NEW JERSEY HUMAN SERVICES

Meeting of the Medical Assistance Advisory Council

January 15, 2026

Agenda

- Welcome and Call to Order – Dr. Deborah Spitalnik
- Comments from DHS Commissioner Sarah Adelman
- H.R. 1 Updates
  - Rural Health Transformation Program – Shin-Yi Lin
  - Eligibility Provisions – Gregory Woods and Natalie Kotkin
  - Provider Taxes – Gregory Woods
- Immigrant Eligibility Topics – Gregory Woods
- Other Eligibility and Enrollment Updates – Kristine Byrnes
- Beneficiary Advisory Council (BAC) Updates – Gregory Woods
- 1115 Comprehensive Demonstration: Upcoming Renewal – Jon Tew
- Behavioral Health Integration Update – Shanique McGowan
- NJ FamilyCare Doula Benefit Updates – Shin-Yi Lin
- Cell and Gene Therapy Program – Dr. Tom Lind
- MCO Contract Changes – Lynda Grajeda
- Planning for the Next Meeting – Dr. Deborah Spitalnik

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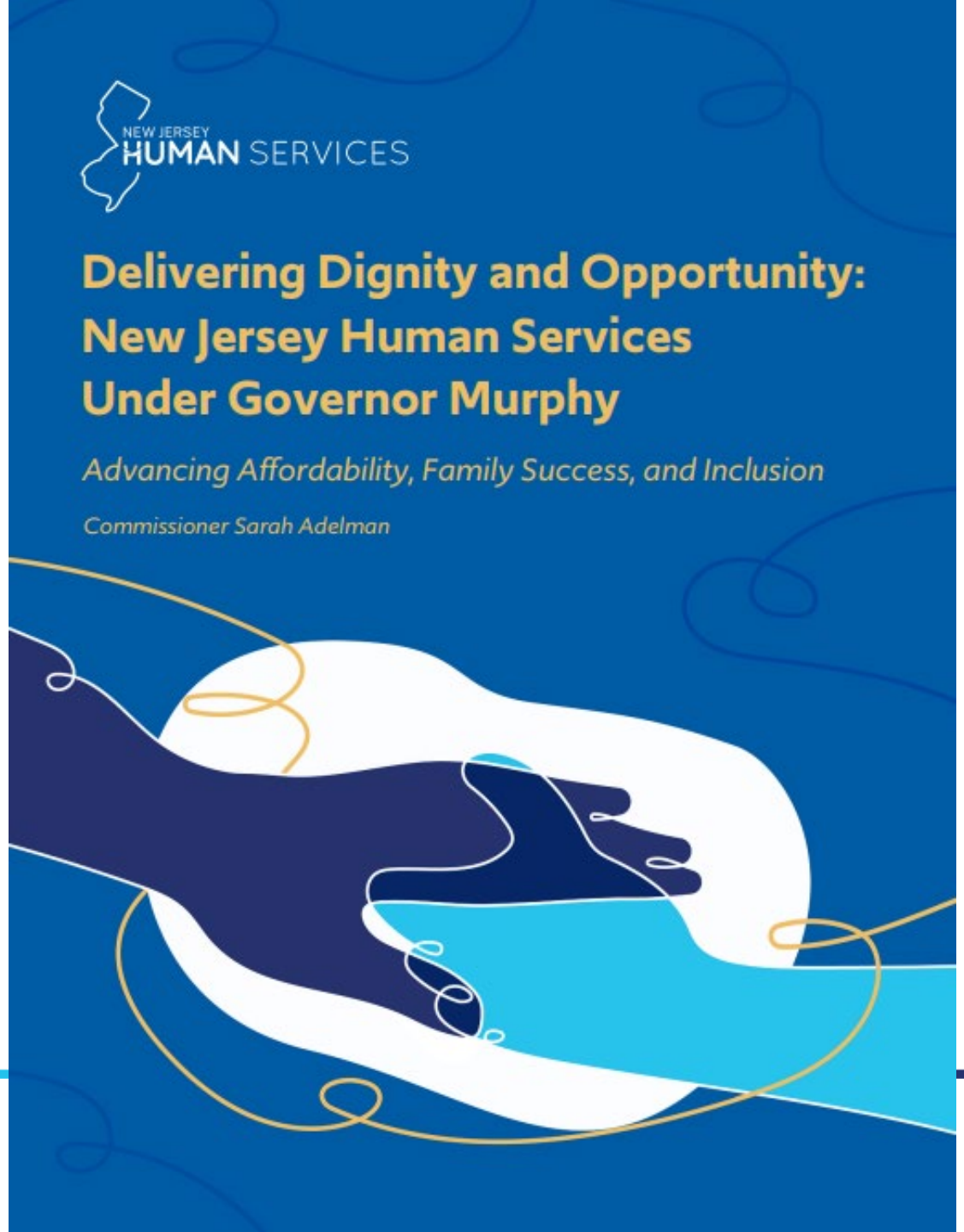
Honoring Vicki Mangiaracina

DMAHS Chief Legal Officer

1956 – 2026


NEW JERSEY
HUMAN SERVICES
Delivering Dignity and Opportunity: New Jersey Human Services Under Governor Murphy
Advancing Affordability, Family Success, and Inclusion
Commissioner Sarah Adelman

H.R. 1 Implementation

H.R. 1 – Key Implementation Updates

- Today's presentation gives status updates on New Jersey implementation of several key Medicaid provisions:
  1. **Rural Health Transformation Program**
  2. Major **eligibility changes** that are effective January 2027:
     - Mandatory "Community Engagement Requirements" (**Work Requirements**)
     - Increased **frequency of eligibility checks**
  3. Restrictions on **Provider Taxes**
- Statutory due dates are aggressive and federal policy remains **uncertain**.
  - Decisions described in today's presentation are provisional and may continue to evolve

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Rural Health Transformation Program

Rural Health Transformation (RHT) Program

- HR1 (“One Big Beautiful Bill Act”) earmarked **$50 billion** in temporary funding (from 2026-2030) to support rural health transformation.
  - Federal RHT website with additional information is here.
- All 50 states submitted RHT applications to CMS in November.
- New Jersey’s was awarded **$147M** in federal fiscal year 2026, with continued funding through 2030.
- This represents about $1,000 per federally designated rural resident of NJ, among the highest ratio in the country.
  - CMS press release
  - Publicly posted excerpt of NJ’s application

NJ RHT: Areas of Focus

Recruitment, training and retention of the healthcare workforce serving rural areas and residents

Targeting investments to transform care (e.g., for hospitals, FQHCs, CCBHCs, and other rural-serving providers)

Promoting access to bring care to where people live (e.g., telehealth, remote patient monitoring, mobile care)

Supporting preventive health interventions

Addressing chronic disease treatment

- NJ RHT targets funding to benefit
  - **1 million rural New Jerseyans** meeting federal and state definitions of rurality—including over **250,000 NJ FamilyCare members**
  - **11 rural counties** (Atlantic, Burlington, Cape May, Cumberland, Hunterdon, Mercer, Monmouth, Ocean, Salem, Sussex, Warren)

NJ RHT: Next steps

- NJ is submitting a rebalanced list of RHT-funded activities to CMS to reflect our final award amount by end of January.
  - Our application was for the maximum funding amount ($200M/year)
    - Must be readjusted for $147M/year
- To get announcements, please sign up to the NJ RHT listserv DMAHS_NJRHT@dhs.nj.gov (QR code, right)
- Contact the NJ RHT team: mahs.njrht@dhs.nj.gov

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H.R. 1

Eligibility Changes – January 2027

Eligibility Changes: January 2027

- Low-income, working age adults covered under the **Affordable Care Act Medicaid expansion** will be subject to **two new major sets of requirements** in 2027:
  1. Must renew their eligibility **every six months** (currently every twelve months)
  2. Must demonstrate compliance with **"community engagement requirements"** (often referred to as "work requirements") at enrollment and at each renewal

- **Intensive operational work** is ongoing to prepare for these new requirements.
- Topics for updates / discussion today:
  - IT system development
  - Eligibility worker readiness
  - "Ex parte" (automatic) renewals
  - Member application/renewal experience
  - Definition of "medical frailty"
- Updates represent **snapshot in time**.
  - Work will continue to evolve

Work Requirements and Increased Frequency of Eligibility Checks: **IT system updates**

Key Question: How will DMAHS **upgrade eligibility IT systems** to assess compliance with "community engagement" (work) requirements?

Existing challenges

- **Aggressive implementation dates** challenge normal state IT timelines
  - Project of this magnitude would typically take multiple years.
- **Multiple legacy IT systems**
  - Includes separate eligibility systems for County Social Service Agencies (CSSAs) and the State's Health Benefits Coordinator vendor (Conduent)

Solutions underway

1. Partner with the **New Jersey Office of Innovation** to develop a new standalone **Community Engagement Compliance Engine (CECE)**
   - Will intake information from available databases and submitted by members
   - Will output a determination of whether a member or applicant has complied
   - Back-end system: will interface with existing eligibility systems
2. **Surge developer capacity** to **existing systems**
   - Build connections to CECE
   - Create ability to collect new kinds of information from members
   - Enhance user experience

Work Requirements and Increased Frequency of Eligibility Checks: **Eligibility worker capacity**

Key Question: How will DMAHS ensure sufficient eligibility worker capacity to handle increased workload of new eligibility provisions?

Existing challenges

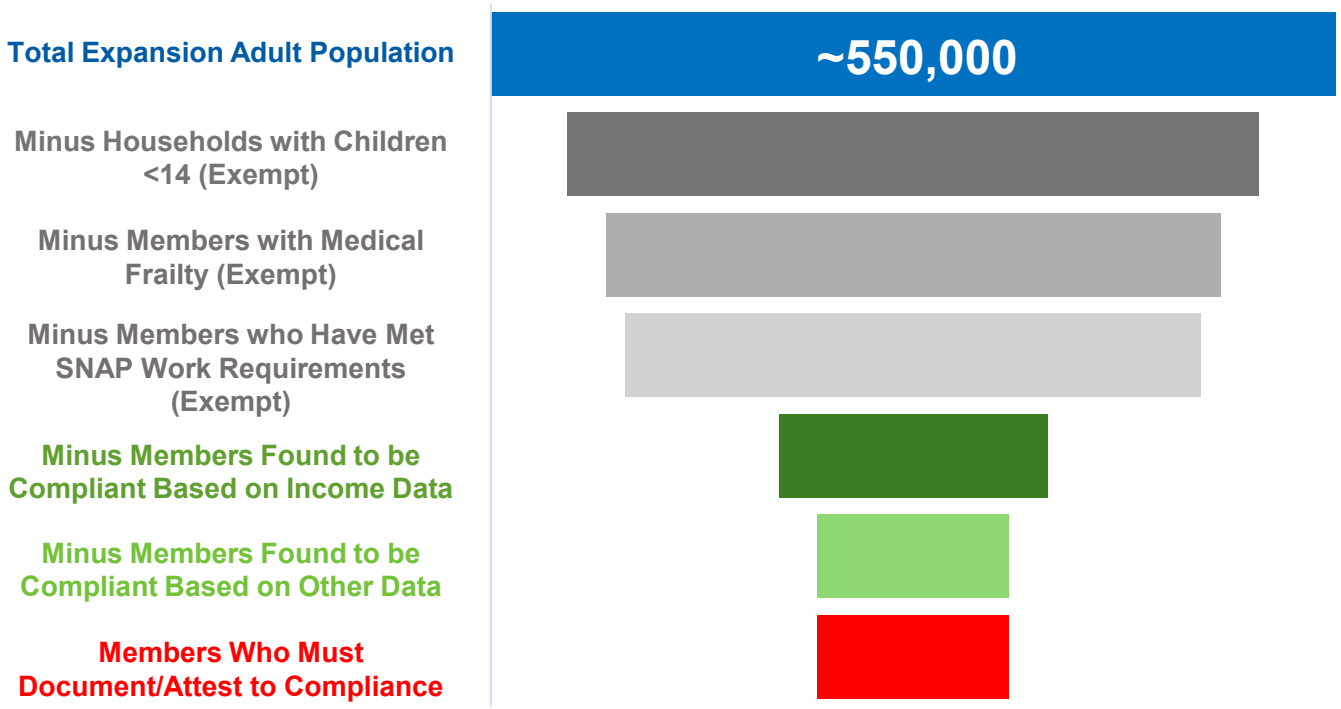
- While **significant progress** was made over the course of 2025, several counties **continue to struggle to meet statutory requirements** for timely processing of Medicaid applications.
  - Uncertain fiscal / policy climate for counties exacerbates challenge
- DMAHS vendor (Conduent) timely performance also **lagged in late 2025**, after vendor transitioned to a new IT system.

Solutions underway

1. Conduct a comprehensive **"readiness review"** of **each county** in early summer 2026
   - Will use standardized template to assess each county's readiness on various dimensions: staffing, training, systems
2. Counties that are assessed **"not ready"** and are unable to rapidly improve may have **cases transferred away**
   - First preference is to transfer to neighboring counties
3. Hold eligibility vendor (Conduent) to **strict performance standards**, with financial penalties
   - "Burn down" plan in place for existing backlog – DMAHS is closely monitoring
   - Negotiations underway on updated contract terms to reflect new statutory requirements

Reminder: Planned steps to evaluating eligibility under new work requirements

1. Begin with **total expansion population** (**blue bar** at the top)
2. Identify **exempt members** using existing data sources (three **gray bars** under the blue bar)
3. Identify **compliant members** using existing data sources (two **green bars** under the gray bars)
4. Request that **remaining members** submit documentation/attestation of exemption or compliance (**red bar** at the bottom)



Work Requirements and Increased Frequency of Eligibility Checks: **Increase Automatic ("Ex Parte") Renewals**

Key Question: How can DMAHS maximize the number of individuals whose compliance with work requirements can be verified automatically?

Existing challenges

- While DMAHS has made substantial progress in improving *ex parte* renewal rates, **work requirements will make it harder** for individuals to be renewed through this process
- In addition, there are **limited data sources for some** work requirement exemption and compliance **categories** (e.g., caregivers to disabled individuals, individuals completing >80 hrs of community service / month)

Solutions underway

1. Continue **to improve existing *ex parte* renewal rate** (currently ~45%) through both CSSAs and eligibility vendor (Conduent), including:
   - Complete verifications of eligible immigration category automatically (Conduent)
   - Adopt policies to address changes in household composition in *ex parte* process (CSSAs)
2. Use **additional data sources** to verify income as well as other compliance and exemption statuses
   - Continue to explore connections to additional national wage databases
   - Continue to explore other data connections (e.g., via educational databases, CMS consent-based income verification tool)

Work Requirements and Increased Frequency of Eligibility Checks: **Member experience**

Key Question: How can the process of proving compliance with new requirements be made as user friendly as possible?

Existing challenges

- Members and applicants have **limited ways to track applications** and interact with eligibility systems
  - For example, the online renewal process is not mobile-optimized and notices go out only through postal mail
- CSSAs and Conduent have **limited insight into each other's** eligibility systems
  - For example, members with vendor-supervised cases may face challenges receiving in-person assistance in county offices

Solutions underway

1. Improve and expand **member portal functionality**
   - Pilot mobile-friendly application and renewal functionality, including member interface and document upload
   - Note: These changes are high priority and will occur iteratively, beginning this year
2. Test ways to communicate with members by **text** and **email**
   - For example, send renewal codes to members by email in addition to by postal mail
3. Make it **easier to receive assistance through any door** for members and applicants (e.g., through Conduent call center for members whose Medicaid eligibility is supervised by a county)

Work Requirements and Increased Frequency of Eligibility Checks: **Medical frailty**

Key Question: How can the state identify individuals who are exempt from work requirements because they are "medically frail"?

Existing challenges

- Statutory language defines **five categories of medical frailty without substantial detail** on each (e.g., "a serious or complex medical condition")
  - While CMS has provided some partial / limited guidance, regulations are not expected until mid-2026
- There **may not be available data sources that can** identify certain groups or circumstances of medical frailty (e.g., member with SUD who has not recently sought treatment)

Solutions underway

1. AcademyHealth's Medicaid Medical Directors Network is working to **develop a consensus national definition** of medical frailty
   - NJ is participating in and tracking this effort closely
2. While work continues at the national level, we are drafting a potential **state definition** of medical frailty drawing on existing data sources (e.g., claims data, eligibility types)
   - **Example**: diagnosis codes, treatments, and service locations associated with cancer

Member Communications: DMAHS intends multiple rounds of member communications about forthcoming eligibility changes

Q1 2026: Jan - Mar

Early, highest-level member communications, targeted to broad audiences & ensuring members know if they're impacted

Begin engaging partners (e.g., MCOs, providers) to develop coordinated messages across mediums and stakeholders

Q2 2026: Apr - Jun

Release first round of direct member comms to those impacted by:

Changes to non-citizen eligibility

Work requirements

Increased frequency of eligibility checks

Q3 2026: Jul - Sep

Final member policy guidance / comms released for all 2026 / 2027 changes

Member forums held (continuing through Q4)

Key Eligibility Milestones

2026 → 2027

External milestones

(CMS guidance, federally mandated go-live date)

Jun 2026

CMS Interim Final Rule on work requirements released by June 1, with additional implementation guidelines for states

Sep 2026

Member outreach for work requirements must begin for states with a 1-month work requirement lookback period

Oct 2026

Certain categories of non-citizens lose coverage

Jan 2027

- Mandatory work requirements and increased frequency of eligibility checks begin
- Retroactive coverage periods shortened

DMAHS implementation milestones

(e.g., member guidance, system change)

Jan – Feb 2026

Initial broad audience communications begin (i.e., high-level, early comms)

Apr - June 2026

Begin direct messaging to impacted populations

Aug 2026

Final member policy guidance & comms released; earlier guidance in Q2 for 2026 changes (i.e., eligibility loss for some non-citizens)

Oct 2026

- DMAHS target for go-live for systems / tech & process changes necessary to implement Jan 2027 eligibility changes given renewal timelines
- Readiness reviews for counties, DMAHS, & MCOs complete

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H.R. 1

Provider Taxes

Provider Taxes

Background

Provider Taxes are targeted taxes on health care providers and health plans

These funds **are reinvested** in the healthcare system.

Payments using these funds are matched with **federal** dollars.

Current federal rules generally allow such taxes to total **up to 6%** of provider / health plan revenue

Bill Changes

Prohibits all **new provider taxes**

Gradually lowers the cap on most existing provider taxes, from 6% of plan/provider revenue in Federal Fiscal Year 2027, to **3.5%** in Federal Fiscal Year 2032 and beyond

This change **only** applies to states that have **expanded Medicaid**

CMS November 2025 – Provider Tax Guidance

- On November 14, CMS issued a letter giving additional detail on how it intends to interpret and implement H.R. 1 changes to rules around provider taxes.
  - Per legislation, a tax must have been "**enacted and imposed**" as of **July 4, 2025** to be grandfathered.
    - Taxes that do not meet this standard are prohibited.
  - CMS's letter signaled a stringent definition of "enacted and imposed" – meaning both that a tax must have been fully enacted in state law and a state must have been **"actively collecting revenue" as of July 4** to be grandfathered.
- Significant questions remain about how CMS will apply this guidance.
  - New restrictions largely go into effect October 1, 2026.

New Jersey Provider Tax Increases - Status

- New Jersey currently has **two provider tax increases** enacted as part of the SFY 2026 budget process on hold, pending CMS approval:
  - Increase in **County Option hospital program** (pre-print submitted for approval to CMS)
  - Increase in **nursing facility tax** (State Plan Amendment submitted for approval to CMS)
- To date, CMS has sent questions on both taxes but **has not granted approval**.
  - DMAHS continues to await CMS response on each tax.
  - Once decisions are received, further information on **options / next steps** will be communicated to providers and other stakeholders.
  - Effective date for new federal provisions of **October 1, 2026** adds complexity / uncertainty.

Non-Citizenship Eligibility

Federal Policy Updates: Medicaid Eligibility for Immigrants

During 2025, federal government has implemented or signaled a range of policy actions related to Medicaid eligibility and coverage for immigrants:

1. H.R. 1 (“One Big Beautiful Bill”) **eliminates eligibility** for certain documented immigrants
2. CMS policy guidance from September **restricts states’ ability** to **provide coverage for undocumented immigrants through managed care**
3. The federal Department of Health and Human Services (HHS) has begun **sharing Medicaid data with the U.S. Department of Homeland Security** for the purposes of immigration enforcement
4. CMS has sent states lengthy **lists of Medicaid members** for re-verification of qualifying immigration / citizenship status

1. H.R. 1: Eliminates eligibility for certain documented immigrants

- Effective October 1, 2026 **only** citizens, Lawful Permanent Residents (i.e. Green Card holders) who have met a five-year waiting period (or otherwise qualify), Cuban/Haitian entrants, and citizens of certain small Pacific island nations ("COFA migrants") will be eligible for Medicaid/CHIP.
- Other immigrant groups, including **refugees**, **asylees**, **trafficking victims**, certain **domestic violence victims**, and temporary **humanitarian parolees** will **no longer be eligible**.
  - Note that certain children and pregnant women in the above groups may maintain eligibility.

DMAHS next steps:

- Developing implementation plan on **how and when to re-assess members' eligibility** under new rules.
  - Awaiting further federal guidance.
- Identifying **alternative sources of coverage** (where possible) for individuals losing Medicaid eligibility.

2. CMS guidance limiting managed care coverage of undocumented immigrants

Background:

- New Jersey operates "**Cover All Kids**" program
- Offers benefit package **largely identical to Medicaid / CHIP**, for children who would be eligible but for their immigration status
- Benefits are provided through **managed care organizations** (subject to terms of general NJ FamilyCare managed care contract)
- Funded with **state appropriations only** (no federal match)
    - Exception – "emergency Medicaid" inpatient hospital services that are eligible for coverage under federal law

2. CMS guidance limiting managed care coverage of undocumented immigrants (cont.)

- In September, CMS issued guidance that (effective in 2027):
  - "Emergency Medicaid" **can no longer be covered through managed care.**
    - Must be paid directly by the State, via fee-for-service.
  - States **cannot use existing Medicaid / CHIP managed care** contracts to cover state-funded services for individuals who do not qualify for Medicaid / CHIP due to immigration status.
    - Instead states must initiate new, "separate and distinct" contracts and payment structure for these services.

DMAHS next steps:

- Consider policy options for Cover All Kids coverage prior to 2027 effective date.

3. HHS has begun sharing Medicaid data with the Department of Homeland Security

Timeline:

- **June 2025**: Media reports that Medicaid data is being shared with federal immigration enforcement authorities.
- **July 1, 2025**: More than 20 states (including New Jersey) file a lawsuit to prevent continued transfer of Medicaid data to federal immigration authorities.
- **August 12, 2025**: Federal judge issues an injunction, preventing HHS from sharing Medicaid data with the Department of Homeland Security, until HHS has completed a “reasoned decision-making process” justifying this change.
- **November 25, 2025**: CMS issues a formal notice of its intention to share Medicaid data with the Department of Homeland Security.
- **December 29, 2025**: Federal judge issues a new injunction preventing HHS from sharing some Medicaid data with the Department of Homeland Security, but allowing HHS to share biographical, immigration status, and contact information of individuals who are "not lawfully present.”

DMAHS Next Steps:

- Continue to **closely review relevant data submissions** to CMS, to ensure strict compliance with federal law.

4. CMS sends states lists of potentially immigration ineligible members

Background:

- In August, CMS began sending states **lists of Medicaid members** "whose citizenship or immigration status could not be confirmed through federal databases"
- CMS gave states the task of determining if further verification was needed and gave loose instructions on what process to follow

Status:

- Four files have thus far been sent to New Jersey
  - **>100,000 names** in total
- Overwhelming majority of New Jersey members reviewed to date have been US Citizens or Lawful Permanent Residents

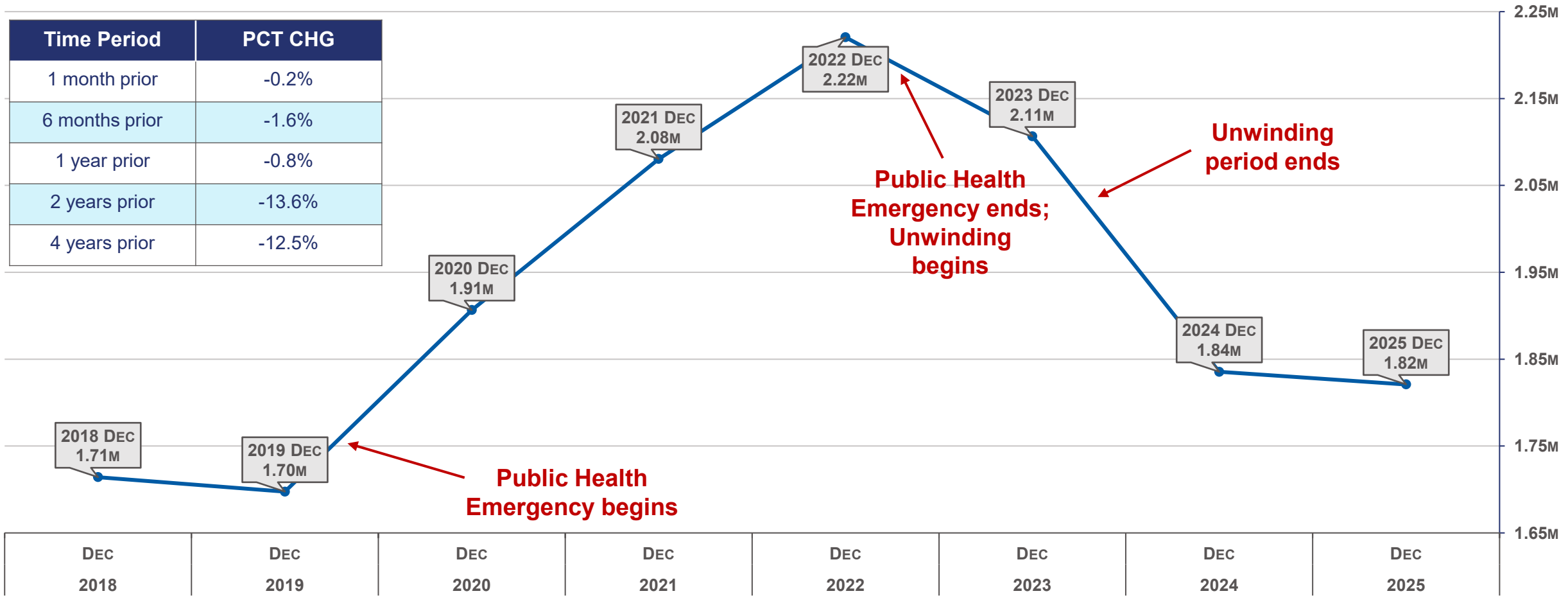
DMAHS Next Steps:

- **Continue review of files**, while refining strategies for most efficient review
- Work with eligibility determining agencies to identify ways to **more consistently capture immigration / citizenship** status, to minimize need for manual review

Eligibility and Enrollment Updates

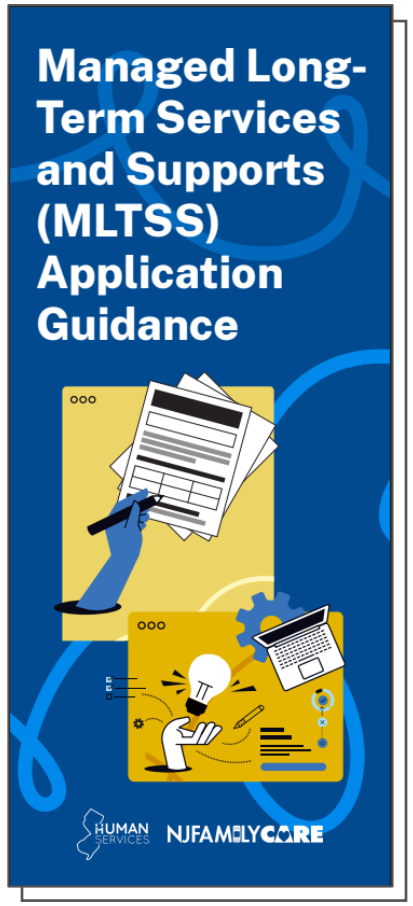
NJ FamilyCare Enrollment

Time Period	PCT CHG
1 month prior	-0.2%
6 months prior	-1.6%
1 year prior	-0.8%
2 years prior	-13.6%
4 years prior	-12.5%



New Resource Spotlight: MLTSS Application Guidance Brochure

- Managed Long Term Services and Supports ("MLTSS") program provides comprehensive care in a variety of settings, including assisted living facilities, group homes, nursing homes, PACE programs, or in the community.
  - The goal of MLTSS is to enable people who require a nursing home level of care to live in the location of their choice with the care they need.
- The criteria to qualify for MLTSS are relatively complex and have both financial and clinical elements.
- New Application Guidance brochure explains the eligibility criteria and details of the application process, including many frequently asked questions.
  - All County Social Service Agencies and Area Agencies on Aging have printed copies available for distribution.
  - Brochure is available in English and Spanish.
  - Online resource as well as a printable version (with directions for printing) can be found here.



Beneficiary Advisory Council (BAC) Updates

Beneficiary Advisory Council: Second Meeting

The BAC met for the second time on December 11th.

- Agenda topics included:
  - Approval of the September 29th meeting minutes
  - Work / community engagement requirements as mandated by H.R. 1 and going into effect in 2027
  - Building, maintaining, and improving provider networks for NJ FamilyCare members
- Next steps include:
  - Hold third meeting in March 2026
  - Finalize representatives to serve on the MAAC

NJ 1115 Waiver Implementation

1115 Demonstration: Overview

- The NJ FamilyCare 1115 Comprehensive Demonstration grants the state **federal authority** to:
  - Test **innovative strategies** to broaden Medicaid eligibility;
  - Offer **alternative benefits**;
  - Modify **payment mechanisms**;
  - **Improve care** delivery.
- The demonstration was initiated in 2012
  - Must be renewed by the federal government **every 5 years**.
- Current five-year approval period expires on **June 30, 2028**
  - New Jersey anticipates submitting a request to CMS to renew the demonstration for an additional five-year approval.
- Due to the complexity of CMS negotiations, which historically have extended past the expiration date, renewal planning must begin multiple years in advance.
  - CMS generally requests **renewal application** be submitted **a full year in advance of expiration date** (June 2027 for New Jersey)

1115 Demonstration: History

2012 - Demonstration initially approved

- Consolidated Authority for managed care delivery system
- Enhanced HCBS Services for aged and disabled populations
  - MLTSS
  - I/DD Adults (Supports)
  - SED and I/DD Children (CSOC)
  - DSRIP

2017 – 1st Renewal

- Converted Community Care Program for I/DD Adults to 1115 status
- Consolidated SED/IDD children's program into Children's Support Services Program
- Set timeline for DSRIP Phase-out

2017-2020 – Demonstration Amendments

- Introduction of SUD demonstration elements (2017)
- Authority for Home Visiting and OPG eligibility pilots (2019)
- Temporary COVID-19 Flexibilities (2020)

2023 – 2nd Renewal (current Demonstration)

- Addressed Health-Related Social Needs
- Integrated Physical and Behavioral Health
- Piloted new approaches to care such as the Community Health Worker Pilot

1115 Demonstration: Elements

The 1115 Demonstration includes authority for a wide array of programs and pilots that contribute to NJ FamilyCare. They include:

Authorization

- Managed Care Authorization
- Post-Partum Eligibility Extension
- Quality Improvement Strategy (QIS)

Programs

- Managed Long Term Services and Supports (MLTSS)
  - Nutrition Services
  - Caregiver Supports
- DDD Programs:
  - Community Care Program (CCP)
  - Supports
  - SUD/OUD Services
  - SUD HIT

Programs (cont.)

- Integration of BH into Managed Care
- BH Promoting Interoperability Program (PIP)
- Children' Support Services Program (CSSP) I/DD and SED
- Premium Support Program (PSP)
- Housing Support Services

Pilots

- NJ Home Visitation (NJHV)
- Community Health Worker (CHW)
- Medically Indicated Meals (MIM)
- Adjunct Services Autism Spectrum Disorder (ASD)

1115 Demonstration: Objectives

NJ's **key objectives** for the current demonstration period include:

- Improve care quality and efficiency through managed care
- Enhance access to community services through MTLSS and other HCBS Programs
- Implement innovative service delivery and payment models
- Address health-related social needs (HRSN) to tackle social determinants of health
- Enhance maternal healthcare quality and reduce existing disparities
- More effectively integrate physical and behavioral health services
- Ensure predictability, stability, and transparency for all involved stakeholders

We plan to revisit these objectives during the renewal stakeholder process.

Navigating a New Landscape: Our 1115 Renewal Under Shifting Federal Priorities

The current federal administration is implementing significant policy shifts that will shape Section 1115 Medicaid demonstration renewals in new ways. Key policy shifts include:

- **Health-Related Social Needs (HRSN):** Federal guidance that once previously offered a framework for leveraging waivers to address essential HRSNs like housing and nutrition has been rescinded.
  - As of yet, there is no clear replacement framework.
- **Budget Neutrality:** Revised budget neutrality policies resulting from OBBBA may restrict the degree to which states can rely on “savings” projections when submitting their demonstration applications.

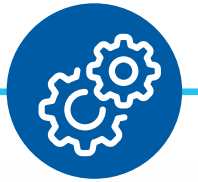
Shifting Federal Priorities: What This Means for Stakeholders

Proactive Engagement

We need your input to design effective and compliant programs.

Strategic Demonstration Design

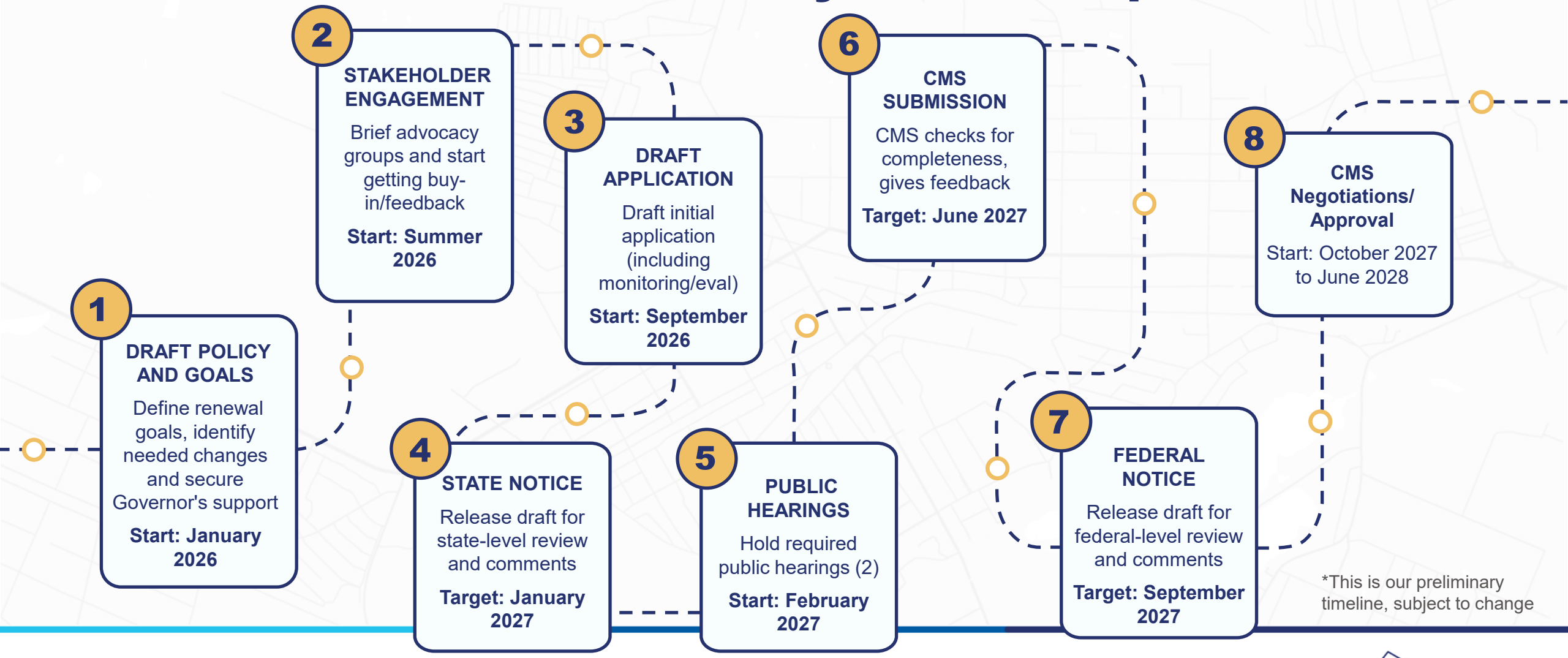
Balancing state priorities with federal expectations.



Opportunity for Innovation

Leveraging remaining flexibility within new frameworks to test innovative approaches.

1115 Renewal Preliminary Roadmap



*This is our preliminary timeline, subject to change

1115 Renewal Planning

DMAHS is proactively preparing for renewal and plans to start reaching out to stakeholders, other government agencies, and conduct several listening sessions beginning later this year.

Specific dates will be announced at a future MAAC meeting and subsequently published on our website.

In 2026, our primary objective will be to significantly enhance and prioritize our strategic approach to stakeholder engagement.

We encourage all stakeholders to provide input or suggestions regarding the renewal process and the upcoming listening sessions.

Have ideas or questions? Send them to:
DMAHS.CMWcomments@dhs.nj.gov

Behavioral Health Integration in the 1115

Phase 1 of BH Integration went live January 1, 2025 and is taking a phased approach to integrating BH services into managed care

Jan 1, 2025

Phase 1

Outpatient BH Services
(for both adults and children)

- MH outpatient counseling / psychotherapy
- MH partial hospitalization
- MH partial care in outpatient clinic
- MH outpatient hospital or clinic services
- SUD outpatient counseling
- SUD intensive outpatient
- SUD outpatient clinic
  - Ambulatory withdrawal management
  - Peer support services
  - SUD care management
- SUD partial care

TBD[1]

Phase 2

Residential & Opioid Treatment Programs

- Adult mental health rehab (AMHR) / MH supervised residential
- SUD short-term residential
- SUD — medically monitored inpatient withdrawal management
- SUD long-term residential
- Opioid treatment programs (OTPs)

Phase 2 of BH Integration will be delayed to go-live after January 2026

TBD[1]

Phase 3

Additional BH services
TBD

- Opioid Overdose Recovery Programs (OORPs)
- Psychiatric Emergency Screening Services (PESS)
- Behavioral Health Homes (BHHs)
- Community Support Services (CSS)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted case management (TCM):
  - Program of Assertive Community Treatment (PACT)
  - Children's System of Care (CSOC)
  - Intensive Case Management Services (ICMS)

Phase 1: Transition Period

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

- State has implemented a **transition period** to:
  - **Promote continuity of care** for members served by providers not yet contracted with the MCOs
  - Provide additional time for MCOs to **expand and stabilize provider networks**
  - Give providers time to learn and practice how to successfully **submit prior authorization requests**
  - **Minimize barriers** to timely and accurate claims submission and MCO payment to providers

Beginning Nov 1, DMAHS began a process to end the transition period

DMAHS began a process to **end Phase 1 transition period** for all MCOs on November 1, 2025

Transition policies are being lifted on **an MCO-by-MCO basis over the coming months**, as each MCO demonstrates readiness to end the transition period

Aetna ended Phase 1 transition period policies on November 1

All other MCOs will continue transition period policies until further notice

Transition Period

- Remaining MCOs (other than Aetna) will continue to implement transition period policies:
  1. Providers **must submit prior authorization (PA) requests**
     - However, PAs must be **automatically approved** and will not be denied for medical necessity
  2. MCOs will continue to **pay out-of-network providers** using Medicaid fee-for-service rates. These claims must:
     - Be submitted with **no errors**
     - Have a PA on file for PA-required services
- Remaining MCOs will end transition period policies at different times once they successfully complete their final readiness reviews and **hit required performance milestones**.
  - Stakeholders will be given advanced notice from the State and MCO each time an MCO exits the transition period

Behavioral Health Integration: Stakeholder Communications

Monthly E-mails

Monthly **e-mail newsletter** to all behavioral health integration stakeholders will include information about:

- **Ending** the **Phase 1 transition** period
- Upcoming meetings and trainings
- Existing and new DHS and MCO resources available for providers, members, caregivers, and advocates
- Updates on other Medicaid program or policy changes and **any impacts on behavioral health services**

Quarterly Provider Office Hours

At least **once each quarter** (and more frequently if needed) office hours will be held for providers

- Will include:
  - Staff from **DMAHS** and **Division of Mental Health and Addiction Services**
  - Behavioral health teams from **all five MCOs**
- Provides opportunity to resolve issues related to claims, billing, credentialing, prior authorization, and care management
- **New** for 2026

Need help? Visit the state's BH Integration Stakeholder website or contact the member's MCO; if you cannot reach a resolution, outreach DMAHS

BH Integration Stakeholder Information website[1]

The Provider Resources webpage on the BHI stakeholder website has the following resources:

- Provider guidance packet
- End of transition period readiness guidance document
- Prior DMAHS training materials and recordings
- Additional resources with information on program processes

Member's Managed Care Organization

For specific member inquiries and MCO-related questions, please contact the member's MCO:

Aetna

Fidelis Care

Horizon NJ Health

UnitedHealthcare

Wellpoint

Refer to key MCO points of contact here or also in provider guidance packet

DMAHS – Office of Managed Health Care

If your issue is related to **contracting & credentialing**, **claims & reimbursement**, **appeals,** or **prior authorizations**, then contact **OMHC**:

dmahs.provider-inquiries@dhs.nj.gov

- Include specific details regarding your claims
- If multiple claims are impacted, the information should be summarized using an Excel file
- All Protected Health Information (PHI) must be sent securely

DMAHS Behavioral Health Unit

If your issue is related to **policies & guidelines**, **access to services**, or **general questions**, then contact DMAHS **BH Unit**:

dmahs.behavioralhealth@dhs.nj.gov

1-609-281-8028

NJ FamilyCare Doula Benefit Updates

NJ FamilyCare Doula Benefit

- NJ FamilyCare's benefit package includes coverage for pregnancy-related **doula care**
- Our statewide doula policy is developed in collaboration with NJ Maternal and Infant Health Innovation Authority (MIHIA) and NJ Department of Health.
  - MIHIA is hosting quarterly Doula Town Halls (next Town Hall scheduled for April 9th). Register here.
- A primary goal has been to **increase the number of doulas serving Medicaid members**.
  - We have launched **two complementary efforts** to increase the number of NJ FamilyCare's community doulas.

NJ FamilyCare Doula: New Efforts

1 NJ FamilyCare Doula Trainings Approval Packet and Rubric Tool

- **Goal: "Widen the door" to accept more of the state's doula workforce in Medicaid**.
- We are using a standardized Rubric Tool to help the state efficiently and transparently approve quality doula trainings.
  - Approval by NJ FamilyCare makes doulas educated by those trainings eligible to apply to be NJ Medicaid provider.
- **We invite all doula training organizations to seek NJ FamilyCare approval of their doula training by filling out the Approval Packet (including the Rubric Tool)** here.
- NJ MIHIA is providing technical assistance in English and Spanish for organizations and is responsible for accepting the approval packets from organizations.

NJ FamilyCare Doula: New Efforts

2

NJ Doula Assistant Tool

- **Goal: "Focus on care, not paperwork" by helping doulas fill out the application to become a Medicaid provider**.
- We have created a new online tool that clearly communicates the requirements of our fee-for-service provider application—producing a near-complete application in 20 minutes.
  - Modeled after "Turbo Tax" – i.e. user-friendly approach to complex data submission.
- **We invite all doulas who are not yet enrolled with NJ FamilyCare to access the tool here: https://nj.gov/humanservices/dmahs/info/doulahelp/form/welcome**
- For doulas who would prefer one-on-one help with their provider application, it is still available through our **Doula Guides**, who can be reached at mahs.doulaguide@dhs.nj.gov
- Development of this tool was a collaboration with NJ's Office of Innovation and involved human-centered design research with NJ doulas.

NEW JERSEY HUMAN SERVICES

Cell and Gene Therapy

CMS Cell and Gene Therapy Access Model: Status Update

- National Cell and Gene Therapy (CGT) Access Model, focuses on therapies for Sickle Cell Disease (SCD)
- **Goals**:
  - Increased access to CGTs in qualified regional medical centers
  - Improved health outcomes for members with SCD
  - Lower state costs for SCD treatments Casgevy and Lyfgenia via prior CMS negotiation of outcomes-based agreements (OBAs)
- **Model start date**: January 1, 2026
- **Status**:
  - 13 NJ FamilyCare members have met CMS criteria for Model participation, have completed the prior authorization process, and have been approved for treatment

CMS

- Negotiated with pharmaceutical manufacturers, creating outcome-based agreements with enhanced rebates
- Waived federal rules to allow manufacturers to reimburse providers for fertility-preserving treatments
- Approved NJ FamilyCare participation – December 2025

DMAHS

- Entered into agreements with CMS and pharmaceutical manufacturers – November 2025
- Updated MCO contract to mandate alignment with model requirements – January 2026
- Will collect rebates and outcome-based payments from manufacturers

Manufacturers

- Will pay NJFC both outcomes-based and other enhanced rebates
- Will reimburse providers for fertility-preserving treatments

MCO Contract Changes

MCO Contract Changes – January 2026

Provider Network / Directory Changes

Require MCOs to **upgrade online provider directories**, to incorporate enhanced **search and filter options**

Require **MCO dental provider directories** to incorporate specific **ages of patients** that providers see

Require MCOs to **disenroll providers** who **fail to meet / comply** with certain **general Medicaid provider requirements**

Behavioral Health

Align contract with **transition period requirements** for behavioral health integration (see Behavioral Health Integration slides above)

Update and clarify expectations for MCOs' **Behavioral Health Claims Specialists**, to **strengthen customer service** for behavioral health providers

Benefit Enhancements

Mandate coverage of **Continuous Glucose Monitors without prior authorization** for members with certain diabetes diagnoses

Implement new **Community Based Palliative Care benefit**

Community-Based Palliative Care Benefit

- NJ FamilyCare's new Community-Based Palliative Care benefit will launch **April 1, 2026**.
  - Delayed from previously scheduled launch date (January 1, 2026) to support full systems readiness.
- Eligible providers will include **existing hospice** and **home health, physician,** and **clinic** providers who meet additional eligibility criteria.
  - More information will be available soon.
  - Provider enrollment process will begin in **February 2026**.
- DMAHS will host a 3-part **provider training series**, interested providers can email MAHS.CBPC@dhs.nj.gov to register.
  - Provider training dates: 1/20/26, 1/27/26, & early February date TBD.

Community Based Palliative Care:

- Person- and family-centered care that optimizes quality of life
- Anticipates, prevents, and treats suffering caused by serious illness.
- Addresses physical, intellectual, emotional, social, and spiritual needs
- Delivered by an interdisciplinary team working together
- Can be provided along with curative treatment

Planning for the Next Meeting

April 22, 2026