NEW JERSEY HUMAN SERVICES

Meeting of the Medical Assistance Advisory Council

October 23, 2024

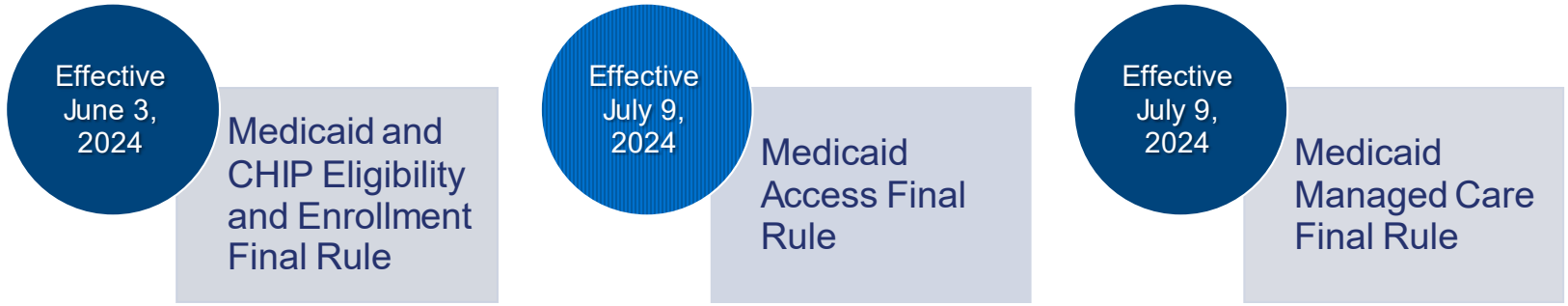
Agenda

- Welcome and Call to Order – Dr. Deborah Spitalnik
- CMS Medicaid Access Rule: Medicaid Advisory Committee and Beneficiary Advisory Council Discussion – Gregory Woods
- NJ School-Based Health Services: Special Education Medicaid Initiative (SEMI) Update – Jeffrey Wilkes
- Coverage for Justice-Involved Children (CAA 2023 5121) – Natalie Kotkin
- NJ FamilyCare Eligibility and Enrollment – Gregory Woods and Lynda Grajeda
- Behavioral Health Integration Status Update – Shanique McGowan
- 1115 Demonstration Highlight: Housing Supports – Jonathan Tew
- Planning for the Next Meeting – Dr. Deborah Spitalnik

CMS Medicaid Access Rule: Medicaid Advisory Committee and Beneficiary Advisory Council Discussion

Recap: Recent CMS Rulemaking

- The federal Centers for Medicare and Medicaid Services (CMS) **finalized several Medicaid rules earlier this year**, which have now gone into effect:



- While effective dates for each rule are in 2024, specific *provisions* within each rule have varying applicability dates.
- Today, we will discuss the **Medicaid Advisory Committee (MAC)** and **Beneficiary Advisory Council (BAC)** provisions of the **Access Final Rule** in more detail. With one exception, these provisions go into effect in **July 2025**.

Medicaid Advisory Committee (MAC)

Requirement	DMAHS compliance status today	Additional efforts required
Increase areas on which MAC must advise*	In practice, no limitations to areas on which MAAC advises	Update processes to ensure MAAC has opportunity to advises on all topics named in the Final Rule
Post governing bylaws	MAAC does not have written bylaws	Establish and publish MAAC bylaws
Post meeting minutes and membership list	(Outdated) membership list appears on Governor's Office of Appointments website; meeting recordings posted on DMAHS website	Post full, up-to-date membership list and restart posting written minutes

*Note: Previous federal regulations required advising only on health and medical care services. The Access Final Rule expands the scope of topics on which MACs advise to include at least: changes to services; care coordination; service quality; eligibility, enrollment and renewal processes; beneficiary and provider communications; cultural competency, language access, health equity and disparities, and biases in the Medicaid program; and other issues that impact the provision or outcome of services.

Medicaid Advisory Committee (MAC)

Requirement	DMAHS compliance status today	Additional efforts required
Meet quarterly, with at least two meetings open to the public and incorporating public comment	MAAC meets quarterly, and all meetings are open to the public	Establish a public comment period at two or more meetings each year
Require certain stakeholders to be included in MAC membership, including BAC members	MAAC members fulfill certain required stakeholder groups (see detail on next slides)	Add membership from MCO(s) and other state agencies (see detail on next slides); add members from BAC after established
Ban consecutive membership terms	MAAC members do not currently have term periods, or they have ended	Create staggered transition plans for existing MAAC members

Current MAAC Membership

Name of Member	Organization Represented
Christine Buteas	Healthcare Institute of New Jersey
Mary Coogan	Advocates for Children of New Jersey
Theresa Edelstein	New Jersey Hospital Association
Dr. Nicole McGrath-Barnes	KinderSmile Community Oral Health Center Trenton and KinderSmile Foundation, Inc.
Dr. Deborah Spitalnik	Formerly of the Elizabeth M. Boggs Center on Developmental Disabilities at the Robert Wood Johnson (RWJ) Medical School
Wayne Vivian	National Alliance on Mental Illness Hudson County and Coalition of Mental Health Consumer Organizations of New Jersey

Federal MAC Requirements

The Medicaid Advisory Committee (MAC) must include membership from all of the following groups:

- State or local consumer advocacy groups or CBOs that represent or provide services to Medicaid members
- Clinical providers or administrators
- Participating MCO(s) or health plan association
- Other state agencies serving Medicaid members (but serve as nonvoting, ex-officio members)
- Beneficiary Advisory Council (BAC) members*

Groups in dark blue are currently represented on the MAAC.

*Note: Proportion of MAC membership composed of BAC members must include at least 10% of MAC membership from July 2025 through June 2026, 20% from July 2026 through June 2027, and then 25% thereafter.

Beneficiary Advisory Council (BAC)

Requirement	Projected DMAHS compliance effort
Establish BAC meeting membership requirements	Recruit BAC members; must include individuals who are or have been Medicaid members and individuals with direct experience supporting Medicaid members
Establish areas for BAC guidance	Establish BAC topic areas to match MAAC requirements
Post meeting minutes and membership list	Establish process to post membership list (individual BAC members can opt-out) and minutes
Post governing bylaws	Establish and publish BAC bylaws
Meet quarterly, in advance of MAC meetings	Establish meeting cadence
Ban consecutive membership terms	Establish membership terms and turnover procedures

Note: DMAHS is investigating reimbursement options for BAC member participation in the BAC and MAC.

Discussion Questions

- Do you have recommendations for the drafting of MAAC bylaws?
- Should we consider hybrid (in-person and virtual) MAAC meetings when there is public comment?
- Do you have recommendations for specific communities or perspectives that should be represented as members are added to the MAAC?
- Do you have recommendations for specific communities or perspectives that should be represented on the BAC?
- How can DMAHS most effectively and equitably recruit BAC members?

Note: All MAAC members and members of the public can provide feedback by email at dmahs.maac@dhs.nj.gov

Next Steps for MAC and BAC Compliance

- Conduct detailed planning to **establish all MAC and BAC provisions**
- Provide **update on compliance efforts** at each upcoming MAAC meeting
  - The goal is to introduce new MAAC members at the January 2025 meeting and vote on bylaws at the April 2025 meeting.
- Comply with all MAC and BAC applicability dates:
  - Effective date for most provisions is **July 2025**.
  - There is a **multi-year phase-in for the proportion of MAAC members that must be BAC members**, beginning in July 2025 and culminating in July 2027.
  - In addition, states must publish an **annual report** for the MAC and BAC. The first report must be completed by **July 2026**.

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Medicaid School–Based Health Services

An Update on the Special Education Medicaid Initiative (SEMI)

Medicaid School–Based Health Services

- Medicaid school-based health services (SBHS) are healthcare services provided to Medicaid-enrolled children in school settings or similar outpatient settings through school-based providers.
- Schools can receive reimbursement to cover the costs of delivering covered Medicaid services provided by Medicaid-enrolled providers to children.
- The costs of certain administrative activities are also eligible for reimbursement.

Overview of the SEMI Program

- Established in 1996, the federal and state Special Education Medicaid Initiative (SEMI) provides direct rehabilitative school-based healthcare services to New Jersey's students with disabilities.
- Medicaid-eligible special education students with Individual Education Plans (IEPs) are enrolled in participating SEMI school districts. An estimated 90,000 students receive these services across New Jersey.
    - Individualized Education Plans determine students' special education instruction, supports, and related health services that children need in school.

Participation in the SEMI Program

- **NJ School Districts**: 408 of 697 (59%)
  - 2024-2025 Academic year was the highest participation in program history.
- **Individual School Participation**: 2,081 of 2,508 (83%) of NJ public schools
- **Approved Private Schools for Students with Disabilities**: 138 schools
  - Approved Private Schools for Students with Disabilities (APSSDs) serve over 10,000 New Jersey students with complex disabilities.
  - APSSDs are an important resource for local public schools, who are responsible under state and federal law for delivering appropriate and individualized special education services to all students who are eligible.

Multi-Agency Cooperation

- SEMI is supported by state and federal funding.
- Since 2012, the SEMI program has received $2.8 billion in reimbursements.
- SEMI program is jointly operated by:
  - ✓NJ Department of Human Services – Division of Medical Assistance and Health Services
  - ✓NJ Department of Education
  - ✓NJ Department of the Treasury

Expanding School-Based Health Services

Adding Medicaid-Enrolled General Education Students

- Bill A3334 (Enacted July 2023): Requires Medicaid to reimburse for behavioral health services provided within public school districts (pending federal approval)
- Enhanced funding for school districts through expanded federal funding to support special and general education Medicaid-enrolled students:
  - Behavioral Health Services – July 1, 2026
  - Primary Care Services – TBD
- 50% of NJ public school population is enrolled in CHIP or Medicaid.

Next Steps

- Improve Program Compliance
  - Multiple audits and disallowances in past years; proactively working with CMS to mitigate potential losses to school districts and the state
- Behavioral Health Services Implementation
  - Planned effective date: July 1, 2026
  - Expand Medicaid reimbursement to cover general education students
  - Ensure program operations mirror existing SEMI program
  - No changes to existing BH services or practitioners
  - Develop training materials for schools, families, and the community
- Upcoming Work
  - Review and plan to expand SEMI to cover primary care services for Medicaid-eligible students in school-based settings
  - Continue to explore gaps in school-based behavioral health services

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Coverage for Justice-Involved Youth

Provisions from the Consolidated Appropriations Act of 2023 (CAA)

Introduction: CAA 2023 Requirements

- The federal Consolidated Appropriations Act (CAA) of 2023 requires states to **provide a limited set of Medicaid and CHIP services to incarcerated youth**, beginning on **January 1, 2025**.
- What is changing? Section 5121 establishes new Medicaid and CHIP requirements:
  - Services: **Health screenings, referrals, and case management** services for 30 days prior to reentry, and care management to support transition for 30 days after reentry
  - Eligibility: States **may not terminate eligibility for CHIP enrollees** who are inmates of a public institution and **must process any application submitted on behalf of the individual and make an eligibility determination**. These requirements mirror those established for Medicaid members established in the 2018 SUPPORT Act.
- Who is impacted?
  - Eligible youth are those **under the age of 21 (or under 26 with a history of foster care)** who were **eligible for or enrolled in NJ FamilyCare** prior to incarceration

Details: Pre/Post-Reentry Service Requirements

Screening and Diagnostic Services

- **Medical, dental, and behavioral health screenings or diagnostic services** indicated as medically necessary under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements
- Screenings and diagnostic services **must occur during the period that is 30 days prior to the eligible juvenile's reentry** (or no later than one week, or as soon as practicable, after reentry)

Case Management

- **Targeted Case Management (TCM)** must be provided during the **30 days prior to, and for at least 30 days after, reentry**
- **Must include referrals** to appropriate care and services available **within the geographic region of the eligible juvenile's home** or residence (where possible)

Overview: Juvenile Corrections in New Jersey

Context: New Jersey is a national leader in reducing the number of youth in secure detention facilities. As a result of the Juvenile Detention Alternatives Initiative (JDAI), the average daily population at juvenile detention centers has decreased almost 75% compared to pre-implementation.

State Entity		Eligible Populations (all youth must be post adjudication)	Number of Youth <21 years old
Juvenile Justice Commission (JJC) – 2 secure care facilities		• Individuals less than 21 years old • Individuals 21-26 years old with previous foster care experience	~324 in 2022
Department of Corrections (DOC)	19 County Jails	• Individuals 18-21 years old • Individuals 21-26 years old with previous foster care experience	~14 in 2023
	9 State Prisons	• Individuals 18-21 years old • Individuals 21-26 years old with previous foster care experience	~123 in 2023

Source: NJ Office of the Attorney General, Juvenile Demographics and Statistics (data as of 1/6/23); NJ Department of Corrections, Population Characteristics Report (data as of 1/3/23)

DMAHS Planning for Pre/Post-Reentry Services

- The majority of eligible young people reside in facilities operated by the Juvenile Justice Commission (JJC), so DMAHS has been focused on implementation of pre- and post-reentry services there.
- DMAHS has also started working with the Department of Corrections to coordinate services in state prisons. Future plans include additional coordination with state prisons and county jails.

Core areas of engagement:

- Eligible juveniles
- Medicaid / CHIP eligibility and enrollment/suspension
- Services – screening and diagnostic (pre-release)
- Services – case management (pre- and post-release)
- Billing

DMAHS Planning for Pre/Post-Reentry Services

Future opportunities:

- CMS did not approve DMAHS's request in 2022 to cover a broader pre-release services package as part of the most recent 1115 Demonstration extension. The State and CMS continue to work together to explore this opportunity.
- DMAHS will continue to consider the option available via CAA Section 5122 to provide Medicaid and CHIP coverage for youth who are pre-adjudication.

Next Steps for Pre/Post-Reentry Services

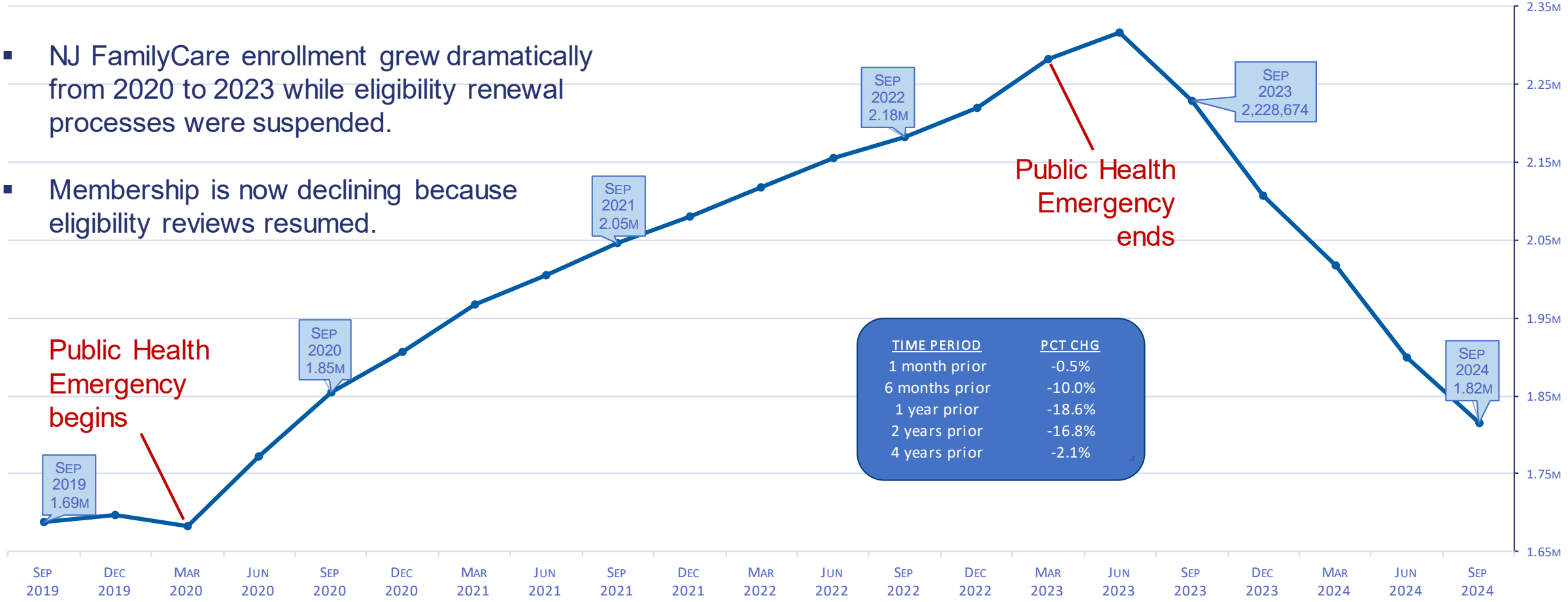
Context: DMAHS must have an internal operational plan for required services by 1/1/25 and submit required State Plan Amendments by 3/31/2025. CMS has established a fully ready / partially ready / not ready framework for reviewing states' plans to acknowledge that states will require a longer timeframe to comply with all requirements.

Area of Work	Upcoming Milestone(s)
Eligible juveniles	Initiate / continue discussions with state prisons and county jails around eligibility and services
Medicaid / CHIP eligibility	Map and update existing Medicaid and CHIP enrollment / suspension / termination practices in state prisons and county jails
Services – screening and diagnostic	Document required screening and diagnostic services already provided in state prisons and county jails
Services – case management	Document case management services provided pre- and post-reentry by state prisons and county jails
Billing	Determine most efficient billing / claiming mechanism for services already provided by JJC facilities

Eligibility and Enrollment

NJ FamilyCare Enrollment

- NJ FamilyCare enrollment grew dramatically from 2020 to 2023 while eligibility renewal processes were suspended.
- Membership is now declining because eligibility reviews resumed.



TIME PERIOD	PCT CHG
1 month prior	-0.5%
6 months prior	-10.0%
1 year prior	-18.6%
2 years prior	-16.8%
4 years prior	-2.1%

Post Unwinding MCO Outreach

To maintain effective and coordinated outreach to members, DMAHS preserved most elements of the current MCO member outreach strategy while making some modifications to improve effectiveness.

The current monthly "color file" structure will continue to be used to share lists of members for MCO outreach.

Initial Outreach File (Green File)

- Includes full cohort of members initializing renewal process except those successfully renewed Ex-parte
- Sent to MCOs 70 days prior to member being at risk of termination
- Text and email outreach required; postcards required in the absence of valid email and phone number

Outreach File for Members at Risk of Disenrollment (Red File)

- Includes members who have not responded to renewal package and are at risk for disenrollment
- Sent 35 days prior to member being at risk of termination
- Three live attempts to high-risk members are required
- Non-high-risk members are required to be outreached but "robo" calls are permissible

Outreach File for Disenrolled Members (Purple File)

- Includes members that have been disenrolled on the last day of the prior month due to non-response or ineligibility
- Sent to MCOs w/in 5 days post disenrollment
- Post termination letters to all Purple File members are required to be sent within 10 business days of receipt of file
- Phone outreach to all ABD members on Purple File is required

CMS Guidance and Flexibilities

The Centers for Medicare & Medicaid Services (CMS), Center for Medicaid & CHIP Services (CMCS) recently outlined additional flexibilities that State Medicaid Agencies (SMAs) may use to complete unwinding-related Medicaid and CHIP renewals.

These flexibilities are discussed in an August 29, 2024 CMCS Informational Bulletin (CIB) entitled "Guidelines for Achieving Compliance with Medicaid and CHIP Eligibility Renewal Timeliness Requirements Following the Medicaid and CHIP Unwinding Period."

Key Takeaways:

- States must complete all unwinding-related renewals by no later than December 31, 2025.
- Subject to certain conditions, states can redistribute timelines for renewals in 2025 to smooth workload.
- States may not terminate a member for ineligibility based on renewal application more than 6 months old.

CMS Guidance and Flexibilities, cont.

Conditions for Redistributing Renewals:

- Cannot shorten an eligibility period to < 12 months
- Cannot disenroll an individual for a change in circumstance without completing a full renewal
- Must continue to seek to have up-to-date contact information for all members

Special considerations for renewals pending > 6 months:

- Option 1: Initiate a new renewal for remainder of current eligibility period
- **Option 2: Defer pending renewals into the next cycle**

CMS Guidance and Flexibilities, cont.

New Jersey intends to exercise Option 2 from the CIB – i.e., re-initiate pending renewals twelve months after the previous renewal was initiated.

Strategy for unprocessed renewals received prior to termination date:

- Returned renewals that are five months or older will no longer be processed.
- Member eligibility will continue until next scheduled renewal date (e.g., May 2025 for an individual with an original 12-month eligibility period ending May 2024).
- Letters will be sent to members notifying them that their renewal packets were received and that their coverage is extended.

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1115 Comprehensive Medicaid Waiver Demonstration Highlight: Behavioral Health Integration

Behavioral Health Integration Overview

Context

- While physical health is managed by MCOs, many behavioral health (BH) services are still managed through FFS
- BH includes mental health (MH) services and substance use disorder (SUD) services
- To prioritize whole-person care where all healthcare services across the care continuum are managed under the same entity, NJ is embarking on BH integration by shifting BH services from FFS to managed care

Goals of BH Integration

- **Increase access** to services with a focus on member-centered care
- Integrate behavioral and physical health for **whole-person care**, with potential to improve healthcare outcomes
- Provide appropriate services for members in the **right setting, at the right time**

Behavioral Health Integration

- In anticipation of **integration** of some behavioral health services into the **managed care benefit** for all populations in January 2025, DMAHS has significantly strengthened behavioral health requirements for MCOs.

- **Policy Priorities**:
  - Ensure access to a **robust provider network**
  - Ensure **continuity of care** for members actively involved in treatment
  - Improve **provider experience**
  - Enable **streamlined, integrated care delivery**

How BH Integration Will Work: Phase 1

We will utilize a phased approach. In each phase, we plan to review and discuss the potential integration of certain services into MCO contracts.

Phase 1 – Outpatient BH
Some MCO integration exists today for mental health (MH) and substance use disorder (SUD) services

Discussions began *Fall 2023* for implementation in *January 2025*

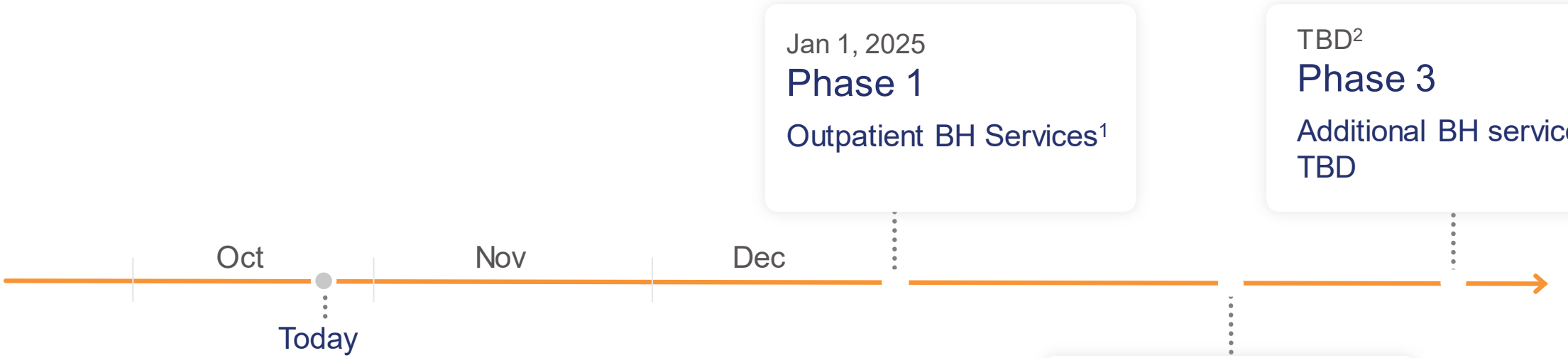
- MH and SUD Independent Clinicians – includes Psychiatrists, Psychologists, Advanced Practice Nurses, and Licensed Clinical Social Workers
- MH Partial Hospitalization and MH Partial Care in an outpatient clinic
- MH outpatient hospital or clinic services
- SUD intensive outpatient
- SUD outpatient clinic services – including Ambulatory Withdrawal Management
- SUD Partial Care

Future Phases:

- Residential Services
- Opioid Treatment Programs (OTP)
- Other BH Services

Behavioral Health Integration Timeline

NJ is taking a phased approach to shifting BH services from FFS to be managed by MCOs, with Phase 1 go-live planned for January 1, 2025



Preparation for Phase 1 Implementation

- Member communication
- Provider trainings
- MCO readiness assessments and contract amendments

1. Outpatient BH services are currently covered by managed care for members enrolled in MLTSS / DDD / FIDE-SNP programs and will be integrated for general managed care population during Phase 1
2. Scope and timing of Phase 2 and 3 to be determined after Phase 1 go-live

Behavioral Health Integration Overview

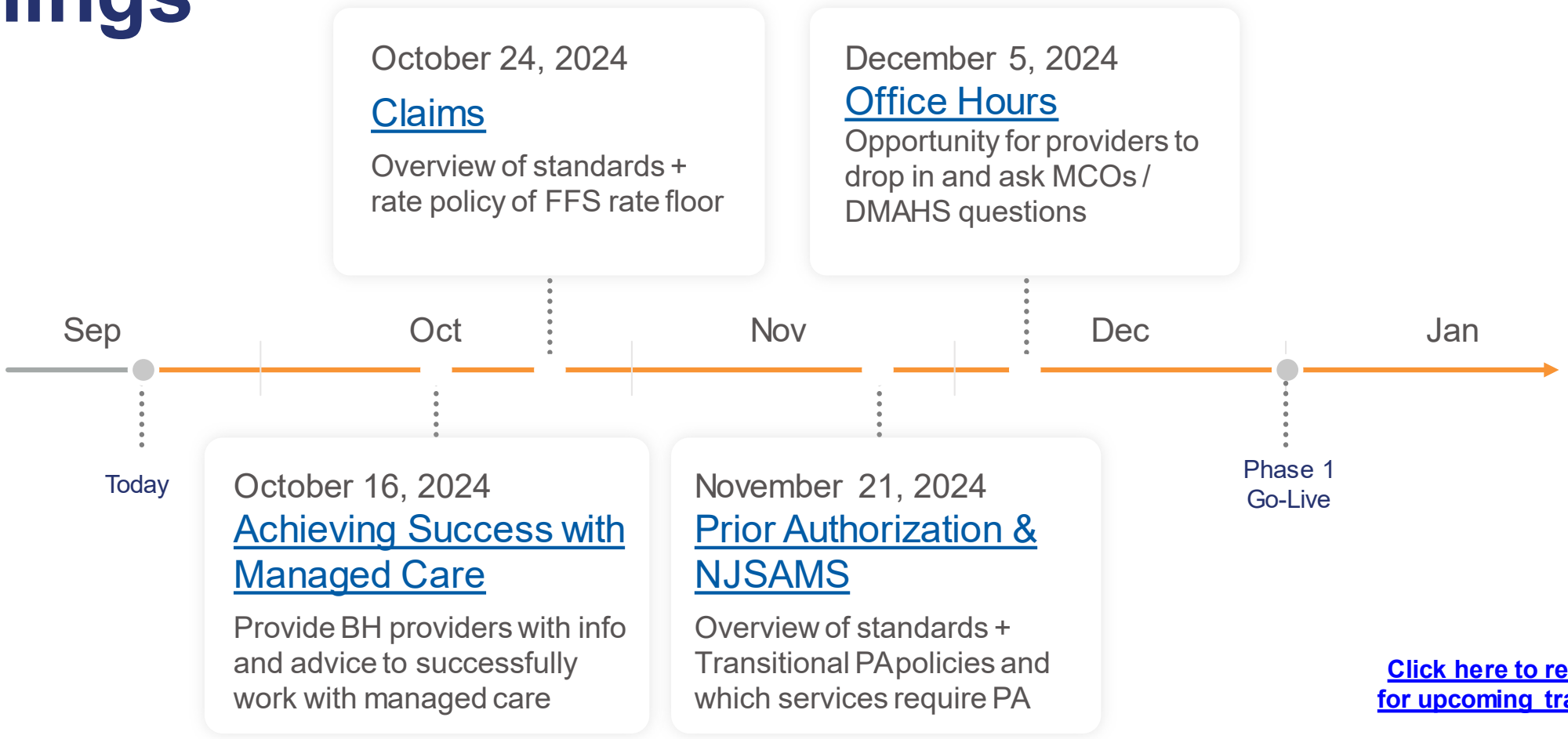
Member Engagement

- October – December 2024: Meeting with and outreach to partner organizations to identify questions about transition
- October 2024: Develop FAQs and other resources
- November – December 2024: MCO outreach to members
- December 10, 2024: Member-centered virtual meeting

MCO Readiness

- Issued detailed guidance on **care management, prior authorization** and **quality monitoring**
- Utilizing reporting tools to track MCO compliance with target deadlines
- Reviewing MCO policies, protocols, and process flows through desk audits and site visits

Behavioral Health Integration Provider Trainings



Click here to register for upcoming trainings

Many New Standards Have Been Introduced to Drive Behavioral Health Integration Goals

Program Area	New Contract Standards (non-exhaustive)
• Network adequacy, access, and continuity of care	• MCOs must accept any willing provider for first 24 months • MCOs must contract all active FFS providers • Establish time & distance standards by BH service category
• Enrollment and credentialing	• Reduce credentialing turnaround time from 90 to 60 days • Require MCOs to integrate data from third-party platform CAQH
• Prior authorization	• Auto-approve all BH authorizations for the first 90 days of integration • Establish minimum authorization durations • Reduce non-urgent turnaround times from 14 to 7 days • Require MCOs to use NJSAMS reports for SUD prior authorization
• Care management	• Adapt CM screening/assessment tools • Strengthen care management caseload and outreach requirements
• Payment	• Reduce BH claims payment times from 2 weeks to 1 week • Reduce BH claims processing turnaround times to align with MLTSS • Set FFS rates as a floor for MCO reimbursement of BH services
• Quality monitoring	• Require MCOs to submit annual BH integration quality report
• MCO staffing	• Require hiring of BH medical director, BH care management supervisor, BH quality monitoring supervisor, and BH network relations director

Quality | An Annual Quality Report will be used to Track MCO Performance on Behavioral Health Integration Goals and Identify Opportunities to Improve Program Design

Overview

Each MCO required to submit annual report and presentation

- Owned by: MCO BH Quality Supervisor
- First report due 2026

DMAHS has developed detailed guidance and data collection / report template to standardize reporting

Quantitative Components

1. Summary of key BH integration MCO operational performance reports (e.g., credentialing, prior authorization, CM, claims)
2. Member satisfaction survey results[1]
3. Provider satisfaction survey results[2]
4. Quality & outcome measures
5. Disparities in care across member satisfaction/outcomes

Qualitative Components

1. Narrative summary of performance for past year and goals for year ahead
2. MCOs' strategic plans to address performance gaps

1. MCOs will be required to use a standard, nationally-recognized CAHPS survey to measure BH member satisfaction.
2. The state will centrally administer a standardized, state-designed survey to measure BH provider satisfaction across MCOs. MCOs will be responsible for circulating the survey to in-network providers

Next Steps

DMAHS will:

- Finalize the January 2025 contract standards
- Finalize and release remaining provider guidance and resource documents
- Conduct remaining MCO site visits, provider trainings, and member-centered meetings
- Continue internal state (i.e., cross-agency) and public communications plan for launch
- Begin monitoring identified metrics post go-live
- Maintain and update relevant information and resources on the Stakeholder website
    - https://www.nj.gov/humanservices/dmhas/information/stakeholder/

Please contact the NJ FamilyCare Behavioral Health Integration Team at dmahs.behavioralhealth@dhs.nj.gov with questions.

1115 Comprehensive Medicaid Waiver Demonstration Highlight:
Housing Supports

Housing Supports Overview

Goals	• Help **find & maintain housing** for housing insecure members to **improve health outcomes** • Drive greater connection of the housing and health care ecosystems
Authority	• 1115 demonstration approved by CMS through June 2028
Geography	• Statewide
Services	• **Pre-tenancy services**: case management supports to help member find housing • **Tenancy sustaining services**: case management supports to help members maintain housing • **Residential modification and remediation**: modifications or repairs to home to ensure health & safety • **Move-in supports**: payment to support the setup of new housing or a move • Does not include payment for rent or housing production
Eligibility	• MCO enrolled • At least 1 clinical risk factor (e.g., chronic health condition, mental health condition) • At least 1 social risk factor (e.g., homeless, at risk of homelessness)
Provider qualifications	• Pre-tenancy and tenancy sustaining services: organizations with experience serving housing insecure populations; can demonstrate experience via participation in other comparable government programs • Modification and remediation services: licensed home contractors will deliver • Move-in supports: housing supports providers or MCOs can pay directly and be reimbursed for these costs
Admin model	• MCOs responsible for building network, paying claims, authorizing services, and MCO care management • Housing supports providers responsible for delivering services

Implementation Update

- **Finalizing program design**
  - Aiming to have completed drafting MCO contract language and program guidance before the end of the year
  - Aiming for go-live first half of 2025
- **Significant investment in training and capacity building**
  - Partnership with DCA to provide grants/start-up funding - "*Provider Readiness Grants*"
  - Partnership with the Regional Health Hubs (RHHs) to provide trainings and technical assistance
- **Meaningful stakeholder engagement**
  - Hosted MCO Meet & Greet in August to bring together program partners
    - Plan to provide additional opportunities for interested agencies to learn more about the program and grants over the next several months
  - Continue meeting with housing agency partners

How Providers Can Prepare for Readiness Grants

- DMAHS and DCA are partnering to distribute Provider Readiness grants to eligible housing organizations to incentivize provider readiness and cover startup costs
- Housing organizations will **complete "milestones" demonstrating** key steps towards provider readiness (e.g., apply for NPI, contract & credential with MCOs)
- To be considered, housing organizations will be asked, among other requirements, **to prove engagement with at least one MCO** through a **Letter of Intent (LOI)**

Tentative Timeline

Waiver Approval
April 2023

Provider Readiness Grants RFP Released
November 2024

Finalize MCO Contract Language
December 2024

Finalize Program Guidance
December 2024

Begin Trainings
Late 2024/ Early 2025

Services Available
First half of 2025

Planning for the Next Meeting

January 30, 2025