MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Video Conference
January 21, 2021
10:00 a.m.

FINAL
MEETING SUMMARY

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

MEMBERS NOT PRESENT:
Mary Coogan
Dorothea Libman

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

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

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

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, Chair of the New Jersey Medical Assistance Advisory Council (MAAC), and it's my pleasure to welcome you to the January 21, 2021 meeting.

I will begin by reflecting that our meeting has been established pursuant to the New Jersey's Open Public Meetings Act, with adequate meeting notice. We are, as everyone is aware, meeting in a virtual format. I'll go through our agenda and explain our ground rules. We have the agenda up on the screen.

First, we will start with introductions and welcome. Our procedure is that the MAAC members and the leadership and staff of the Department and the Division of Medical Assistance and Health Services (DMAHS) are panelists, which means that we can speak. We welcome all of our stakeholders, but with the constraints of the medium and the press of our agenda, we can't offer you the opportunity to ask questions or comments. However, we will try to also monitor the chat for your questions. And as time permits, with information available, we will raise your questions for consideration.

My pleasure is to start with a welcome and congratulations to a dear friend of the Medicaid program and colleague and leader, Sarah Adelman who is

now the Acting Commissioner of the Department of Human Services.

Sarah, welcome. And would you like to introduce yourself further? I'll call on other panelists when you're done. Welcome and congratulations and thank you for taking on these responsibilities.

MS. ADELMAN: Thank you, Dr. Spitalnik, good morning.

DR. SPITALNIK: Good morning. I would then ask Jennifer Jacobs who is the Assistant Commissioner and oversees the NJ FamilyCare program to also greet us.

MS. JACOBS: Good morning, everyone. It's nice to see you. Happy 2021.

DR. SPITALNIK: Thank you. And then I will ask the other members of the MAAC to unmute and introduce themselves, please.

MS. ROBERTS: Good morning, everyone. This is Bev Roberts with the Arc of New Jersey.

DR. SPITALNIK: Thank you.

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

DR. SPITALNIK: Thank you.

Others.

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

DR. SPITALNIK: Thank you. Theresa.

MS. EDELSTEIN: Theresa Edelstein with the New Jersey Hospital Association.

DR. SPITALNIK: Thank you. Did I hear Wayne?

MR. VIVIAN: Yes, Deborah. Wayne Vivian from New Jersey Coalition of Mental Consumer Organizations.

DR. SPITALNIK: Thank you.

Chrissy.

MS. BUTEAS: Good morning, everyone. Chrissy Buteas from the New Jersey Business and Industry Association.

DR. SPITALNIK: Thank you. And is Dot Libman with us or Mary Coogan this morning?

Hopefully, they will join us.

We have a large agenda of approval of minutes, policy implementation, informational updates, information on COVID, other policy information, NJ FamilyCare enrollment updates, Managed Care Organization (MCO) contract changes, and then a wrap-up. I would like to, before we go to the minutes, introduce another agenda item which I have conferred

with other members of the MAAC. And at this time, I would like to propose, with concurrence from the members, that as the Medical Assistance Advisory Council, we send communication to former Commissioner Carole Johnson who has left her role in New Jersey to take on the huge responsibility with COVID under the new Biden administration. May I have the sentiment of the MAAC? And if I have affirmation, I will take the responsibility for making that communication. I ask the MAAC members for your input on that.

MS. ROBERTS: Yes, yes. Absolutely and heartily endorse. Absolutely, please. We are very thrilled for Carole Johnson, and for the country, that she's going to be taking on this role.

DR. SPITALNIK: Great. Thank you so much. And I will convey that.

We now move to approval of the minutes of our last meeting, which was October 20, 2021. There is a summary of the meeting. Are there any corrections, comments, or additions?

Hearing nothing and seeing no noddings, may I have a motion to approve the minutes?

MS. BRAND: This is Sherl. I move to approve.

DR. SPITALNIK: Thank you. A second,

please.

MR. VIVIAN: I'll second it. Wayne Vivian seconds.

DR. SPITALNIK: Thank you.

All those in favor?

THE MEMBERS: Aye.

DR. SPITALNIK: Any nay votes or abstentions?

The meeting of the minutes of October 21st are approved, with thanks to Phyllis Melendez and to Lisa Bradley for her wonderful transcription.

We now move to the first larger agenda which is policy implementation. And I turn to Jennifer Langer Jacobs our Assistant Commissioner.

MS. JACOBS: Thank you, Dr. Spitalnik. When we have a lot to cover in a meeting,

We want to give it sort of a narrative arc. And the first important thing we wanted to discuss was policy being implemented January 1st because here we are on January 21st, the first full day of a new presidential administration. And, obviously, it's been a busy year so far in the nation and in New Jersey. There were five important things that were happening for January 1st that we wanted to make sure we covered the ground on. And so Carol Grant is going

to walk us through the first few, and then I'll chime in towards the end.

MS. GRANT: Thank you. Good morning, everyone.

Well, one of the largest things that we've done is get our federal Electronic Visit Verification (EVV) mandate met on January 1st. So we'll go over where we are today. This is, obviously, an initiative that will get rolled out over time. The Centers for Medicare & Medicaid Services (CMS) via the 21st Century Cures Act mandated that EVV will be required for all Personal Care Services by January 1, 2020, and all Home Health Care Services by January 1, 2023.

New Jersey Medicaid received approval from CMS for good-faith effort exemption to the January 20th implementation mandate. But our EVV system in New Jersey went live on January 1, 2021, per the conditions of that good-faith effort exemption.

The mandate requires Electronic Visit Verification that documents the type of service performed, the individual receiving the service, the date of the service, the location of the service delivery, the individual providing the service, and the time the service begins and ends. In the future, we will add some of the bells and whistles that better

support program integrity and things like missed visits.

Medicaid and DMAHS, actually, continues collaboration with the workgroups and the EVV steering committee to ensure successful operation. We knew this a child that had to be raised by a village, and we have done this in partnership with the stakeholders in the system, members, providers, family members, et cetera. Our aggregator, selected through a public competitive process, in partnership with DMAHS and the MCOs continue to host trainings on how to use EVV. They provide technical assistance, post go-live to ensure the smooth operation of EVV with members and by providers. They are, in fact, a vendor with a lot of experience, some here in New Jersey and in other states. We have set up an EVV web page where EVV information is posted as well as a general e-mail box where EVV-related questions, issues, or concerns, and we monitor those daily. We have, in fact, issued a fact sheet and newsletter detailing important information. And you can see in the slides where you can, in fact, find that information.

Our north star, which we always set for initiatives of such magnitude, really has as a basic principle members get service and providers get paid.

But this is a federal mandate that requires compliance. And we have set some benchmarks where provider agencies will demonstrate increasing compliance over time with verified visits submissions between January 1, 2021, and June 30, 2021. And in the slides, the minimum compliance threshold is defined, and it is the percentage of all personal care service claims submitted by providers which are verified by EVV technology. This is going to be sort of a growing number. You can see it here. I don't think I need to read it. But we expect ever-increasing compliance, and that's what we're monitoring at the State and we and the plans are working closely with providers and with our stakeholders, either through the steering committee or through the family member groups, et cetera, to ensure that we continue to see growth and compliance. That's what will be expected of us.

Also, we have initiated an EVV and self-direction pilot really to ensure a smooth transition to EVV with really adequate supports for members and caregivers. We're using and implementing an EVV pilot for self-direction as follows: Members of Amerigroup and their caregivers participating in the Personal Preference Program, PPP, will be fully trained and supported with EVV by the fiscal intermediary,

Public Partnerships Limited (PPL). These are the only members self-directing through PPL who will implement EVV during the pilot.

Members using the Division of Developmental Disabilities (DDD) self-directed options through Easterseals will be trained and supported with Electronic Visit Verification (EVV) by Easterseals and HHAeXchange. Based on member and provider experience during the first 45 days of the pilot, DMAHS may define additional rollout group and compliance thresholds for self-direction.

Self-direction operates on a different paradigm than the rest of the system. You are really talking about members and -- family members or authorized representatives who function as small businesses, but where the learning curve may be steeper and it is sort of a different program model. So we feel and we have, in fact, defined that this is the way we will approach self-direction ever moving towards the compliance we're required to achieve.

So that's our EVV efforts. And we encourage you to use the mailbox with questions, concerns, comments. This is an enormous undertaking, but it has rolled out with minimum disruption and ever-growing learning and participation of providers and members.

DR. SPITALNIK: May I stop you there and find out if anyone from the MAAC has -- Beverly has a comment, please.

MS. ROBERTS: Thanks very much, Deborah. And thanks, Carol, for this information.

I wanted to just mention one thing that I've learned from being on the EVV, the groups that have been working on this. That if somebody is doing self-direction, including PPP, and they live in the same home as the person who's receiving the service, then they are not required to participate in EVV even after everything is fully rolled out. And I just think it's important for people to know that.

MS. GRANT: Yes. And I'll confirm that. Where you have a live-in situation like that, they are exempt from EVV. So thank you for reinforcing that.

DR. SPITALNIK: And, Carol, I have an additional question which is: When will this pilot begin or has it begun already?

MS. GRANT: The pilot has begun. And as you can see, we're evaluating the experience in the first 45 days.

I don't know, Jen, whether you wanted to add anything here.

MS. JACOBS: Sure. I would just add that

the Amerigroup piece of the pilot is the first part that's rolling out. And I believe the Easterseals come very shortly but may not have formally begun training workers to use the technology yet. Carol, I haven't checked in on that in a week or so, but Amerigroup has definitely begun coordinating with PPL and their members to get the trainings underway and make sure that people are getting the support that they need. It's really very different for a self-directed worker than for a home health agency.

MS. GRANT: Right.

DR. SPITALNIK: As we move to the update on perinatal risk assessment reimbursement, I really want to express admiration and gratitude as a participant in the EVV stakeholder group for the dedication of all the members, but of DMAHS's leadership and efforts to continue to refine materials and make them broadly available. I think it's been a very important process with increasing clarity and always active listening. So thank you for that.

Let's move on to perinatal risk assessment. Thanks, Carol.

MS. GRANT: The clinical assessment of perinatal risk, a very important initiative because early detection helps to prevent and treat conditions

that could be unhealthy for the pregnant individual and baby. So identifying and treating risk factors early in the pregnancy is key to improving birth outcomes. The Perinatal Risk Assessment or the PRA promotes early and accurate identification of prenatal risk factors and special needs that a pregnant member may have so that providers and MCOs can coordinate to improve the delivery of medical and community services to that member.

Public Law 2019, Chapter 88, requires the completion of the PRA plus first visit form at the initial prenatal visit and an update in the third trimester using the PRA plus third trimester form. Provider reimbursement for prenatal care requires the permission of the PRA plus the first visit form. The implementation began January 1, 2021, as planned, and there's information that can be found at the website that will be provided in the slides.

DR. SPITALNIK: Any questions or comments from the MAAC?

Hearing nor seeing none, Carol, back to you, with gratitude.

MS. GRANT: Okay. Very good. Another initiative effective January 1st, reducing early elective deliveries. The American

College of Obstetrics and Gynecology, ACOG, has recommended against elective delivery of an infant prior to 39 weeks gestation due to multiple studies showing increased likelihood of infant mortality, NICU admission, and serious complications compared with infants at or after 39 weeks.

Again, Public Law 2019 Chapter 87 prohibits health benefits coverage for certain nonmedically indicated early elective deliveries under the Medicaid program, SHBP, and SEHBP. Early elective delivery equals induced OR C-section delivery before 39 weeks of gestation. To be reimbursable, an early elective delivery under 39 weeks must include a diagnosis code justifying that early delivery. Denials may be appealed for medical review. And, again, this is effective January 1, 2021, as planned. And there is a newsletter that will provide additional details on this.

Questions?

DR. SPITALNIK: I'm not hearing any. Please continue. Thank you.

MS. GRANT: Two important initiatives, really part of the overall First Lady push for better maternal and infant health, and we're really quite proud to be participating in this. So I just want to

make that clear.

I have a few MCO updates that will, occur outside of some of the updates on the January contract. We're pleased to announce that Aetna has initiated a new FIDE SNP plan. Aetna Assure, Premier Plus, which began operation on January 1, 2021, in Bergen, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union Counties.

DR. SPITALNIK: Carol, may I interrupt you to just unwrap the acronym for us?

MS. GRANT: Fully Integrated Dual Eligible Special Needs Plan.

DR. SPITALNIK: Thank you.

MS. GRANT: You're welcome. Sorry. We forget that not everybody lives with acronyms all the time, at least not these.

MS. JACOBS: And what that means, just as a translation for folks, is the Medicare and the Medicaid benefit are covered by the same health plan.

MS. GRANT: Right, for the purpose of really doing better coordinated care for those members. Aetna went through a very rigorous readiness review process, which is required by CMS. We continue to monitor the plan as it rolls forward. The enrollment numbers initially, obviously, are low to

enable the program to get off to a successful start, but we welcome Aetna to the FIDE SNP family of plans that we have in New Jersey.

I also would like to report that United HealthCare Community Plan is open for new enrollment statewide, effective January 1st. Some of you may recall in October of 2019, as a result of the review of issues at United Community Health Plan, the DMAHS actually imposed a temporary freeze on enrollment of new beneficiaries in United. DMAHS has now determined that United has, in fact, resolved issues identified that were requiring program improvement, a set of issues that the State closely monitored and reviewed data and assessed progress throughout the entire period of the freeze. We have found that United has, in fact, resolved those issues and, therefore, we are authorizing effective January 1, 2021, that members can select to enroll in the United. In addition, auto-assignment will resume in January for future dates. The action to unfreeze enrollment has also be agreed to by CMS and so everything is moving forward, and we continue to monitor over the next 12 months to ensure that everything goes smoothly and improvements are firmly in place.

DR. SPITALNIK: Thank you.

Questions or comments at this point?

Jen Jacobs.

MS. JACOBS: Thanks, Dr. Spitalnik.

I wanted to just add on to our official information here in United that we had a question about the termination of the network relationship between United and Children's Hospital of Philadelphia, and really specifically, we have been monitoring the operational impact and, obviously, any potential quality or clinical impact of that, of the change in that relationship. And so I would just like to give you a brief update. And to Carol's point, this is also a situation that we will continue to monitor.

With respect to the termination at this stage, we are still in the required continuity of care period which is really applicable to anyone who is in an active course of treatment at CHOP for specific types of treatment. And so that is standard, required in the contract, something that we monitor. But in addition, because of the special nature of this, United and CHOP have taken steps to ensure that we have close coordination and really minimize impact on our members. So I'll describe to you a few ways that that's happening.

For one thing, United has maintained the

connection between children and their primary care provider who may be a CHOP provider but will remain their pediatrician in spite of the termination of the in-network relationship. So that is 6600 children who will remain with their primary care provider who is a CHOP-affiliated provider. And we appreciate that continuity, particularly in the current public health emergency.

In addition, to the standard continuity of care provision that is required in our contract, United and CHOP have agreed that there are about 1500 children here in New Jersey who need to continue treatment at CHOP. They have established relationships there that are specific to their needs, and both United and CHOP have agreed it is clinically appropriate for those children to continue in care at CHOP beyond the required continuity of care period, so that will be happening.

United and CHOP are meeting weekly around operational concerns. They are co-rounding biweekly for clinical discussions, and they are holding a monthly joint operating committee. So that is assigned to us that the two organizations are maintaining close communication, and our hope and intention is that they will address issues and troubleshoot as needed through

that infrastructure. And then in addition to that so that we have a line of sight, we have required United to give us a biweekly grievance report, the calls that are coming into them from their members specific to the issues that members may be experiencing at CHOP or related to CHOP. So we are monitoring that report biweekly. Carol and I put eyes on it with Jerilyn who leads our provider relations team, and we will be noting any issues that we see that might represent trend or pattern, need for provider education, and anything else that might be going on in that respect.

So that's just a brief update, but I was asked to provide a sense of where things are, and I thought that might be helpful.

DR. SPITALNIK: Beverly.

MS. ROBERTS: Thank you. Thanks, Deborah. And thanks very much, Jen. That's helpful information. It's also helpful to hear some numbers, like 1500 children in New Jersey were able to continue to receive care from CHOP. So is it possible for that number to be increased? Because there was a decision made about 1500. Just for example, I know of a couple of other cases, not a gigantic number, but I'm just wondering about others that would really like to be in that 1500 group.

MS. JACOBS: United and CHOP have been co-rounding, and we are aware that as they have identified cases that may need to continue, they have added people to the list. But I would also caution you that I think people have gone over and over and over the lists, so I can't speak to any likelihood of a change in that regard at this point. But, Bev, please feel free to share cases with us as they come up.

MS. ROBERTS: And I also want to be sure I understood. Are you saying all of the New Jersey children -- you mentioned a 6600 number -- that they are able to continue to see their PCP with whom they had a relationship previously? Because originally, I think I heard it had to be like a primary care center that was a CHOP center. But there were certainly, of course, PCPs not part of a primary care center that was CHOP. So I just want to be sure I'm understanding that correctly.

MS. JACOBS: I do not want to misspeak, so let me get the technical answer to that question for you, Bev.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Thank you. Other questions or comments from the MAAC?

Thank you both.

And, Carol, we return to you around the update or community doula services, please.

MS. GRANT: I think, Jen, you're doing community doulas, right?

DR. SPITALNIK: I apologize.

MS. JACOBS: Dr. Spitalnik, we have presented to the MAAC before on the doula, the community doula stakeholder process that we engaged in, the partnership, as Carol mentioned, with the First Lady's Nuture NJ initiative, and really what we believe community doulas can offer to our members. I just want to touch on that last part. I don't want to repeat everything that we've talked about before. But I do want to touch on that last part because it's important.

We really learned in our conversations, in our listening with our doula stakeholders who very much represent the community we serve, that the community doula model was a very important aspect of our path forward. There are lots of doulas in the world, but community doulas are those who have been trained to understand what our members are up against. And so when you think about institution bias, you think about trauma informed care, community doulas are more familiar with the experience that our members have, frankly, in life and in accessing the health care

system than a standard doula. So we wanted to make sure that we incorporated that aspect in order to serve our members the best way possible. We've talked about that a little bit before, but that really does undergird all of the other work that we've been doing.

We have described to you here two kinds of change. I think I may have talked with this group about this before but, again, just to repeat, we have technical change and we have adaptive change. Technical change is the switches that we have to flip to turn something on. Adaptive change is about hearts and minds.

And so for January 1st, we have achieved technical change. We have turned on the switches that will let us enroll doulas as providers in our Medicaid program, and we have applications we are processing today. And we have turned on the switches that will allow us to pay those doulas. So all of that remains work-in-progress because you find things out as you go. But the technical change is in place.

What is next and really important is the adaptive change, the hearts and minds piece. So we are very focused now on working with the first lady and her team to make sure that there is awareness in the community of the availability of community doula

benefit and the care and service that is provided through that benefit and that we are supporting relationships between doulas and the women they're serving and more traditional health care providers. Although arguably, you doula is the oldest tradition. When we think about traditional health care providers in America, we're thinking about OBs and hospitals. And we've got to make sure that we're building bridges there.

So that is important work that goes forward for us in 2021, and we just wanted to point out to you that maternal health awareness day is just moments away, and there are lots of activities going on in that regard. So the First Lady has put out some great social media, and more is to come about different events that will be happening across the full spectrum of maternal health care including the doula work that we're doing.

DR. SPITALNIK: Thank you.
There are some specific questions about doula training, which I will ask people to contact DMAHS directly about.

Any other comments or considerations from the MAAC?

As we close this segment, I think no matter

how involved one is with Medicaid, with NJ FamilyCare, the breadth of the program is always breathtaking, and our appreciation for everyone working on all fronts.

It's now my pleasure to turn to Commissioner Sarah Adelman who will speak with us about COVID-19 updates and vaccine distribution.
Commissioner.

MS. ADELMAN: Thank you Dr. Spitalnik. And good morning again, everyone. I know that Jen is planning to jump in and help me a bit here with some additional details, but I just want to give some high-level overview remark for folks to start us off. I just want to begin by acknowledging that our State, and just like the rest of the nation, continues to grapple with the devastating impact of COVID-19, but we look with optimism to the new administration and the progress we hope to make in the coming weeks and months in the fight to end this pandemic.

I believe many of you see the Governor and the Commissioner of Health providing regular updates at their press conferences about the statistics for New Jersey. I will share the latest statistics as of yesterday. There were 4,582 newly-reported COVID-19 positive tests and, very sadly, 122 additional deaths,

for a total of 18,543 deaths in New Jersey to COVID-19. There are currently 3,547 individuals hospitalized with 635 in intensive care. And to date, 432,220 vaccines have been administered in New Jersey.

I will focus most of my comments today on vaccine updates. I know that's top of mind for most of you all. But I did want to note for the benefit of the group and to recognize the work across our Department that our Department does continue to support individuals and families in new ways as a result of COVID through the various program we administer. We have seen program growth across our Department as a result of COVID as many people need assistance for the first time because of their experience right now in the pandemic. Our Department serves 1 in 3 New Jersey children and 1 in 5 New Jersey adults across our various programs.

In particular, I wanted to highlight one update that I thought would be of interest to you all. And that is that since March, we have been able to issue the maximum allowable benefit of SNAP food assistance for all SNAP households in New Jersey regardless of income and that in the latest federal relief bill, we received an increase in SNAP benefits by an additional 15 percent, which began this month in

January benefits. And we believe will continue at least through June. I wanted to highlight that, as many of our Medicaid families are also benefitting and relying on food assistance at this time.

So with that, I want to move right into some vaccine updates for the group. And I'll talk high-level about some things, who can get vaccinated, where you can get vaccinated, how to sign up, and a few other details. So I will start by just reminding everyone of New Jersey's strategic aims in our COVID vaccination program. The first is that we will provide equitable access to all individuals who live, work, and are educated in New Jersey. We will achieve community protection, assuming vaccine effectiveness, availability, and uptake, and our goal is to reach 70 percent vaccination across our State and to build sustainable trust in the COVID-19 vaccine and other important vaccines.

Right now, and you see on your screen here a snapshot of everyone who is eligible to receive the vaccine as of January 14th, earlier this month. You all know, I'm sure, that our program in New Jersey started by vaccinated health care workers as well as residents and staff of long-term care facilities. And there were two ways that those vaccinations were

happening. In our health care settings, vaccines were being distributed directly to hospitals and other health care settings that were able to properly store the vaccines that were available with cold chain or ultra cold chain storage. And there is a federal pharmacy partnership program where CVS and Walgreen's have contracts with the federal government to be onsite in each long-term care facility to vaccinate staff and residents of those facilities. Both of those programs are ongoing. Health care workers across the State continue to receive the vaccine as part of 1A, as do the long-term care facilities across our State. As CVS and Walgreen's complete vaccination of the nursing facilities and specialty care nursing facilities, they will move on to assisted living facilities and some other congregate long-term care type settings that were also included in that federal pharmacy partnership program.

As that work continues, we've also expanded access in New Jersey to some additional groups, and as a result of recommendations from the CDC, as of January 14th, those additional groups included individuals over the age of 65 as well as individuals between the ages of 16 and 64 who have at least one of the chronic medical conditions that pose high risk for

severe COVID-19 that you see listed here on your slide. And you may have seen reported in the news, I think it's an important moment to pause and recognize that as a result of these categories being added for vaccine eligible, there are now a significant number of individuals who are eligible for the vaccine, who are interested in receiving it, and who are hoping to make appointments. There are estimates that indicate that around 4 million New Jerseyans are eligible throughout these categories.

And it's important to note here that New Jersey continues to receive about 100,000 doses of the vaccine from the federal government each week. So we have 4 million individuals eligible but continue to receive only 100,000 vaccines per week. So there is now right a notable gap between supply and demand. We had hoped to begin receiving additional doses of the vaccine this week after some announcements under the Trump administration that they would begin releasing some of the stockpiled vaccine doses. And we learned shortly thereafter that those doses actually did not exist and would not be available to the states. So we at this point continue to look ahead over the coming weeks and anticipate receiving the same level of supply that we have been seeing in recent weeks, about a

hundred thousand doses per week. So as we all for our loved ones and the members who we serve through our programs and through your organizations as we all help individuals try to sign up for a vaccine -- and I'll talk a bit more about that as well -- it's just important to note that we are scheduling into the future at this point and look with optimism to begin receiving more doses than we are today so that we can increase the volume and frequency of vaccines that are available to those who are currently eligible.

And I think it's worth noting that we also intend, as soon as we're able to, to expand access to other essential frontline workers beyond health care workers who we know are on the front line serving individuals who are at risk themselves and serving individuals who are at risk today and look to the future when we can announce those additional eligibility phases.

So I touched a bit on who can get vaccines. Just to talk for a minute where vaccines are available, there currently vaccine sites available in New Jersey at a number of different Points of Dispensing or PODS. There are mega sites. There are acute care hospitals. There are pharmacy programs, chain pharmacies, urgent care centers, federally qualified health centers, and

local health departments all receiving a supply of vaccines and able available for individuals who sign up for vaccines.

Here is a good time to talk about the State's vaccine registry. There is a State website to sign up for and register for vaccine appointments. In addition to the State's vaccine scheduling system, you may also register and schedule directly at many of the vaccine sites that are available, both the mega sites and some of the Points of Dispensing are also allowing direct scheduling through their own websites. And so as a follow-up to this meeting, we can share with the MAAC list the website where you can look up in every county every website where you can register for a vaccine. I think as individuals are looking at the vaccine sites that are nearest to them and where they may want to receive their vaccine, you can use this as a resource to figure out where you should be signing up and getting in the cue for a future appointment.

I think I will move next to talk about the call center for individuals who aren't able to register online. The Department of Health earlier this week announced that they are launching a call center particularly for our older New Jerseyans but also available to others who may not have access to the

Internet or may not be able to register directly online so that folks who need phone assistance to sign up and schedule their appointment have that assistance. So the phone number for that call center we can share as follow-up as well is 855-568-0545.

Right now, there is an ought response system when you call that number, but the live agents are being trained this week and the call center will move toward live agent answering in the coming days. So that number right now goes to an automated system, but soon older New Jerseyans and others will be able to reach a live person to seek assistance for vaccine registration and sign-up.

I think that largely concludes the things I wanted to share, Jen. I will just conclude by saying that we appreciate all of your support in the stakeholder community to help, one, promote vaccination among the individuals that we serve. We know that we need 70 percent vaccination to achieve herd immunity across our State, and that's the goal we're all working toward. And there are communities where we still see vaccine hesitancy, so as we continue to ramp up the supply of available vaccine and vaccine appointments, we also want to balance that with ongoing work to build public confidence in the vaccine. And you all are

trusted leaders in the community, and we know that our members look to you and to your guidance about these things, so on behalf of the State, we ask for your help in this. And I thank you in advance and we appreciate your support in helping us build public confidence so that we can reach our 70 percent goal across New Jersey. So please engage with your members on this. And to each of you, please don't hesitate to reach out if you have questions. Please stay safe, stay healthy, and get vaccinated. Thank you.

DR. SPITALNIK: Thanks so much. There's such clarity about the unclarity and the complexity between the role of the Department of Human Services, the role and responsibilities of the Department of Health, and the guidance from CDC, all of which have interplay.

Beverly has a question as a MAAC member and there are you few other points that I will bring to you from the chat, but with an appreciation of the boundaries of responsibility within the State.

Beverly. Please.

MS. ROBERTS: Thank you very much.

And thank you, Commissioner. Congratulations on your new position as Commissioner.

So the first thing I wanted to do is thank

you for your help in the work that's been done for individuals with IDD living in group homes to be able to have a way to get vaccinated through Walmart. That information was distributed by DD, I guess, at the end of last week and we very much appreciate your help with this. We know that all of this stuff takes a lot of time and effort to get set up.

This is the question that I have. And I see clearly on the slide that's on the screen where it talks about persons who have at least chronic medical condition that poses high risk for severe COVID. Down syndrome is listed correctly, as it is listed on the CDC website. The problem is down syndrome is not listed on the State's registration website. And we've been contacted by a number of families with a family member who has down syndrome asking why is down syndrome not listed and how can we make sure that it does get listed because, obviously, if there's somebody who's under the age of 65 and doesn't seem to have any of these high-risk conditions, they're not going to be viewed as a priority. People with down syndrome, of course, should be viewed as a priority. So anything that you can do to get down syndrome added to the State's registry would be greatly appreciated.

MS. ADELMAN: Thanks, Beverly. So down

syndrome was one of the categories. All of these listed here are conditions identified by the CDC, the body that is making recommendations to states about what conditions to be looked at. The addition of down syndrome happened more recently, just in the last couple of weeks. So when the State's registry website went up, it had not yet be recommended. It was subsequently recommended, and the Department of Health is adding that. I think they actually may have already. I have not checked it in the last day or so. But if it is not already added, it is being added to the website. And for individuals who may have registered before it was added who do have down syndrome and want to make sure that that is added to their registration, I understand that the call center phone number that I provided might be a good way to achieve that. So if you've preregistered and you're not able to add that to your registration online, you can call that call center and seek assistance to make sure that that's documented for that's already occurred.

MS. ROBERTS: Thank you so much. Could you just repeat for one last time that call center phone number?

DR. SPITALNIK: In fact, I'd ask DMAHS staff

to add it to the chat box please so it's more accessible.

MS. ADELMAN: I do want to reiterate here that folks should give this another couple of days. Right now when you call, it is still an automated system. But the live agents are finalizing their training now and will begin in the following days answering those calls. So again, just to reiterate, if you call today, there won't be a live operator. But we will have another announcement about this just in the next coming days when live agents are available. The phone number is 1-855-568-0545. And we will also share this with members.

DR. SPITALNIK: Thank you.

Another question for you directly, Commissioner. What is the plan for vaccination in the State hospitals?

MS. ADELMAN: Is the question about --

DR. SPITALNIK: If it's the State psychiatric hospital, is that the province of the Department of Health in terms of what their plan is?

MS. ADELMAN: Yes. I cannot speak to this in detail. The State psychiatric hospitals are under the Department of Health, but I do know that they have been vaccinating in the State psychiatric hospitals,

residents and staff, as have we in our Department in the State developmental centers.

DR. SPITALNIK: And there are some questions which may be beyond what can be answered here about the requirement around birth and Social Security numbers that seem to be deterring people from participating and hope for a streamlined process. The other set of issues, and again we appreciate this may be within the province of the Department of Health rather than your auspice, about vaccinating elderly people or people with significant disabilities if they have difficulty leaving their homes.

MS. ADELMAN: I appreciate that question. And we just had a call on Tuesday with the Commissioner of health and many advocates and organizations that serve older New Jerseyans and senior services agencies, and that is something that the State is very focused on.

Beverly mentioned the Walmart program for group home residents with IDD. That's part of what's called a closed POD or a closed Point of Dispensing where we've been able to arrange a dedicated supply of vaccines for a specific population at specific locations. So there are days of the week in hours of those days where that location is only going to serve

individuals who are residents of group homes with intellectual and developmental disabilities. That is a model that can exist and does exist for some other specialty populations. So there is a similar kind of closed pod model, for instance, for home health care workers. I think we are thinking similarly about the aging community, especially individuals who are truly homebound. And I know that the Department of Health is looking at options for mobile vaccination with pharmacy partners or other provider partners for that population.

There are some limitations for us right now because of the storage requirements of the Pfizer and Moderna vaccines. They require ultra cold chain and cold chain storage. It makes door-to-door vaccination a little bit more difficult. But we do anticipate with the approval of the J & J vaccine that's upcoming and some additional supply that may not have those same kinds of storage constraints that a meaningful mobile vaccination option will be available in the future for those individuals.

So I don't have much to report on that today other than to reassure everyone that is top of mind for all of us, and we are working or solutions that we'll roll out as we realistically are able to do that.

DR. SPITALNIK: Thank you so much. We're very appreciative of both this information and, of course, your ongoing advocacy as well as the national constraints that we're all experiencing right now.

MS. JACOBS: Dr. Spitalnik, we did have a question come in before the meeting from an attendee, so I just wanted to very briefly speak to that. The question was how we will deploy our care managers from our health plans to support our members in getting access to the vaccine and also potentially to address the hesitance that we know many folks feel about the vaccine and vaccines generally, as Sarah was describing.

So I just wanted to share with you briefly that we are formulating a plan with our managed care organizations. As Sarah described, there's a large portion of our NJ FamilyCare community that technically is already qualified to go out and get this vaccine. So the discussion that we needed to have was, who do we reach out to first since we can't reach out to everybody today. We're having that discussion with the MCOs, the Managed Care Organizations, both in the context of the complexity of medical conditions. So, for example, if you have three of these high-priority conditions, you are at a very serious risk level. And

we've talked about age and we have also, importantly, we have thought about social factors. So someone who has support in the community is at less risk relative to the person who has the same medical conditions and has no support in the community. So we really wanted to think not only about medical conditions but also about somebody's likelihood to fall through the cracks and to make sure that we're using our managed care teams as advocates to address some of that social risk while we are also addressing medical risk. And so as Sarah described, we are doing all of that in the context of the supply and demand environment and, frankly, the fact that the logistics of this is still rolling out. But I did want you to be aware that next time we talk, we'll be able to report back to you on the partnership with the Managed Care Organizations and the care managers who are available to help us reach out to our members and make sure that nobody falls through the cracks.

DR. SPITALNIK: Thank you so much.

Commissioner, anything to add at this juncture?

MS. ADELMAN: No. Thank you very much. Thanks for the chance to provide some updates today. I know you are all very eager for this information, and I

just want to reiterate again how much we appreciate your partnership and sharing this with your stakeholders and your partnership with us as we continue to roll out these efforts in New Jersey. So thank you and we'll continue to be in touch through our divisions and our Department between MAAC meetings but in future meetings as well.

DR. SPITALNIK: Thank you so much. There was a question about Type 1 diabetes in terms of risk conditions. And I would ask the commenter to refer them to the Department of Health who is establishing the guidelines.

With that, we move to two other policy updates, and I'm joined in that with Greg woods, the chief innovation officer at DMAHS. But I've been asked to present first on the autism spectrum disorder stakeholder meeting held.

Carol, I'll try to hold myself to the same acronym that I was asking of you. As we have discussed in previous meetings, New Jersey has, under guidance from CMS, a State plan amendment under EPSDT that provides for services for Medicaid beneficiary children, FamilyCare beneficiary children, with access to services for autism under the early periodic screening diagnosis and treatment benefit and that the

design of the benefit was a result of a stakeholder process that included the Children System of Care and the Department of Children and Families, the staff of DMAHS and community stakeholders. And that collaboration has continued now to a quarterly stakeholder meeting that reviews and provides input on the actual implementation of the benefit.

So from the last stakeholder meeting and data as of the end of December of last year, we can report that 690 children are receiving Applied Behavior Analysis services. Seventy-six new contracts of providers have come on board for those services and that the benefit for developmental and relational therapy, which has been challenging because there's no existing code in Medicaid nationally, but New Jersey has established one and new providers are contracting with Managed Care Organizations. A reminder that these services are coordinating and authorized by the child's Managed Care Organization and at each meeting, each MCO reports on their approach and their progress.

The other elements that are being addressed is the crucial need for developing education for families and providers to have families understand and access this benefit. A resource list has been developed and will be posted, including Internet

resources. The workgroup and DMAHS is working on frequently asked questions to try to clarify this information and trying to establish a directory of providers that have services that are accessible for people who English is not their primary language.

This is a complex undertaking and also reflected of the state of practice statewide and nationwide around services to people with ASD. The importance of the lack of providers or the limited resource of providers and the work to continue to expand providers network, also to develop consistent payment and billing procedures so there are webinars re being developed with and between the MCOs to provide consistency.

As an additional support to this complex process is that there's now a phone line that's available to people and an e-mail dropbox to address provider and family concerns. And I would also request that we put in the chat box and that we include that in the minutes of the meeting or, even before that, we post the slides.

Are there additions, Carol or Jen, that you would like to make? And are there questions or comments from the MAAC?

MS. GRANT: Can I weigh in just on the last.

DR. SPITALNIK: Please.

MS. GRANT: The phone line and the e-mail dropbox, we're not quite ready to put out there yet. We really would like the phone line to have a live person at the other end so we're still working out some details around that. And it's really sort of an under-construction but intended sort of service that we can provide to people. And as soon as that information is active and live, we will, in fact, share it.

DR. SPITALNIK: Thank you. Other questions or comments?

I'm not seeing any in the chat box, and so I turn to Greg Woods, chief innovation officer, to speak with us about the 1115 listening sessions.

Welcome, Greg.

MR. WOODS: Thanks, Dr. Spitalnik.

So I'm just going to give an update on our planning for our 1115 Demonstration renewal application, which we intend to submit to the federal government later this year. This is something that I think we had talked during the last MAAC meeting, so I just wanted to give everyone a status update on where we are.

So just as a reminder, the 1115 Demonstration is sort of the umbrella structure through

which we negotiate and agree with our federal partners around various elements of the Medicaid program, sort of everything that diverges from our State Plan is different from the standard Medicaid benefit structure. Last time during the MAAC meeting, our Comprehensive 1115 Demonstration is coming up on 10 years old, so we had an initial performance period that lasted five years. We are now in the second performance period which also is scheduled to last five years. So what we are looking towards is a renewal application that would establish the terms of a third performance period that presumably would also last five years, and that would start in the middle of 2022. In order to do that we need to submit an application to CMS for renewal to our federal partners for renewal a year in advance, so June of this year. And as part of that process, back in November we had a couple of open listening sessions for stakeholders where we requested input on things we should be considering as we move toward that application this coming June. So we had those sessions. I think we were very pleased. We had really robust participation from a range of stakeholders and got comments on a bunch of different areas which we are taking under consideration as we move forward with our demonstration

planning. We also got a number of written comments which are also part of our process. So we appreciate all of the input we've received from a wide range of stakeholders.

Where we are now is we are taking a look at those comments. We're working intensively through our internal process. And our expectation is that we will release some time in the spring, my guess, though this is not a firm date, is it will be the towards the end of March or the beginning of April a detailed proposal for public comment on what we intend to submit to CMS as part of our renewal process. That's a standard part of the process. There will then be a public comment period.

As part of that public comment period, we will have multiple public forums. And I think it is likely -- obviously, timelines can be a bit fluid, but our expectation is that our next MAAC meeting we will devote a significant share of the agenda, with the agreement with the MAAC members, to talking through the details of what's in that proposal that will be out of that point, we hope, for public comment. So that's where we are in the process.

And then once we receive public comments, once we have those public forums, we'll take that and

make changes if necessary to our proposal, and then the submission to CMS to our federal partner will need to happen by the end of June. So that's where we are in the process.

Like I said, my expectation is that during the next MAAC meeting we'll have a lot of detail about what we expect to include in our 1115 renewal proposal. I think for now, we did want to just talk about the emerging themes that we're seeing as we think about that proposal and some of the core elements that we expect to be a part of it.

So just quickly, first, I think it's important that we intend to preserve and strengthen the existing Demonstration elements that work. The Demonstration covers a lot of our Medicaid program. A lot of that we think has been successful and so where things are working, we expect to propose to preserve those, to continue those. So that's one piece.

A second big theme that we expect to be part of our renewal proposal is to promote maternal and child health, as some of the other panelists have mentioned. We are collaborating closely with the First Lady Nature NJ Initiative, which is just focused on maternal and child health. There are a number of different Medicaid elements to that, but we think

several of them may make sense to incorporate into our 1115 renewal application. So some more to come on that.

We're looking right now at innovative approaches that we can test to address social determinants of health. I think we all know that if we want to improve the health of the population that Medicaid serves, that health care is not the only lever there and that looking and being aware of and coordinating with services that address or initiatives that address the social determinants of health are also very important. So we're looking at innovative approaches there.

In general, we're looking to streamline and rationalize programmatic rules and requirements. I think, as is always the case with any program over five years, things evolve. We learn certain procedures or policies or administrative requirements may be working, some may not be, some may need to be updated. So this is sort of a good moment for us to pause and review those things and identify areas where there are opportunities for streamlining for improvements, for updates.

Another theme is thinking about ways to integrate care between Medicare and Medicaid for dual

eligibles. I know we alluded earlier to we now Aetna have all five of our MCOs with operational FIDE SNPS that provide integrated care across Medicare and Medicaid. But I think beyond that, we're looking at whether there are other things we can do programmatically, opportunities to promote that. And then just generally, I think a real focus of all of our strategic planning work, all of our thinking about the Medicaid program is how we can promote equity program-wide. And that, I think, will sort of flow through all of the other areas that I've alluded to, but it's very much sort of a north star principle for us as we think about how to move forward with the 1115.

So as I said, the next steps here are we intend later in the spring to release a detailed concept paper that outlines what we intend to put in our renewal application to CMS, and then there will be the State public comment period and public forum, including we expect forum at our next meeting.

There is an inbox where we have received already, as I said, a number of written comments from stakeholders. If stakeholders have outstanding comments, we continue to check that. It's not too late if there are things you want to submit, so please feel

free to use that resource.

DR. SPITALNIK: Thank you so much.

Jen, anything to add before I ask MAAC questions?

MS. JACOBS: No, nothing from me.

DR. SPITALNIK: Thank you.

Are there any questions from the MAAC or comments at this point?

Seeing or hearing or sensing none, to the best of my technical ability, thank you so much, Greg. And we look forward to continuing to work with you on this.

Our next agenda item is a NJ FamilyCare enrollment update. And we welcome Heidi Smith, the chief of operations for DMAHS. Heidi, good morning.

MS. SMITH: Hi. Good morning. I think Greg is going to do the enrollment update.

DR. SPITALNIK: Please, go ahead.

MR. WOODS: So just quickly before I hand off to Heidi. I know we've been providing regular updates on where we are with overall NJ FamilyCare enrollment. So as you can see on the slide, as of the most recent numbers from December, we are a little above 1.9 million total enrollees. That represents an

increase of a little bit more than 200,000 members since the beginning of the pandemic. Prior to the pandemic, enrollment has very gradually been trending downward, as often what we see during periods of relatively strong economic performance. But since the beginning of the pandemic, we've had fairly steady increases month over month.

As I think we've discussed previously, that's a critical factor here is the ongoing maintenance of effort requirements that we're complying with which is sort of to say the continuous enrollment. By and large, we are not disenrolling members during the public health emergency.

I know that we had had a question following the last MAAC meeting around to what extent can the growth in the program that we have been saying be explained by that continuous enrollment requirement, that people are not coming off the program, versus a surge in new enrollment. And I think the short answer to that is it's complicated and a little bit hard to quantify because we don't know what the counterfactual would have been had the public health emergency not occurred. So we don't know which individuals who are enrolling would have enrolled anyway. We don't know which individuals who are staying on our rolls might

have been disenrolled in a non-pandemic scenario. With that caveat, we did want to provide a little bit rough order of magnitude sense about this. So just to give you a sense -- and I'm going to use some round average numbers because there does tend to be quite a bit of noise from month to month. Before the pandemic, in a typical month about 50,000 beneficiaries would come off our rolls every month. Since the maintenance of effort requirement, the continuous enrollment requirement that has been in place, that number has fallen. The vast majority of those individuals are staying on our rolls. The number who come off of rolls is not zero because there are still people who voluntarily disenroll or move out of state or pass away, but it's a very small fraction of what it was before.

Meanwhile, since we've been in public health emergency period, we have generally been seeing about 35,000, give or take. And, again, there's significant noise from month to month, new enrollees every month. So when you combine those two things where we're seeing, relative to past experience, very small numbers of people coming off the rolls and about 35,000 each month coming on. That's what's driving the new enrollment or the overall program growth.

So I don't know if that directly answers some of the questions we've had in the past, but it does help to give you some sense of what we're seeing here.

DR. SPITALNIK: Thank you.

Questions or comments from the MAAC.

Greg, I appreciate that.

In terms of the State Based Health Insurance Exchange, Heidi, will you for that?

MS. SMITH: Yes.

DR. SPITALNIK: Thank you.

Bev, do you have a question?

MS. ROBERTS: I have a quick question. And I don't want to go into the details of a problem, but it's something that is -- I'm sure it's a mistake -- having to do with a person who is a DAC, did everything they were supposed to, to get Medicaid continued with SSDI and was told that they would have to re-enroll in Medicaid again which would also probably be a lapse of PPP. So my question is -- I have the details of problems which I got this morning shortly before this meeting -- to whom should I be sending this information about the glitch?

MS. SMITH: Bev, I don't know if I should put it in the chat or whatever, but you could send that

directly to Cathy or Brian, Brian Brennan, and we'll look at that.

MS. ROBERTS: It's gone through the county. In other words, it wasn't done through Brian.

MS. SMITH: That's okay. If you e-mail us, we can follow up.

MS. JACOBS: Cathy's team works directly with the counties every day.

DR. SPITALNIK: Thank you.

Sherl, you have a question.

MS. BRAND: Thank you. I just wanted to go back to the same topic, the overall enrollment. I just want to check to see any reported delays in application processing? And then also do you expect -- we are still amidst COVID, do you expect that we'll continue to see on average around 35 new enrollees a month? Do you see it growing? I'm just trying to get a sense of what you expect the trend line to do.

MS. JACOBS: There's a little bit of crystal ball factor there because we don't know what will happen with the economy, what will happen with people's concerns as we're approaching a full year of public health emergency. We did have a sense early on that people were not prioritizing health insurance because they were prioritizing food insecurity. People were

working the issues as they came. So will we see an increase related to that? I think, Greg, maybe you were thinking about the re-enrollment factor. Did you want to briefly explain that?

MR. WOODS: I would say the number of new enrollees we see every month, the overall trend of that has been very gradually downwards. And to be transparent, I don't think we know all of the factors that are driving that. But we think one of the issues or one of the things exist in forming that trend is because disenrollments are vastly lower than they would have been prior to the pandemic, there's some level whereas people remain as part of our program longer, they're not reenrolling and so they don't get captured. To restate that, under normal circumstances, we do have situations where someone will come off of the program at some point and then several months later their situation will have changed or they require medical care and they come back on. Those people now, we think, are mostly just staying on the program so we may not be seeing them come back on. So the longer the public health emergency lasts, that may continue to drive those numbers a little bit lower.

The only other thing I was going to mention is -- and Heidi may be able to speak to this also -- I

would expect in January we may see some higher numbers due to the open enrollment period through this State Based Exchange. So that may make the curve look a little bit different just because of that calendar issue.

DR. SPITALNIK: I think as a wonderful bridge, Greg, that you just provided to the issue of State Based Exchange, but as is our practice, we keep track of issues and continued items to be raised at the next meeting. Clearly, enrollment is one of them, and there are some questions about previous trends that we'll make sure get fed into the consideration for the next update on enrollment. So thank you again.

And, Heidi, I'll turn to you around the New Jersey State Based Exchange (SBE).

MS. SMITH: Thank you, Dr. Spitalnik.

So this is the homepage of the GetCoveredNJ, and it's found at https://nj.gov/getcoverednj/. This is where you will find the most current information about the program and the eligibility requirements, and that will all be listed on that website. You can visit the site to get an overview of GetCoveredNJ and also the frequently asked questions with the responses.

This legislation, Public Law 2019 141, gave the State authority to build its own health

exchange and not to be reliant on the Federally Facilitated Marketplace, or the FFM.

So the benefits of having our own State Based Exchange instead of relying on the Federal Facilitated Marketplace, or FFM, since the legislation was enacted in 2019, DOBI -- that's the Department of Banking and Insurance -- and DMAHS have been a working collaboratively on this build. It gives us more control over the health insurance market. It allows us to have more outreach and trained assistors in to help in the community, and it also streamlines the process between the Marketplace, between our State Based Exchange, GetCoveredNJ, and the FamilyCare.

System implementation. Now I'd like to present on the two newest NJ FamilyCare eligibility system enhancements to improve its functionality. This is not about get covered. This is about what NJ FamilyCare has done to its eligibility system. So the first thing is about the ABD application enhancement. Most applications that we receive now are online. That's great. We've asked for that. We've encouraged you to submit them online. But paper applications, they are still out there, and they are still being submitted. So this has to do with a worker data entering the paper ABD application that they received.

DR. SPITALNIK: Heidi, would you please just share the acronym of ABD?

MS. SMITH: Aged Blind Disabled. So the Aged Blind Disabled applications, they can come in online and they can also come in on paper. We're asking for online, we're encouraging online. But when they do come in paper, on paper we wanted those applications to have the same benefit of an online processing. So we were able to do a build on this and program for this so that the paper application, once it's data entered, it would have all of the automatic verifications and the standard notices that the online application receives.

There's two pieces of paper that we sort a screen shot on here. The applicant would get a confirmation page just as if they applied online. This shows that the application has been received. This page is printable. It's called the confirmation page. It tells where it went, it tells what phone numbers. If it went to county, it would give the address and phone number of that county. And it also talks about next steps, like what to expect so we can do some and anticipatory guidance there.

The second page to the right, in the corner of the right, it's called draft only. That's a sample

notice. Once the paper application is data entered, a notice of anything missing would be produced. If nothing's missing, this isn't produced. But often with a paper application, people skip sections or skip answers, and so our file or request for information would be produced now out of this system standard notice asking for the applicant to send in anything that's missing.

The second feature that we recently developed is the ABD or Aged Blind Disabled provider assistor portal. It's a special portal a provider, a Medicaid provider, would use. And it's an import portal, and we're actually piloting that now in four counties. So Medicaid long-term care provider could apply for ABD application, can make an application for their patients, through this special online portal. They could attach any documents that the patient provides to them or maybe the family brings in to them during a visit. And they could also check on the processing status of that application. This feature eliminates the telephone calls that are going on right now between a provider agency and the CWA. They call to say, we submit it, where are we at with it, is it missing anything. Right now the provider those that are piloting right now can go in and they can check on

that status only of the applications that they submitted. And this will show them any case updates.

This is just a screen shot of what the provider would see. This is their view when they log into their special portal.

Thank you. Any questions?

DR. SPITALNIK: Heidi, thank you so much.

Any questions from the MAAC at this juncture?

MS. EDELSTEIN: I have a question for Heidi. This is Theresa.

Awesome job getting these enhancements done. I really appreciate all of the work and look forward to hearing about the outcome of the pilot so we can continue to march forward.

I have a question for you about the State Based Exchange, I'm not sure you'll be able to answer it. But NJHA has one of the DOBI grants for navigation assistance. And in this environment just like, I'm sure, all the other grantees, this has been a very challenging time to get people focused on enrollment for all the reasons Jen mentioned and probably a ton more.

Is there any conversation about extending that January 31st deadline, or is this some statutory

reason why we can't?

MS. SMITH: So we work very closely with them. And, no, there has been no conversation on extending that deadline that I am aware of. We meet with them regularly.

MS. EDELSTEIN: Okay, thank you.

DR. SPITALNIK: Anything else at this juncture?

Thank you so much, Heidi.

There was a question about the availability of these slides, and they are posted and I'll review that later, but to reassure people who might be trying to franticly take notes.

We'll now go to Carol Grant to share the Managed Care Organization contract updates.

MS. GRANT: This is really to give you the highlights of proposed contract changes. We normally don't post the full contract with all of its changes until it has the approval both in the State, the managed care companies, and CMS. And this year has been an interesting year because many of our contracts have required changes to incorporate increased rates and things related to the public health emergency that it's kind of hard to nail down the final version of the contract. But we do want to go over what might be the

highlights that are coming in the January 2021 contract.

We always add, refine, and streamline definitions around a number of things. This contract does that for the Division of Developmental Disabilities, for Family Planning, and for the Screen For Community Services.

We've had to add, and you'll see that woven throughout what I'm going to say, language that complies with new rules. One is the CMS Interoperability and Patient Access Final Rule which really will impose additional requirements on us and on Managed Care regarding the electronic exchange of information and increase patient access to their health care information.

We have clarified language in the contract requiring the Screen For Community Services and assessment for NF level care. NF, being Nursing Facility for members requesting Managed Long Term Services and Supports (MLTSS) custodial services.

The contract has clarified an existing policy that requires that family planning services and supplies are the MCOs responsibility, whether the member chooses to use their MCO's network provider or

any other New Jersey Medicaid participating provider.

We have updated the perinatal risk assessment that we talked about before, the forms, and made them effective January 1.

We have ended reimbursement for nonmedically indicated early elective deliveries, effective January 1. We discussed that earlier.

We clarified scope and format for the submission of MCO pharmacy formularies.

We've established a procedure whereby the DD waiver program members are allowed up to 180 days in NF short-term rehab before being considered custodial care. The member would then need a screen for Community Services and a DDD/MLTSS screening referral prior to completing the New Jersey Choice Assessment. The MCO would coordinate with DDD for enrollments from the DDD waiver. Disenrollments from the DDD waiver and enrollment in MLTSS. Our goal here always is to ensure that the person is being served in the proper program sufficient to meet their needs. So we have, in fact, established and are formalizing that procedure.

We've added language to require the MCOs to develop a provider Directory Application Programming Interfaces, API, accessible through public-facing

provider directories on their websites no later than January 1, available to current and prospective members and must include at least provider names, addresses, phone numbers, and specialties. We've made a particular point of ensuring that provider directories have ease of use for our members so that they can, in fact, find the provider that is necessary to meet their needs.

We've also updated a requirement for the MCOs to implement a provider network monitoring plan, including quarterly provider network analysis, provider network gap analysis, audits and reviews of the quarterly provider network file data quality. MCOs must also submit analysis of deficiencies and corrective actions and improvement strategies to resolve identified issues. Provider networks are always an important subject, both for the MAAC, for the State, for our members and our plans. And we intend to continue to refine the process so that we really know what is, as Jen normally puts it, the true-true, related to provider networks and making sure that there is an ease of use for the members that we serve.

We have added CMS-approved language for emergency provisions and modifications of contract requirements that DMAHS may use during a future public

health emergency. We're trying to learn from what we've lived.

We've added language for CMS-approved Upper Payment Limit Program for MCOs to make State-directed payments to any Class II facility with more than 500 licensed beds. This was effective 10/1.

We've added a time limited quality improvement bridge payment, effective 9/17/20, to support the stability of all New Jersey acute care hospitals, effective 10/1/2020.

We have, in fact, specified in the contract that the MCO shall not exceed a 3 percent unsatisfactory MLTSS assessment audit rate, as calculated by the Division of Aging Services. MCOs exceeded that three percent must conduct analysis of the report and implement a remediation plan.

The contract will require mandated annual trainings for care managers for NF and SCNF level of care. SCNF level of care need in the community, medical day care level of care, and regulatory requirements as well as PASRR, Pre-administration Screening and Resident Review.

We have introduced more stringent care management caseload ratios with the expectation that plans will, in fact, monitor and maintain contractually

required ratios.

We have increased compliance standards for external quality review annual care management audits from 75 percent to 85 percent.

We have added a requirement for the MCOs to perform separate geographical accessibility analyses using both their complete quarterly certified provider network file and for providers with at least $600 or more than 10 paid claims the previous year. We are looking to track lower activity and higher activity providers within the network to give us a better picture of who is actually available to provide service.

We have added a Medicaid Fraud Division Operational Workbook to the contract appendix. And we have updated the notification of newborns report format.

I think that's the last slide.

DR. SPITALNIK: Thank you, Carol. And thank you for the way that you distilled down this complexity for all of us.

Sherl, you had a question.

MS. BRAND: Yes. And I echo Deborah. Thanks, Carol, this was a really good update. I appreciate it.

I know just recently hot off the press is the CMS Interoperability and prior auth. rule which has extensive requirements and enhancements for both Fee For Service, Medicaid, and CHIP, and Managed Care programs.

And, of course, I anticipate perhaps New Jersey commented but certainly is spending time reading the 433 pages of the final rule, which I am also reading.

Typically, just because I don't understand the process on the State side, for a final rule as extensive as that with a lot of changes, when do you typically make adjustments to the contracts and provide more public information about some of the activities that will be happening as a result of that?

MS. JACOBS: I think you may have been talking with the lawyers about our status on that, so I'm looking to you first. I'm not prepared, Sherl, to (audio distortion).

DR. SPITALNIK: Thank you.

Sherl, anything else at this juncture?

MS. BRAND: No, that's it.

DR. SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: Thanks so much, Carol. I

really appreciate these highlights on the proposed contract changes. So I'm very eager -- I know you don't have information and numbers yet because this is brand-new stuff, but especially with the more stringent care manager caseload ratios and the provider networks to see what's real and true-true and all that. I'm hoping that in each meeting that we have of the MAAC at any point when you can give us updates on this, I am sure we are all very, very eager to hear what you're learning so that's great.

I also have a question, which I don't know if you can answer, but I was particularly interested in the issue for folks who have DDD services who could be in a rehab setting for up to six months before there would be a decision that they need to become long-term care, MLTSS. Do you have any more details on that?

I'm interested also in somebody, let's say, who was in a rehab setting for just under six months but then can be discharged, which, of course, if that's appropriate, that's what we want to see. But what would happen to them in terms of, let's say, they had a group home placement and now they haven't been in the group home for all of those months so it may take some time for them to get placement and what do that mean. Do you have any information on that, or should we be

talking to Jonathan?

MS. GRANT: I don't know that I can answer that in any detail here. I mean, the real goal here is to make sure the person is in the right setting based on their level of need. I think we want people not to turn back and forth between systems and, I think, we can provide more information as we proceed. We have always had a procedure where DDD actually screens first to determine whether an individual might be more appropriate to a system with more active special services as opposed to custodial arrangement. This really gives a more formalized part of that process so that these decisions are made timely and appropriately for that person's level of need. I think we might need to have more conversation about that going forward, but I don't know that I can answer much more than that now.

MS. ROBERTS: Thank you. For example, I could see situations where the person might have been in a regular group home previously now might need a medical group home. So if in the right setting, they would be perfectly fine. But there is no medical group home availability at that point and so they stay in the rehab/nursing facility setting waiting for -- that's the kind of stuff.

MS. GRANT: That's right. I think those are

challenges that are everyday challenges we face today. The idea is to make sure that, in fact, we are making those kinds of decisions. And where we point out sort of gaps in the system for addressing that individual's needs and making sure that they are in the right setting and stay in the right system, you know, we're going to have to grapple with that going forward.

MS. ROBERTS: Well, thank you. That's very helpful information.

DR. SPITALNIK: Thank you.

Other questions for Carol?

Carol, thank you.

There was a question raised that maybe Jen, as you move in the wrap up for 2020 but I might ask you please address, which was can you be in both the exchanged and in NJ FamilyCare Managed Care Organization? That's a question of eligibilities.

MS. JACOBS: Thanks, Dr. Spitalnik. I think that technical answer to that is no. It is possible that people will have come through -- because this is a new process and the focus was on making sure that folks people got coverage. It is possible that people came through unintentionally, signed up for both, and it is expected that there will be a look back to address that so that there isn't double coverage.

DR. SPITALNIK: Thank you.

With that, we turn to you for looking back on perhaps the most challenging year in the history of the Medicaid program since 1965 and in all of our life experience. So even before you start, I'm going to thank you for your leadership and grounding us in values and action.

MS. JACOBS: Thank you, Dr. Spitalnik. And in return, I'd would like to say that we appreciate the MAAC and all of the attendees who come to this meeting and ask thoughtful questions. This is the fourth time that this committee is meeting remotely instead of in person. And I never loved that drive out to the facility where we typically held our meetings. I think I got lost every single time I ever went there. And then once I was on the property, I wasn't sure how to get to where I was going. And maybe some of you had that experience, too, or at least you'll nod along with me so I don't feel alone. Certainly, when we moved into this remote mode, it was in our minds that it might be for a very long while, but it was not in our hopes that it would be. And so here we are, we've completed a full year of MAAC meetings essentially in this remote format.

Most of what we have talked about in this

meeting so far today has been very forward-looking. I said at the beginning, when we have a long agenda, we try to have a narrative arc to it. We started with what was in effect January 1st that folks needed to be aware of. And then we talked about other things that are still in motion. We also felt that in a year like what you described, Dr. Spitalnik, it frankly made sense to take a look back at what we intended to do when we were 150 years younger last January and what we have achieved relative to the goals that we set. And so we've prepared to present that to you today, but I do want to point out that this is all done in the context of what our community has told us in years before this and during the public health emergency and, frankly, what leadership set as a vision for us. So through Commissioner Carole Johnson and now Acting Commissioner Sarah Adelman, the Department of Human Services has really had this service-focused vision and solved the problems that people are experiencing. So that is work that will keep us busy for a lifetime, as you know. But we did want to speak to it. And I also want to be very clear that there's a small army that does this work. And I say army because they are waging the fight every day. They are passionate and committed. They use their muscle and they use their

brains and they use their hearts. And we will never have all the soldiers that we want in that army, but we are small and mighty and they are really an incredible team to work with. It has been my great honor, frankly, to come through this really unusual year. And frankly, we're walking into a really unusual year. And I get to work with this team, and I couldn't feel better about that.

So I have shared this slide with you before. I showed you this slide when we met in our first remote meeting after the pandemic began. I feel like it was late April. I said to you in the beginning of 2020 we set four goals, and they look like this. We said we would serve people the best way possible, that we would experiment with new ways to solve problems, that we would focus on integrity and real outcomes. Bev, you made my heart happy when you said the true-true because that has very much been a focus for us this year. And then goal four, we would show people we care. Goal four is our culture goal. Not all the things we're going to do but how are we going to go about doing that.

So what I want to talk to you about today really is the accomplishments that we had relative to the goals we set last January. So we've already talked

a little bit about the autism benefits that launched. We know we still have some work to do there, but we see the team from inside and outside of DMAHS that has gathered around that.

We've talked a little bit about maternal and child health initiatives today. Those are ongoing, but we launched key policy changes January 1st on schedule as anticipated in spite of the public health emergency. We expanded office-based addiction treatment availability for our members.

We increased FIDE SNP membership. Again, that's that program where people get their Medicare and Medicaid coverage through the same coordinating health plan.

We expanded that membership by 15 percent. We have the largest FIDE SNP program in the nation. And we, as Carol described, we launched the fifth plan January 1, 2021, on schedule.

Some of the details that you don't see every minute with respect to goal one, serve people the best way possible, we put some provider rate increases into effect, both related to the public health emergency and unrelated to the public health emergency. Although ultimately, everything becomes related to the public health emergency.

Our special eligibility team stayed on track completing initial and renewal eligibility remotely. This is a document-heavy complex process where annuities and trusts are involved. And this was a team that had never worked remotely in the past. That was a really significant achievement that isn't going to get headlines. We'd get headlines if it hadn't happened. We also did work around pediatrician hearing aids, which was something we were hearing from our community.

And very importantly, we have a fiscal team that is really committed to the well-being of our members and our program, and they were very focused on navigating the budget process in this unprecedented year in a way that avoided any negative impact to our members.

But goal one wasn't only about the intentions we had set in January. We also had to think about serving people the best way possible through this public health emergency, and that meant maintaining eligibility under the maintenance of effort requirement for the federal government, which is a huge operational and logistical IT task, authorizing telehealth in new and creative ways that we've talked about before.

We worked with our health plans to outreach

high-risk members in ways that other states did not. And we're proud of the work that we did, and we've appreciative of the partnership from health plans. Likewise, we had partnership from our transportation vendor as we thought about new ways to make sure that people got the services and support that they needed.

And here is some more stuff that will never make headlines. We really provided critical technical support in the form of data and logistics to make sure that the federal government had high-quality data on the New Jersey Medicaid provider community so that as people were applying for the initial round of HRSA funding and then for later rounds of coronavirus relief funding for PPE, all that information was available to whoever needed it to make sure that those funds got to providers. So whether it was a federal distribution or state distribution, we were behind the scenes on that. And we also behind the scenes on the prison release where we had many individuals who were coming back out into the community from correctional facilities, and we needed to make sure that they were hooked up with their NJ FamilyCare coverage and could get treatment they might need immediately. That was a rapid response that required action from multiple

parts of the Division that was sort of flying under the radar, but we were doing what we needed to do to support those individuals as they were coming back out into the community.

Under goal two, we said that we wanted to experiment with new ways to solve problems. And Heidi has already spoken to you today about important improvements we made in our eligibility systems so I don't want to repeat anything she said, but I do want to applaud the work of the eligibility and IT teams and our county partners who had a big part of this.

And then in addition as Heidi described, we launched the State Based Exchange on November 1st according to schedule, and as of the date we put this slide together had accepted 40,000 transfers from that State Based Exchange for Medicaid eligibility processing. I think that number has gone up since we put the slide here.

We also did a lot of work that you hear Greg talking about a little bit but you will see the evidence of in the course of 2021 and '22, and that was around the perinatal episode of care. If we had set that aside, we would be significantly delayed right now, but the team kept it moving. And then as Greg described to you we also did a lot of advanced planning

for the 1115, and there is discussion yet to come on that.

We launched the EVV system, as required by the federal government, avoiding the penalties that were built into that mandate. We did that for January 1st.

And again, we had a cross-divisional team that really included folks from other divisions as well. We got our vendor late summer. We rallied the health plans. We put together stakeholder groups. We tried to do that the best way possible in partnership with all those parties. And then we also transitioned our MMIS system formally from what had been envisioned as a big bang modernization -- old terminology. We pivoted to the modular approach that CMS is now looking for, our federal partners. And that is really meant to make sure that the system is responding to the needs of the program, and we're very excited about that new model.

It was a significant lift. You're hearing a lot of systems and IT work that was going on in DMAHS this year. All of that was planned. What was unplanned was the public health emergency, and we've talked a little bit over the last few meetings about different pieces of our response that kind of fall

under this new technology and troubleshooting goal. And I really want to point out that some of this was experimentation. CMS gave us the opportunity to develop an expedited provider application, and that gave us some learnings that we can take forward completely unrelated to the public health emergency.

Heidi and her team moved heaven and earth to make the presumptive eligibility possible for the ABD population, as she discussed with you earlier.

Really, this was a team that was not equipped for remote work, so we have our IT wizards who turned us from a fully office-based organization into almost a fully remote organization. And they did that in a matter of what felt like 17 seconds with a lot of muscle and a lot of effort. And really, if you think about what was going on last spring, I think that was just incredibly noteworthy and I think of them as heroes because they were able to keep us going.

And then I would also point again to the tremendous lift in the system to ensure that the maintenance of effort was working the way that it should. We had folks with eyes on that every single day because the system is designed to do the normal routine. It is not designed to deal with a year-long public health emergency. So that's been just a

tremendous effort on behalf of the eligible team and the IT folks who work with them.

Under goal three, we said we were going to focus on integrity and real outcomes. The true-true. Carol talked to you about how we worked through 2020 with leadership at United to manage that performance improvement plan and make sure that they would be ready to receive new membership by the end of the year. And they were. And that was a strong partnership between Medicaid staff, CMS, and the leadership at United HealthCare Community Plan.

As Bev pointed out, the MCO network adequacy contract changes really were meant to show us the true-true about MCO networks. We have heard over time that people feel sometimes the information in the network files is not current or not complete, and we thought one way to get at that -- one way. It's not every way, but one way to get at that is to look for providers who have recently submitted claims, because a claim is evidence that the provider is serving the members. So we made that contract change. And just as Bev said, we're excited to see what it shows us. And then as Carol described, we enacted liquidated damages in the MCO contract for caseload noncompliance and those went into effect January of this year. So we

felt that we made a lot of progress around managed care.

Accountability and likewise we made progress with our county partners.

There, I would just point out to that there has never been a time when all of the counties were on a common Memorandum of Understanding that established the relationship between State of New Jersey and those counties. And this MOU that we've had them sign is consistent with the requirements of Senate Bill 499, which said you need to have incentives and penalties in place so that your system runs well. And in a world where Amazon knows where our package is every minute, I should at least have a sense of what's going on with Medicaid eligibility. And we thought that all made sense. We worked hard with the counties. I remember this very well in the spring because they were getting hit as hard by the pandemic as anyone. Their workers are very much frontline workers. They were doing the same things we were doing to try to move as many people remote as possible. And in that context, we agreed on the common MOU that I'm describing to you now that gave us the performance standards that we would work together on. We have established inventory reports with the counties which we go over on a weekly basis,

and our application processing time has significantly improved, all in the context of a public health emergency that's gone on for a year.

The details of program integrity do not always get people excited. And I do recognize that we're running a little bit late. So this is here as a credit to the folks who do this research behind the scenes who make sure that we are square with the federal government with respect to our compliance who calculate performance metrics that are required by the federal government and also really important for us to know the health of our program.

And in response to the public health emergency, we had to think about goal three a little bit differently because we now had to also make sure that we were submitting the emergency waivers that we needed to have in place to do what we needed to do for folks in our community during this public health emergency. And we needed to get those waivers in place while we were taking the action that was reflected in those waivers. So we had a CMS strike team that was working very hard throughout this cooperating with all different parts of our Division to make sure that the action we were taking was fully documented and authorized by the federal government.

We put risk corridors in place with our Managed Care Organizations. We took this step. To our knowledge, we were the first state to take the action that CMS had approved that allowed us to address the actuarial impact of the public health emergency, and our Managed Care Organizations worked with us to implement that. That was a significant effort on behalf of our fiscal team.

And we have been working with sister agencies. As many of you know, there has already been some analysis of the circumstances that unfolded during the initial days of the pandemic when everything was uncertain and PPE wasn't available and no one knew exactly what was going on with this thing. It's always a good time to ask how can we do this better. And so some of that information is available to us through various reports that have come out nationally and specific to New Jersey. And we've been working with sister agencies to go through those reports and understand the improvements we can make and, frankly, to address the new legislative mandates that are in place.

And then finally, goal four was our culture goal. We really wanted to be sure that we were demonstrated compassionate service, that we were

developing new leaders across our organization -- and there is nothing like a crisis to make that happen -- and that we were managing change effectively. And so when we set our 2020 goals, which were all of the slides that I've described to you and then a whole lot more, we did that in January with broad participation across our organization, getting input from everyone we could including -- this is sort of unthinkable now and we'll have to find a new way to do it this year -- but including we put all the managers in a room together. The room was wallpapered with easel sheets. We talked about our priorities, what we were hearing from our community. And then -- here's the best part -- we walked the entire Division down the hallway of easel sheets so everyone could process what we had discussed, what we would be focused on in 2020, and what their own role in that would be. People signed the sheet where they thought they saw a role for themselves or for their team. And that was a really cool exercise we won't be able to do remotely, but we're going to do the best we can to make sure that we have that kind of collective goal-setting in 2021.

We also maintained a cadence of connectiveness throughout the year; frankly, that began in March when it became essential. But it had been in

our plan to make sure that our units were talking to each other to make sure that we were able to hit those other three goals really effectively.

As Greg referenced earlier, and Carol may have as well, we set north star principles for some of our key projects, including the MMIS project I described to you, the EVV role-out, and frankly, our management of the public health emergency. We said these are the principles that we will use in the decisionmaking we will need to do for this going forward, and we stuck to those principles. We came back to them so many times, they were memorized. And then as I said, when you are thinking about leadership development, you may turn to resources, in our case, the Center For Health Care Strategies has been a phenomenal partner in helping each of us to develop as leaders. And then you end up with a crisis that new leaders emerge. And so we had just an incredible amount of leadership coming out of our entire team, people taking responsibility for things they had never had responsibility for before or things that had never existed before as responsibilities of ours; building bridges, engaging with new solutions, and just figuring out how we would get the work done for our community under the circumstances of the public health

emergency.

So, Dr. Spitalnik, I recognize we're out of time, but I did not want to shortchange the look-back on this very unusual year because I feel that we have successes to report. We certainly have work that is ongoing, but I could not possibly be more proud of my team. And I wanted to take the opportunity to share some of the detail with you.

DR. SPITALNIK: Well, of course. And I beg the indulgence of both the MAAC and our colleagues that we'll take another five minutes. And we could not end of year without reexperiencing the depth and breadth of both the level of activity, but the organization and grounding in values and the incredible intersection of head and heart that everyone has brought to this, and to recognize your leadership, Jen, and everyone in the Division and in the Department.

Theresa, you had a quick comment to make. And then hearing no others, I will then quickly develop with you our agenda for our next meeting.

Theresa.

MS. EDELSTEIN: Thanks, Deb.

Jen, that was really a terrific walkthrough all that you have managed to achieve with dignity throughout this year.

I do want to, though, remind you that you have other partners. Your PACE organizations are critical partners in keeping frail and disabled adults safe in the community. They have garnered national attention during this pandemic for their ability to turn on a dime and make their programs without walls and serve every single one of their participants in the community every single day with nursing services, meal services, recreation services, mental health services, transportation services, anything they could possibly need. And they have done that miraculously without a significant increase in hospitalizations or ERUs, without a significant increase in death, without a significant increase in institutionalization of their participants at a time that was almost virtually impossible, and they have also not had a high degree of infection among their participants or among their staff.

So I think it's very important to elevate PACE to the same pedestal that the MCOs are on. They're all working hard. They're all partners and collaborators in this endeavor. And they all serve a very difficult population. So I would appreciate future inclusion of them in the accomplishments of the Division and the Department as a whole. Thanks.

DR. SPITALNIK: Thank you.

In summary, the presentation from today is posted on the Department of Human Services DMAHS web portion of the website.

For our agenda next time, I have the following items: Look at participation and access to vaccines from the perspective of the autism spectrum, the sort of benefits, the issues of the adequacy or the difficulty in finding providers.

Greg Woods raised the issue of stakeholder input into the Comprehensive Medicaid waiver renewal development. Thank you for the preliminary view on enrollment and are looking forward to continued depth into what that represents.

The ABD provider portal. There was interest in the outcome of the pilot.

Relevant to the contract changes, there was an interest into the impact of the case management caseloads and more attention to that.

Are there other things in addition to, of course, the ongoing informational updates that are provided?

MS. ROBERTS: Deborah, it would be helpful, because Jen talked a little bit about CHOP and how they're monitoring the children that are not able to go

to CHOP anymore. So an ongoing update on what's happening with children would really be appreciated. As well as if there is additional information on the contract change that would allow folks that are DDD eligible and then they go into a rehab setting, what happens with the six-month period when it expires but yet they don't need to be long-term but there's no placement at that point in the community.

DR. SPITALNIK: Okay. So we'll capture that issue.

Other things.

So I think, as always, we anticipate a packed agenda. Let me remind us that our next meeting is April 22nd. But for the course of the year, our meetings get set in accordance with the requirements for publication, so our next meeting is Thursday, April 22nd; subsequently, Thursday, July 22nd; Thursday, October 21st. And we are working to resolve any potential conflict with DDD's informational webinar which will not even an issue until October. And I have the vain hope that we will send out driving directions and we will be meeting in person.

I want to close on behalf of all of us, again, to thank Commissioner Adelman.

MR. VIVIAN: Deborah, can you hear me.

DR. SPITALNIK: Yes, Wayne. Please go ahead.

MR. VIVIAN: I couldn't unmute my phone. I meant to have an agenda item maybe for next meeting.

DR. SPITALNIK: Yes, please.

MR. VIVIAN: Okay. I was wondering with regarding CSS, when will the Medicaid begin authorizing the prior authorizations? Do they have an idea when they'll be reviewing individual rehabilitation plans to give authorization numbers, when that may restart again?

DR. SPITALNIK: Okay. Thank you. Jen, did you want to speak to that, or should we note it for next time?

MS. JACOBS: I was just going to ask Wayne to repeat the question.

MR. VIVIAN: Okay. With CSS, with Community Support Services for housing for people with mental illness and so on, right now the Medicaid is not reviewing the IRPs for authorization. They're reviewing them just to make sure like the address is correct and everything, but they're not doing an actual review of the content of the interventions and the goals and the objectives and all that. Does the Commissioner have any idea when that may start again,

when they may start authorization again, when they may restart reviewing the IRPs, the Individual Rehabilitation Plans?

MS. JACOBS: Thanks, Wayne. We will definitely look into that. I don't know if that is about our field nursing being out in the field or something else going on.

MR. VIVIAN: No, that's what they call the IME. I forgot what it stands for. They review the IRPs for approval so that you can bill Medicaid for them. I mean, right now you have approvals, but they're not reviewing them. They're just giving you approval as long as basic information is correct.

MS. JACOBS: Thanks for that, Wayne. We will do the homework there.

MR. VIVIAN: Okay, thank you.

DR. SPITALNIK: Having gone through the planning, I'll ask us to advance two slides towards thanks. Again, thank you. And our heart and admiration to Jen, for your leadership and everyone's leadership in whatever role they've been playing in this incredibly difficult time.

I close with great hopes for the availability of vaccine. I think that's a shared national prayer right now. And we also want to close

with condolences for all those who have suffered losses. Our best wishes for people who are suffering in myriad ways. And we look forward to a brighter spring.

Thank you all, and thank you again to Phyllis Melendez and Jen Jacobs and Carol for all the work not only that you're doing, but for continuing to raise up the stakeholder process and all the preparation to bring us today.

Thanks, everyone. Be well. Wear your masks. And we look forward to seeing you in April. Take good care. Thank you for being with us.

(Meeting adjourned at 12:17 p.m.)

CERTIFICATION

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

_____

Lisa C. Bradley, CCR

The Scribe