportunity.

So I'm going to call on Mary Coogan and then Wayne Vivian with questions. And thank you both for this preliminary presentation. And we'll look at preliminary questions now.

Mary.

MS. COOGAN: Thank you. So, Greg, just two clarifications. Lots of good stuff in here. But when you mention the home visiting, is that in conjunction with the legislation that just got passed in terms of universal home visiting?

MR. WOODS: That's a great question, Mary. I think we should think about this as actually two separate but related programs. So there is the pilot that was previously approved as part of our 1115 Demonstration. And that's focused on a few different modalities of home visiting and it's focused on both pregnant women and families with children up to age 3. And then there is, as you alluded to, there is specific legislation that I think is currently on the Governor's desk that if it's signed is a very specific, I think, with a complementary but somewhat different focus on the first three months of life, universal home visit. They are related, and we would be working with our partners at the Department of Children and Families on both of those, but they are separate programs.

MS. COOGAN: Okay. So you are talking separate programs. Okay, thank you.

And then the other thing is when you talk about visitation services to kids in Child Welfare System, is that visitation when kids are in foster care? Or are you talking about, like, a caseworker going out to family services?

MR. WOODS: This is one of those things that I would probably want to defer questions to when we have the subject matter experts from the Department of Children and Families on the line in a future conversation. I think conceptionally at sort of a high level, the focus here is on services provided for children who are part of the foster care system who are then having visitation with their family.

MS. COOGAN: Okay. Thank you.

DR. SPITALNIK: Thank you.

Wayne.

MR. VIVIAN: My questions are specifically regarding the supportive housing issues in the preliminary waiver. Is there any talk about expanding the reimbursable services in the supportive housing waiver? Like, I'm talking mostly about the Community Support Services, CSS. I know there was a task force that was working on making some changes, significant

changes, to the program. I know that all got delayed because of the COVID emergency. But is there any talk about reconstituting that, implementing those changes, including some of those changes in the Comprehensive Waiver, and expanding reimbursable services in the waiver?

MR. WOODS: I was just going to suggest -- and, Jen, you may want to add to this. I was going to suggest I think that's a really good question that we may want to defer when we have some of our partners from the Division of Mental Health and Addiction on the line. I think there's a lot to dig into there.

MS. JACOBS: Agreed.

Thanks, Wayne. We'll make sure to cover that when we get back together again on this.

DR. SPITALNIK: Thank you.

Mary Pat.

MS. ANGELINI: Thank you.

First of all, thank you very much for this preliminary presentation. And I look forward to hearing more of the details.

I'm very encouraged and pleased to see about making the CCBHC model more permanent. So thank you for that.

I have a question. I don't know where it

fits, but my question is where does extending telehealth permanently, where does that fit or how does that fit in this? Or does it.

MS. JACOBS: I can speak to that a little bit, Mary Pat.

COVID has given us a whole new view of telehealth at the federal level and at the state level. A lot of the decisions around what's permissible for telehealth are not ours to make. We are followers, not leaders, in that regard. So from a compliance point of view, for example, will the audio-only option continue beyond the end of the Federal Public Health Emergency? Will the non-HIPAA compliant platforms be acceptable in the future? Those are not decisions we will get to make. But what we have done, given the flexibilities we've had during this period, is assessed our services to say which of our services can be effectively delivered through telehealth in an emergency situation, but then also in a non-emergency situation. And we probably think of those things slightly differently. So that's our role. And we're actively engaged in that discussion.

The other thing that we're really actively engaged in, with the leadership of Louise Rush from Division of Aging Services, is people have to have

reliable phone access and preferably smartphone access to be able to engage in telehealth. Unfortunately, a little known fact is that every one of our Medicaid members qualifies for a free smartphone through the federal program that is called Lifeline, which is different from the New Jersey State Lifeline Utility Assistance.

So with Louise, we are working on how do we broaden access and awareness with this program so that we know that all of our NJ FamilyCare members have a smartphone in their hands because it's available to them. Right now, because of the Federal Public Health Emergency, there's a special program which actually makes available unlimited talk, text, and wireless to folks who are participating in that program. So this is where Louise has said, Hey, across our organization, we need to make sure we're reaching out to folks in every way possible and we're developing a strategy for doing that so that even when the Public Health Emergency has ended, we will know that our folks have what the need to access telehealth under whatever federal rules and state rules are established for the long haul.

MS. ANGELINI: Thank you very much.

DR. SPITALNIK: Beverly.

MS. ROBERTS: Thanks, Greg, for this really helpful presentation.

A couple of quick questions. And I don't know if you can answer them, but I thought I would ask anyway.

The enhanced access to Medicaid for certain pediatric populations, do you have any additional information on that.

MR. WOODS: I don't have a lot more to share at this point. I think that's definitely one where we're still working through the technical detail, and I would expect a lot more detail to could.

MS. ROBERTS: The additional federal support for behavioral health providers, any detail on that?

MR. WOODS: So what we're anticipating there is that would be -- I'm requesting additional federal funding for the Promoting Interoperability Program that we currently have for SUD providers and then that we are hopeful we will be able to expand to other categories of behavioral health providers. So it works in a complementary fashion with what we had discussed earlier as part of the HCBS spend plan. We're hoping that we can get federal approval to use some additional federal dollars to support and expand those programs.

MS. ROBERTS: And then finally, but this

might be more for Jenn, the free Lifeline phones is something that I was not really aware of. Is there a link that Phyllis could post so that I could become up to speed on that?

MS. JACOBS: That's exactly what we're working with Louise on. So if you Google New Jersey Medicaid free cell phone, you will see our managed care organizations member handbooks popping up because they speak to how to access these programs. The federal websites for this are really not consumer-friendly. And I say that coming from the perspective of state websites aren't always consumer-friendly either. So our intention with Louise is to develop a broad strategic communication that folks will actually understand what they're looking at. There's a couple of vendors in particular who, through the federal program, are providing those free smartphones in New Jersey. So when you Google New Jersey Medicaid free phone, you will see SafeLink and you will see Assurance. Those are the two vendors. And our Medicaid members can go, as I understand it -- and we're still sort of working through the technical specifics here. MCO care managers tend to understand the details of this and they're talking to their members about it. So they are more expert than I am.

But when you go to those two sites, you can sign up for the free cell phone. Each of those vendors has partnerships with more or one of the Managed Care Organizations in New Jersey. And where those partnerships exist, for example, there may be extra minutes available to that member. The phone may be set up so that calls to their care manager don't count against their minutes. So there are some specialized arrangements that are made, which is great. What we need to do is better communicate about that program overall, and then what are the specialized arrangements that are available based on who you are and how you access. And the other thing that is important to mention, Natasha Johnson from our Division of Family Development (DFD)is also part of this workgroup because her Supplemental Nutrition Assistance Program (SNAP) clients also qualify. So it's an income-level determination. It's not about you are a Medicaid member or you are a SNAP member; it's about income level. And the fact that you qualify for Medicaid or SNAP tells the program, this person is in the door. So for Louise, for her aging population, some of those folks are income-eligible, some of them are not. They're not all automatically in the door. For Natasha and me, the people we serve are in the door. And so

there's definitely complexity to the federal program. And, hopefully, we will very soon have some state resources that help to just streamline and clarify all that information.

DR. SPITALNIK: Thank you for that response. As we also know, it's a pediatric issue.

One more comment from Wayne, and I need to bring us towards adjournment.

MR. VIVIAN: Thank you for taking another question.

Regarding the telephone, the smartphone, during when the telehealth was being implemented, we had several consumers that really do not know how to use a smartphone at all. So you need to take that into consideration. They just could not navigate the use of a smartphone. Is there any way that they would be able to use, like, a flip phone for telehealth?

MS. JACOBS: Good question, Wayne. That falls in the category of decisions we won't get to make because that is about the audio-only access to telehealth, and that decision will be made at the state level and at the federal level, and so Medicaid will have to comply. I always say we live at the intersection of creativity and compliance. Medicaid will have to comply with whatever decision gets made

with respect to audio-only.

MR. VIVIAN: Okay. Thank you. It's something you need to consider, really, seriously.

MS. JACOBS: Absolutely. Yes. Thank you.

DR. SPITALNIK: The only comment which I will raise but defer to when we have a more comprehensive proposal around the Waiver is around diversion beds, in terms of psychiatric facilities.

So in respect for everyone's time, let's do two things. We know that there will be a special meeting that will be called to discuss the proposal for the 1115 Renewal, date to be determined, probably sometime in the next month or six weeks approximately, but we'll comply with public notice.

In terms of our next regularly scheduled meeting for October, the items that I have captured so far will be an update on the response to the Federal Medical Assistance Percentages (FMAP) proposal, an update on enrollment and whatever has been able to be culled out from that perspective.

Does anyone have anything else from our discussion that we would want to put on the agenda in addition to the ongoing and typical updates that the Division provides?

Mary Coogan.

MS. COOGAN: I would just ask for an update, nothing major, on any other issues still outstanding on the redetermination process in case there's something all of us should still be doing, if we know anything more in terms of helping with outreach.

DR. SPITALNIK: Thank you for that.

I also realized now trying the decipher my own writing, an update on Cover All Kids and how that has gone into implementation and what would that would look like.

Any others?

As always, and I should have mentioned this in the beginning, the slides and the presentation from this meeting will be posted this afternoon on the DMH website.

Theresa, very quickly, because I pride ourselves on our time.

MS. EDELSTEIN: Just a quick question. Could we get some feedback on what the CMS timeline is for approving the enhanced FMAP plan, like when will you know? So if that's appropriate for the next agenda, that would be great.

DR. SPITALNIK: That may fall under the grade health policy person Fats Waller. Your guess is

as good as mine. Not to belittle the importance of it, but as the intersection, as Jen spoke about.

Anything, Jen or Greg, would you like to say in conclusion? Jen, any other thoughts?

MS. JACOBS: Dr. Spitalnik, I want to thank you for your leadership in talking through all of this with us today. This was a very dense discussion. A lot is happening. So thank you for your patience as we have tried to present with some context but also moving quickly through a lot of things.

I also want to just point out that this week is my two-year anniversary in this role. And two years ago when I got here, I sat at the MAAC meeting with all of you and I knew nothing, and that was scary and wonderful and I was thrilled. And now I'm thrilled more to be here with you two years later. We've come through an incredible time with this pandemic and all of the innovation that is happening here in New Jersey. And I so appreciate all of you that I didn't want to let the opportunity go by to say thank you to our thoughtful members of the MAAC for all of the dialog that we have with you. We really appreciate it.

DR. SPITALNIK: Our thanks to the leadership. I think what you've been confronted with in your tenure gives new meaning to the idea of the

terrible twos in a different context.

Our thanks to Greg Woods, to Heidi Smith, everyone in DMAHS, to Phyllis Melendez who brings us together and is our wizard behind the curtain.

Thank you, everyone, for your participation and your patience with the exigencies of our virtual format. We are over four minutes, so I would consider that criterion. Thank you all. Be well and safe. And we look forward to meeting both at our stakeholder meeting on the waiver and our regularly scheduled meeting on October 21st. I will exert executive privilege and declare us adjourned today. Thank you all.

(Proceeding concluded at 12:04 p.m.)

CERTIFICATION

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

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