MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
Via Zoom Videoconference
October 27, 2022
10:00 a.m.
FINAL MEETING SUMMARY

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

MEMBERS NOT PRESENT:
Chrissy Buteas
Dorothea 'Dot' Libman

ALSO PRESENT:
Lisa Asare, Deputy Commissioner,
NJ Department of Human Services
Jennifer Langer Jacobs, Assistant Commissioner,
NJ Division of Medical Assistance & Health Services
Greg Woods, Chief, Innovation Officer,
NJ Division of Medical Assistance & Health Services
Carol Grant, Deputy Director,
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Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, Chair of the New Jersey Medical Assistance Advisory Council (MAAC). And it's my pleasure to welcome you to the October 27th meeting of the MAAC. This meeting is being conducted in compliance with the New Jersey Open Public Meetings Act.

As is our process, I want to review how we operate particularly in this virtual environment. After I do that, I will ask the members of the MAAC to unmute. I will call on them. When we have presentations, the members of the MAAC may provide comments. And I will ask them to either raise their hand or just unmute. We invite our stakeholders to put questions in the Q&A box on their screen. The chat is not available in this meeting.

I also want to begin with a "thank you" and to underscore the level of effort that goes into planning this meeting and distilling the information from the huge number of programs that are overseen by the Division of Medical Assistance and Health Services (DMAHS) for the over 2 million New Jerseyians who are now Medicaid beneficiaries.

Before I ask MAAC members to introduce themselves, I want to -- and perhaps we can now go to a gallery view so people can see the members before the

agenda. Thank you.

I want to take a moment to recognize Mary Pat Angelini for her service on the MAAC. Mary Pat is retiring from her work at Preferred Behavioral Health and to our dismay also retiring from the MAAC, although we are happy that she's moving on to her next chapter. She's provided distinguished service to New Jersey, serving as a member of the Assembly, as a MAAC member, and most recently a trustee of Brookdale Community College.

Mary Pat, we'll miss your wise and thoughtful presence and guidance, and we wish you the best in the next chapter.

MS. ANGELINI: Thank you very much, Dr. Spitalnik. I really appreciate it. And I really appreciate all the work that this Council has done. I hope that I was able to contribute a small, small piece. So, again, thank you very much for your kind words.

DR. SPITALNIK: Thank you very much. Now I would ask the members of the MAAC to unmute and identify themselves, starting with Mary Coogan, Beverly Roberts, and Wayne Vivian.

MS. COOGAN: Good morning, Mary Coogan. I am Vice President of Advocates for Children of New Jersey.

DR. SPITALNIK: Thank you.

MS. ROBERTS: Good morning, everyone. I'm Beverly Roberts with the Arc of New Jersey.

DR. SPITALNIK: Thank you.

Wayne.

MR. VIVIAN: President of the New Jersey Coalition of Mental Health Consumers, representing mental health consumers.

DR. SPITALNIK: Thank you, Wayne Vivian.

Theresa.

Have I missed anyone with the way my screen is jumping around? If I have, Theresa, start us off, and anyone else, please chime in.

MS. EDELSTEIN: Thank you, Dr. Spitalnik.

Good morning, everyone. Theresa Edelstein, I'm one of the Senior Vice Presidents at the New Jersey Hospital Association.

DR. SPITALNIK: Thank you.

Any other members present with us?

I just heard a little beep. I don't know if it was someone joining us, but before I run through the agenda, I want to welcome Deputy Commissioner Lisa Asare. Thank you for everything you do and for spending time today with us at the MAAC.

I'll now turn to reviewing our agenda. And

may we please -- Sherl Brand just joined us.

Sherl, would you unmute and say hello? You don't have to be visible to speak.

Sherl Brand is here and I'm sure we'll be able to see her during questioning.

I now turn to the agenda which I will review. We've gone through the welcome and call to order.

We'll now turn to an approval of the minutes, NJ FamilyCare membership, a series of policy implementation topics, 1115 Demonstration Renewal, WorkAbility, and the HCBS setting rules.

Assistant Commissioner Jacobs, we have a change in the agenda around the agenda item which is labeled behavioral health analysis but was addressing mental health and people with developmental disabilities. Could I turn to you about this change in agenda?

MS. JACOBS: Yes. Thanks, Dr. Spitalnik.

We had planned to share data analysis with you today on the utilization of behavioral health services via our members with intellectual and developmental disabilities (I/DD). Unfortunately, as we were completing the final review of the data, some technical concerns were identified that we weren't able

to fully resolve. So, unfortunately, that means we're unable to share the planned presentation with you today. We're really sorry about the last-minute agenda change here, and we hope we'll be able to bring that analysis back to this forum soon.

DR. SPITALNIK: Thank you very much.

Our next item as we work our way through the agenda will be the Autism Resource Guide, an update on Cover All Kids, the end of the Federal Public Health Emergency, and planning for the next meeting for which we already have our four dates, which I will announce at that time.

So moving ahead, I turn to the members of the MAAC to inquire if there are any changes or corrections to the minutes. Please unmute and let us know.

MS. ANGELINI: I'll make a motion to accept the minutes, as presented.

DR. SPITALNIK: Thank you, Mary Pat.

Do I have a second?

MS. ROBERTS: Bev Roberts. I'm seconding. Thank you.

DR. SPITALNIK: Thank you.

If there are no objections or abstentions, we approve the minutes of our last meeting.

We now turn to a presentation on New Jersey FamilyCare membership with Greg Woods who is the Chief of Policy and Innovation for the Division of Medical Assistance and Health Services.

Good morning, Greg, and thank you for joining us. And I'm hoping that you will now be spotlighted in the visual. Thank you.

MR. WOODS: Good morning. And thanks, Dr. Spitalnik.

I wanted to take a minute, as we have for the last several MAAC meetings to give an update on NJ FamilyCare overall enrollment. This is the same slide that we've presented to this group a number of times before. It's been updated to show our most recent enrollment data through last month, so through September of 2022. What I would say here is that we're just seeing a continuation of the trends that I have presented to this group before, which is to say that since the beginning of the pandemic in March of 2020, we've seen consistent growth in our total enrollment. And we are now at almost 2.2 million total members. That represents an increase of about 500,000 since the beginning of the pandemic or about almost 30 percent. So it's quite a substantial increase.

As we've discussed before and as we'll talk

about in a little bit more detail later in the presentation or later in today's meeting, we think that one of the key drivers here is the Federal Public Health Emergency which has changed some of our eligibility policies. And we would expect this general trend to continue so long as that Federal Public Health Emergency remains in place. And, again, we'll talk a bit more later about where we are with that. So I think this represents more of what we've seen in the past. The trend has continued. Again, our total enrollment as of last month, we're at 2.2 million.

I'll pause there.

DR. SPITALNIK: Thank you, Greg.

Are there any comments from the MAAC? Questions?

Seeing or hearing none, Greg, I'll ask you to stay at the virtual podium as we move to policy information as you take us through the status of the 1115 Demonstration Renewal.

MR. WOODS: So I wanted to just give a quick update today about where we are with our Comprehensive 1115 Demonstration Renewal. As a reminder, the 1115 Demonstration is what gives us authority to operate many parts of our Medicaid program. It's something that we negotiate with our federal partners at the Centers for

Medicare and Medicaid Services (CMS). And typically, our 1115 Demonstrations need to be renegotiated every five years and reapproved. We are at the 10-year mark of our Demonstration, so we're coming into a renewal.

As many of you will remember, we had submitted a draft renewal proposal for public comment last fall. I should say we posted for public comment last fall. And then we submitted our final renewal application in February of this year.

At a high level, some of the Demonstration elements that were part of our proposal, we propose to continue. Many of our existing elements, while adding new elements to address social determinants of health, to promote integrated care, to expand access to care, and to improve program operations.

So, again, we submitted that renewal application back in February to our federal partners in the CMS. There was then a federal comment period. And then in June, in order to allow us some more time to negotiate that extension with our federal partners, CMS temporarily extended our existing Demonstration period. It had been scheduled to end in June, so they extended it an additional six months to the end of calendar year 2022. And so currently, our current period runs through December 31st. Again, that was just intended to allow

us to have more time to negotiate with our federal partners. And I will just say our substantive discussions with CMS on renewal are very active and ongoing and we're sort of reaching the critical point of those discussions and working through all of the different elements in our demonstration.

I will note -- for those have been following this, you may be aware, but some folks may not be. In recent weeks, CMS has approved some 1115 Demonstrations for other states, so for Massachusetts, for Oregon, and for Arizona. None of those are identical to ours, but they do have some commonalities, and I think they are worth mentioning and calling out because they highlight the framework that I think our federal partners at CMS are using to think about demonstration projects that include the social determinants of health or health-related social needs or HRSN which is the new CMS parlance around that. And I think if those who are interested want to look at those approvals, it will give you a sense of some of the issues that we are working through with our federal partners at the CMS).

So we continue in the active stage of negotiations with CMS. Our hope is that we will get a renewal approval by the end of this calendar year. And then the renewal period would begin in January of next

year. As with anything, this timeline could change, and we're sort of working through each of the elements of our renewal proposal. We hope to get all or as many of them as possible by January. It's possible some may be deferred to future amendments, but we're sort of very much in the active stage of negotiations and discussion with our federal partners. So I would hope and expect by the next time that this group convenes next year, we will have a much more detailed substantive update of where this all came down but did want to just give that update of where we are in the process.

DR. SPITALNIK: Thanks, Greg. We're very appreciative of the update. And it also illustrates the complexity in each aspect of the program in terms of the negotiations with CMS and our work here in New Jersey.

Are there any questions or comments from members of the MAAC?

MS. ROBERTS: Hi, this is Bev. Thank you, Greg. Much appreciated.

What I'm wondering is since I think we are all very eager to know as soon as possible when there has been approval from CMS, would it be possible either to distribute something in writing or to have some other type of update meeting when you know, again, hopefully by the end of December, what has already been approved

by CMS?

MR. WOODS: Bev, I think we could take that back and think about what makes most sense. I will just say my experience of these things is if your deadline is December 31st, you're probably going to get approval sometime after December 15th. So that might be a challenging time of year to set up a separate meeting, but I think I'm happy to talk off-line with the MAAC or members of the MAAC to think about what would make most sense to share that as soon as we have that information.

MS. ROBERTS: Great. Thank you. Thanks so much.

DR. SPITALNIK: Thank you.

I'm happy that we were able to respond to the request to make the slides larger. And I think there are questions about what has been agreed on with CMS, but I think, from what you said, Greg, it's premature to comment on what the decisions are.

MR. WOODS: Yes. As soon as we have that information, we will share it with this group.

DR. SPITALNIK: Thank you. And we'll make sure that it's shared broadly with stakeholders. Thank you very much.

We'll now turn to WorkAbility expansion. And I want to note for the record that I received and

have distributed, as requested, to members of the MAAC a statement that was sent by Nan Tany Kopstein (ph). It's signed Concerned WorkAbility Stakeholders with concerns about implementation. So that will now be included in the public record of this MAAC meeting.

And I turn to Assistant Commissioner Jennifer Langer Jacobs to share with us where we are with policy implementation on WorkAbility expansion.

Jen, good morning.

MS. JACOBS: Good morning. Thank you, Dr. Spitalnik.

Yes, I'm really happy to share some updates with you on the work we've been doing. We spoke with you at the MAAC meeting in July about work underway regarding expansion of our WorkAbility program, just to revisit that to make sure everybody is on the same page if you're not familiar with WorkAbility, this is our program that provides Medicaid eligibility to working individuals with disabilities who otherwise would not qualify for Medicaid. Today, there are some limitations on who qualifies for WorkAbility, but we have legislation that was enacted earlier this year to expand that program so that we will be able to include individuals who were previously ineligible due to income limits, asset constraints, or age, and we are really

excited about this expansion of our program; essentially, in making Medicaid available to all workers with disabilities.

So we have some key activities that are underway with implementation here, and I want to give you a little bit of an update on that today, talk a little bit about incorporating our stakeholder perspectives, both on the current WorkAbility program and the experience that people have with that program today, and then on the design of the expansion that's described in the legislation. There's some details around our work with CMS that I will share a little bit of where we need to obtain federal authority in order to get the federal matching funds to support this expanded program. And then we also have technical implementation work going on which includes reworking eligibility systems logic. We'll talk a little bit about that here today. We've actually gone into more detail with our WorkAbility stakeholder group than we're going to go into here at MAAC. So I wanted to just mention if there's interest in joining that group, it's an open group and we're very happy to bring folks into the more detailed discussions. But here for MAAC purposes, we really wanted to give you just a clear sense of where we're headed and the work that we're doing.

So let's go to the next slide and talk a little bit about stakeholder perspective and our goals for implementation. I think many of you are aware we do a lot of implementation work. And whenever we are talking a policy concept and building a real life program out of it, we want to make sure that we know exactly what our what vision is, what success looks like, what principles will guide us along the way. That is the purpose of this slide. So you've seen versions of this with prior implementations where we are laying out a vision for what the program -- what the implementation would be guided by. That's really what we're going for here.

So in conversation with our advocates, with legislative sponsors, access is a really, really critical piece of this. And the intention here really here is to make the expanded WorkAbility coverage broadly accessible for the people we serve, and that means working closely with our community on the implementation work and then also on the promotion of the program once we're ready to go live.

Second, we have had conversations about the importance of timeliness, having a sense of urgency about this, making sure they were implementing this coverage option as soon as possible within the

logistical and legal constraints that we have but making sure that we're efficient and moving the ball down the field every day.

The next stop is equity. Here, we're encouraged to support that improved access and make sure that the outcomes we're getting from this program are equitable, fair, and inclusive, really with an eye to the incredible expense that people with disabilities experience in their health care costs as a result of having that disability and making sure that we're able to support people being in the workforce.

And then finally, simplicity. Medicaid is inherently a complex system and it is always our job to develop policies and materials that are clear and that support understanding. So I tend to think of that as building bridges of understanding across our program. It is a complex program, but as much as we can make it clear for folks, we need to be trying to do that. So these are really key priorities and goals.

And then we have some technical work to do with our federal partners. So we've shared with our WorkAbility stakeholder group that there are two authorities under which we can access federal matching funds. Some folks in that group are very plugged into this and really understand this right away. Other folks

have not necessarily been supposed to federal authorities language. And that's fine. So if you're interested in a deep dive on this, here's a little bit. If you're not, feel free to tune me out for the next minute or two.

DR. SPITALNIK: I want to interrupt for a second to correct an omission on my part, that these slides will be posted on the Division's website at: http://www.state.nj.us/humanservices/dmahs/boards/maac/. So if people are franticly trying to take notes, know that they'll be available. My apologies for the interruption and for not including that originally.

MS. JACOBS: We have a really good MAAC website that Phyllis has maintained with us for a long time, so all the records are there for you and no need to hurry to take notes.

So we have a couple of authorities that we can use for the federal matching funds. One is called Ticket to Work. That is the authority under which our program currently operates. It has some constraints and some requirements that are unclear for states seeking expansion like we are. And as a consequence, our conversations with CMS are technically complexion here. We anticipate that CMS will be issuing some guidance on the Ticket to Work authority that would be highly

relevant to our expansion. That guidance is not yet available. And recall that we have a real focus on timeliness, a sense of urgency here.

So the next part of the conversation with our stakeholders and our federal partners has been around the Balanced Budget Act, the BBA Work Incentives Program. This is a very similar authority to Ticket to Work, slightly different technical considerations in -- are we still in October? Yes, we are. This month, October 5th, CMS confirmed for us that we can go ahead and use that BBA Work Incentives authority to expedite the program expansion because we don't yet have that additional guidance on Ticket to Work. So we'll be doing a lot of this work on the CMS end through the Work Incentive Programs. Still some technical details to nail down there, but we're having good conversations with CMS and moving down that path.

So that brings us to the next slide, our implementation plan. We're going to -- in the name of efficiency and doing this as quickly as possible the right way for as many people as possible, we're going to tackle this in two phases because there's a piece of this work that takes a little bit longer to do and we don't want to hold up the whole project while we're doing that work that takes a little bit longer. So

we're going to break this into two phases where -- if you'll stick with me for a moment, I know there's a bunch words on this screen. Phase 1 on the left is really focussed on workers who are earning up to 250 percent of the federal property level. That's our current income constraint. On the right, Phase 2, we would be focused on workers making more than 250 percent FPL.

So on the left, what we're really doing is using the existing program infrastructure, that up to 250 percent, and stripping away the other constraints that have existed on our WorkAbility program. So what that means is, we're going to move age as a restriction. We currently only cover up to 65. We'll now be able to cover over 65. We're going to remove the consideration of the spousal income, and we're going to remove the asset limit. We will also make 12 months of coverage available after a job loss. We can do all of this, which is included in the legislation, using our existing infrastructure as a platform and making some changes within the programming of the system that we could make pretty quickly. The advantage of doing that is it let's us cover, rough numbers, probably 15,000 additional workers with disabilities much more quickly than if we wait until this longer part, Phase 2, is complete.

Phase 2 is a little bit more work, and we didn't want to hold up Phase 1.

So Phase 1 is going to be the first piece out of the gate. We're working on what the timing looks like for that. We're just nailing down right now all the technical details. Essentially, we're walking through the policy decisions that had to made. We're saying to the people who code in our system, here is the code that will need to be written. These are rules of the road. They will establish their technical documentation in order to move all of that forward. And then we will know when we can bring Phase 1 out of the gate. So we're pretty close to knowing what that timeline looks like, just not quite over the line yet. As I mentioned, that will be, we think, about half of the eligible population and we're going to be able to get that done as soon as we can in the early part of the new year. And then Phase 2 is where we have a lot more work to do in our system because we need to establish new eligibility groups at higher income levels. That architecture is not in the system today. We need to do some building, and that will take a little bit of time. That's going to be, we think, the other half of the eligible population. So rough numbers here, but maybe it's 15,000 and 15,002. We currently have 6,000 in the

program today. So if we reached full enrollment over a few years, we would anticipate maybe 35, 36,000 people, something like that, enrolled in the program.

Again, these are rough numbers. We're working with some assumptions that we were making based on census data that was available, experience in other states, et cetera. But we are really excited about the possibility of having so many new NJ FamilyCare members covered as a result of the expansion of WorkAbility.

The last thing I would mention -- and, Greg, we'll come back to this a little later. As we move into the unwinding of the Public Health Emergency, we're going to treat our existing WorkAbility members slightly differently in order to move their redetermination process later in that unwinding year. And Greg will go into a little bit of detail on that when he presents on the unwinding plans.

Dr. Spitalnik, I think that is -- that's a high-level update. It's hopefully helpful for purposes of the MAAC and I'm very happy to answer any additional questions.

DR. SPITALNIK: Thank you so much. I appreciate that. Before I turn to my colleagues on the MAAC, I'd like to make a suggestion that we, given the complexity that there's complexity in implementation,

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but as we envision when these decisions are made, there will need to be major outreach and a very significant communication strategy that will really reach those who are eligible who may not know about this program. So I would want to suggest, and I don't know in what form this would take, but with the users, potential users of the program, the implementers of the program, that we begin the stakeholder-driven process of developing an outreach plan and strategy. So when these decisions are made, we hit the ground running and it's not another stop but we really reach the community. In any way that we can be of help, we're certainly interested.

Beverly, I've seen you unmuted and I think you may want to comment.

Jen, thank you for that excellent presentation and clarifying a lot of the complexity of this.

Beverly Roberts.

MS. ROBERTS: Thanks very much.

So thank you, Jen. I have a comment, actually, and a question.

So my comment is -- and I just saw there was a letter that Dr. Spitalnik had referred to at the very beginning of this meeting today. I saw it very, very briefly, just a couple minutes before 10 o'clock this

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morning. I didn't have any knowledge of it. I did not participate in that letter, and I don't know how many people did know about or did participate in putting that letter together. But I just wanted to make it clear that I didn't know anything about it until I saw it just before 10 this morning.

So this is my question: As you know, I represent people with intellectual and developmental disabilities, and there's this very small subgroup of our folks who are employed. If they have SSDI on their own work record, that's fine. It doesn't matter what that amount is. They can have NJ WorkAbility right now. If they have SSDI from the parent's work record due to a parent who retired, became disabled or passed away -- so let's just say, pulling some numbers out of the air, somebody could have an SSDI that today is considered unearned or but it could be $1,200 a month. And maybe their employment is something that they're earning minimum wage for 10 or 12 hours a week. But because their so-called unearned income, the unearned SSDI from the parent exceeds the threshold of $1,133 a month, as of today, they are not eligible for NJ WorkAbility. So that would impact, obviously, people who had it before. And as you're saying, they actually won't be harmed when unwinding ends because they would be at the very end of

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the group that's going to be looked at for redetermination. But anybody who didn't have NJ WorkAbility for whatever reason and then now has this so-called unearned SSDI income over $1,133 a month is considered ineligible for NJ WorkAbility. So I know ultimately when everything is done, they will be eligible, but -- and, again, I don't have data. I think the numbers are relatively small, but very important, obviously, to our community. So I just wanted to point that out in terms of the phase at which this particular issue is recognized and implemented.

MS. JACOBS: Thank very much, Bev.

DR. SPITALNIK: Thank you, Bev. Other comments or questions from members of the MAAC?

Thank you.

And as is our custom as we are proceeding through the agenda, we're also noting items that will be on our agenda for our next meeting.

Thanks again, Jen.

We now turn to a presentation on the Home and Community Based the Settings Rule. And delighted to introduce Joe Bongiovanni, a longstanding colleague and friend and Director of Managed Long-Term Services and Supports, the Division of Medical Assistance and Health Services.

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Welcome, Joe, and thanks for being with us today.

MR. BONGIOVANNI: Thank you, Dr. Spitalnik. And good morning, everyone.

So I'm jump into the presentation on the Home and Community Based Settings Rule.

Background intent of the rule. The rule is to ensure that individuals receiving Medicaid Home and Community Based Services have full access to benefits of community living and the opportunity to receive high quality services in a genuinely integrated setting. That's the focus of the rule.

The federal codes and compliance dates are the next two bullets. The way the State demonstrates compliance is through something called the Statewide Transition Plan. And that Transition Plan is submitted to CMS to be approved, and that's got to be before March 17, 2023. The ultimately compliance date for all states is March 17, 2023. So as you can imagine, that's not a long time from now. We have been working for some time with our partners over at the Division of Developmental Disabilities, Division of Aging Services, and our Office of Licensing to evaluate our home and community based settings for compliance. So the next question is what is a home and community based setting? The setting is

defined by the access and integration it provides to the members who receive those services, either residentially or in a day program. The focus is on equality of a person's full experience in the HCBS setting. It looks at that from both a physical plant perspective and from a quality of life perspective, which I'll get into a little bit later on in the presentation.

The Settings Rule is important because it helps the State stay accountable to providing high-quality care to members in the community. The Settings Rule is to ensure Home and Community Based Services are provided in locations that are truly not institutional. It's going to improve the overall quality of Home and Community Based Services in New Jersey and it's going to provide enhanced protections to members who are living and were receiving services in the community.

So the application of the Rule, the information to the left is where it applies; assisted living, adult family care, community residential services, and social adult day within the MLTSS program here at Medicaid. Community residential services are group homes for individuals with traumatic brain injury, so that spans both DDD and the Medicaid program; licensed funded DDD residential settings, that's group

homes; and then congregate prevocational and day program settings would be your DDD day programs, and those sorts of things.

The information on the right, just to provide a little bit of contrast -- the difference in the coloring here is intentional -- is where it does not apply. So anyone living in privately-owned or rented home with family members, relatives, or roommates, the Rule does not apply to you. Any Medicaid state plan service, so if the State has determined that adult medical day or a adult mental health rehab are, in fact, state plan services, the Rule does not apply; nursing homes, institutions for mental diseases, intermediate care facilities for individuals with developmental disabilities or intellectual disabilities, and hospitals.

CMS prescribed standards within the Rule that help the states demonstrate compliance, so these are the things that CMS and states look at to evaluate how well we're doing with compliance around the Settings Rule.

So the first standard is community integration. Members are able to join in community life just like members who are not enrolled in Medicaid and receiving Home and Community Based Services. They can

go to activities that are scheduled and unscheduled. They have access to public transportation, among other things. An example of that is below. Cindy can meet a friend in town for coffee before she goes in a job interview, just like you or I might be able to do that and given that we're not enrolled in Medicaid and receiving services through a Medicaid provider.

The second standard is choice. Members choose where they live and their day service options from several options during care planning process. We call that option counseling in the MLTSS program where members would receive information about places to live and ways to receive services, and then they make an informed decision. So the example below is Chuck can choose from appropriate service providers based on his person-centered care plan.

The third standard set by CMS is independence. So members must are autonomy, physical access -- that's that physical plant comment I made earlier -- to all parts of the setting in which they serve services. This could be a home or a day program. They get to decide what to do each day, how to decorate their living units and with whom they wish to socialize. The example below is Inez can decorate her living space in her own personal style. She can get a snack with her

friend at any time.

Rights. This is one that we're all familiar with, I believe. Members have the right to keep their health information private, to spoken to with respect and dignity by the staff who are serving them, to have their individual needs and preferences known, and have requests for services and supports accommodated. This is something that CMS has really brought to the forefront, although New Jersey, we do a lot of this already. The example is Robyn is feeling reflective today and she's not pressured to participate in any social activity. She can have quiet and alone time, and that's her right.

So additional requirements for provider-owned and/or operated settings. The translation there is group homes or supervised apartment or assisted living.

So the first requirement is protection from eviction. It's either a legally enforceable agreement such as a lease where tenant/landlord law does not apply, the resident has a documented protection from eviction and/or other negative outcomes in their resident similar or the same as those where tenant/landlord law would apply.

Individuals have the right to privacy. Each

living arrangement, each living space has a lock on it, not just entrance and exit to the place, but bedrooms. If a member is not able to maintain or hold their key, they get to decide who does hold that key. In a group home, there can be a master key with limited access to who has that key. Again, it's all part of the planning process. It's discussed in the care planning process. The member is the ultimate decider of who has access to the key to their living space.

The third standard or third setting requirement is freedom of choice. The resident controls their schedule and they have access to food at any time. If there needs to be exception to that access to food, it's documented in their plan of care and based on an assessment. We don't just get to say, "Well, it looks like the person eats too much so we should write that down in their plan of care." It's got to be documented reasoning why access to food is limited, how you accommodated that access to food, what did you try that was less restrictive than what's in the plan of care and how that all worked. You have to document that all out.

Individuals have the right to receive visitors at any time. They get to choose who comes to visit them and at what hour. The setting's got to have a place for people to meet in private where that might

be necessary.

Physical access is the last requirement. Physical access to all parts of the setting, be it a residence or a day program. If the resident needs it, they have supports, like grab bars and special seats in bathrooms. They have access to appliances, tables and chairs that they can use.

So there is a process called heightened scrutiny for those settings where we've evaluate that they might not necessarily be in a hundred percent compliance. That setting looks like an institution. It either has the effect of isolating someone from the community or it is on the grounds of or in adjacent to an institution. So our partners here in the Department of Human Services can submit evidence, with public input, to the federal government, our partners at CMS, that a particular setting which is presumed not to be HCBS, meaning it looks like an institution, does, in fact, qualify as an HCBS setting and is not an institution. The federal government, they then review the information we send them and either agree or disagree and have further dialog with us around how to meet the requirements of the final regulation.

In July 15th of 2022, we issued a list of settings presumed to be institutional for public

comment. Those are our heightened scrutiny settings. The public comment period closed on August 19th of 2022. Responses were developed and included in the information got sent to CMS. The State's intent is to assist providers to become compliant before March 17, 2023. And that's the key. We want to work towards compliance.

Can you back up a slide, please? Thanks.

Just a quick note about public comment. We got all of two themes, and they resonated around one setting or two settings operated by a particular provider. And the public input into that process was very instrumental in helping us demonstrate that while on the surface, "the judge the book by the cover phenomenon," it looked like it was isolating but, in fact, that setting was not at all isolating. And so we're having dialog with CMS about that particular setting, that situation.

Next slide, please.

So evaluation and enhancement of Home and Community Based Services. New Jersey is evaluating its programs and services in the following ways: We are verifying assessments of residential and day providers. Some of you may have completed a self-assessment. We are going through each of those assessments and verifying compliance with the rule based on what we

received.

We're reviewing our own regulations, standards and policies, and our managed care contract to make changes or improvements, to ensure compliance with the Settings Rule.

We are preparing information and evidence on settings requiring heightened scrutiny to present to CMS.

Submission our of final statewide transition plan to CMS to show findings and to describe how it will make any necessary changes in order to comply with the new rule.

Another second formal public comment period began October 5th and will conclude on November 7th. We really encourage you to provide comment on our statewide transition plan and our heightened scrutiny proces as it's provided in the announcement for public comment.

So our partners with implementing this are also our Managed Care Organizations and providers. Our Managed Care Organizations are going to verify continued compliance in their credentialing and recredentialing processes of both residential and day program. Care management infrastructure at MCOs will be visiting members to evaluate compliance and develop and monitor plans of care with members who are receiving MLTSS in

the MLTSS space.

The MCO contract will be amended to reflect these new responsibilities and other Home and Community Based Service settings requirements.

Providers will ensure newly that established settings compliant. Providers will ensure that existing settings remain compliance. And providers will maintain and provide documented evidence of new and established settings when requested.

Any questions or comments can be directed to the e-mailbox below. It's a resource box that myself and the team who are implementing compliance with the Rule, we monitor that mailbox. It is also the mailbox that public comment that I just mentioned on the previous slide can be sent. Thank you.

DR. SPITALNIK: Joe, thank you so much. In the last side, you're making a differentiation. When you say providers, do you mean community based providers who are developing settings, so the MCOs may not be directly involved, say, for people with developmental disabilities? Is that the case, or am I misinterpreting what you said?

MR. BONGIOVANNI: In the developmental disabilities space, if the MCO is providing care management and develop their plan of care, they would.

If they are not, then they wouldn't be.

DR. SPITALNIK: Great. Thank you.

Comments and questions from the MAAC? Please unmute and ask if there are any questions or comments on this excellent presentation.

I'm not hearing any, but there were questions in the Q&A box about the appeals and grievance process for beneficiary who may reside at a location that's not compliant, how are beneficiaries aware of their rights; and also if that's the case, how would the State ensure alternative locations available that are compliant?

So I would turn to Assistant Commissioner Jacobs or you directly, Joe, to -- I know that you will take these into consideration. I don't know if there are things that you are able to comment on directly or respond right now.

MS. JACOBS: We also have Amy Scartocci from DDD on the panel today. I don't know that we are able to speak to that right now. But, Joe and Amy, I defer to you. And if not, we can bring those answers back.

MR. BONGIOVANNI: So with the appeals and grievance process, right now we're examining our existing infrastructure appeals and grievances that exist today, and we'll be adding the Home and Community

Based Services requirements to them. We have to add in the -- I guess conduit is probably the wrong word, but the methodology for a member to contact the State directly in the event that they are wanting to talk about Home and Community Based Settings Rule and their desire to issue -- to establish an appeal or grievance.

The alternative locations conversation would come through the plan of care process. So our desire and our goal is to ensure that all providers are compliant before the date. If a provider falls out of compliance and we have to relocate a member, we would do that through the person center planning process. We'd get that care management team together and provide options counseling to ensure that the member is making an informed choice if it has to come to that.

Amy, I don't know if there's anything you want to add.

MS. SCARTOCCI: I think you covered it well. Thank you.

DR. SPITALNIK: Thank you both.

And seeing no other questions or hearing no other comments, we'll move to our next agenda item which is the Autism Resource Guide. And I'm delighted to introduce Shanique McGowan who is a behavior health policy specialist that's been shepherding the autism

benefit and this Guide along.

Welcome and good morning, Shanique.

MS. MCGOWAN: Thank you, Dr. Spitalnik.

Hello and good morning, everyone.

As many of you know, the comprehensive autism benefit launched in early 2020 with the goal of offering an array of services for those New Jersey FamilyCare members under the age of 21 with a clinical diagnosis of autism spectrum disorder. To help share information about this new benefit and to equip families with statewide resources, we worked in close partnership with the Autism Stakeholder Executive Planning Committee to develop the Family Guide to Autism Services funded by New Jersey Medicaid. I'm very excited to quickly walk through the different components of this guide.

So the first section talks about eligibility requirements and how to access the services covered in the benefit. As a reminder, each service is available for those enrolled in Managed Care and Fee For Service. The treatment approaches are determined based on the individual needs of the member, clinical evaluation, and family choice. Providers are able to work with each member anywhere in the community, including the member's home.

The second section of the guide gives a

description about each New Jersey care funded treatment option. Some of the services that are covered include Applied Behavior Analysis or ABA, allied health services such as occupational therapy, physical therapy, and speech therapies, augmentative and alternative communication and devices, clinical interventions, and developmental and relationship-based approaches. We also included some resources for families and caregivers to learn more about autism treatment and the various intervention approaches.

For the third section, the Division worked with a range of stakeholders to develop an extensive list of frequently asked questions by families of children with autism spectrum disorder. The answers here provide more information about the services that are available, the approval process, how to find providers, coordination of care, accessing providers if English is not your first language, care management, and the role of the Children's System of Care.

The last section of the guide includes contact information for multiple resources across the state, such as sister agencies, the Managed Care Organizations, and other collaborative partners. We especially want to thank the Boggs Center on Developmental Disabilities for their assistance with the

development of this guide. This document and five translated versions can be found on the Division's website as well as each Managed Care Organization's member resource page. We ask that you use your networks to help us share this information as widely as possible.

If anyone has any questions or comments, you can feel free to contact me or the New Jersey FamilyCare Autism Benefit Inquiry Help Line. And we can provide that information for you.

DR. SPITALNIK: Thank you so much, Shanique.

Any comments or questions from members of the MAAC?

I would echo Shanique's request that people utilize their networks. And I think there's some very important distribution roots that given that this is online could be handled easily which was the Act Early Learn the Signs team which is funded by CDC, the Children's Community Care Consortium which is meeting in two weeks, and the programs of the Department of Children and Families. Certainly, the Children's System of Care, Perform Care, which serves as their care management, but also the Family Success Centers and other programs.

So thank you. And just in the spirit of full disclosure, the Boggs Center was able to use some

funding from the Administration on Community Living for the translation. So we're very grateful to Shanique and Steve Tunny for their efforts.

I think we are ready to move -- I'm apparently placed on mute. I'd like to welcome back Carol Grant, the Deputy Director of the Division, to give us an update on Cover All Kids.

Good morning, Carol.

MS. GRANT: Good morning. I just wanted to congratulate the Boggs Center's efforts and ours on the autism guide. I think it's an enormously important document. So I was involved in the very beginning, and I just wanted to tell you that I'm so glad to see it live.

Anyway, I'm here to talk about Cover All Kids. I am really very pleased to report that we continue to see growth and enrollment of kids. It's just under 2,000 in September, so we're very happy about that. But work continues for full implementation of Cover All Kids. Our systems build remains on track for January 2023 Go Live. When the Go Live is in place and the system is ready to roll, we'll be able to cover children who is income eligible but do not currently qualify for New Jersey FamilyCare due to their immigration status.

Our Cover All Kids Workgroup meetings continue, the most recent having taken place just yesterday.

Work is underway on Communications Strategy as we move into developing sort of a Phase 2 part of this endeavor.

We're working on a communications toolkit whose completion really is expected in the next 30 days. We're making recommendations from our task group to the full group, to the Division, and to the Department, with distribution to follow shortly thereafter. And that's where we are. We're moving straight ahead.

Next slide. We wanted to just give you an example of the number of outreach events that have been going on that delivers critical and key information about Medicaid and its programs and services. I believe this is almost 22 events. I think it reinforces the fact that we're out there, that there's no use in us doing good programs if we can't get the word out and get people to take advantage of them. So this is where we are and we're going to keep you abreast I think as there are events that we should be aware of that have people could tell us. We invite you to let us know.

And that's it, I think, for today for Cover All Kids.

DR. SPITALNIK: Carol, thank you so much.

Any comments or questions from any of the MAAC?

MS. ROBERTS: Yes. Hi, it's Bev Roberts. Thank you very much, Carol. I also wanted to say that I'm really delighted by the Autism Guide that was just discussed a few minutes ago. I'm really eager to be able to share the information. But with regard to what you said, Carol, this is very exciting, obviously. The comment and the question I have about Cover All Kids which is terrific is the coverage would probably end when they're not kids anymore. And in particular, there is a concern about -- and we haven't be able to cover them at this point -- people who are undocumented and need EDD services at 21. So when this is implemented, it will be great for them to be covered as kids. I just wanted to make a comment and ask if there would be a possibility or what the path would be for those kids who are undocumented but would meet the functional eligibility criteria for DDD services. But as you probably know, they have to have Medicaid or they have a green card. So if they have a green card, they're able to get some services, day program services. But we have not been able to provide anything at all for people who are undocumented, don't even have a green card. So I

just wanted to mention this, that it would be absolutely wonderful if there could be a way under the very unusual extenuating circumstances when someone does have an intellectual or developmental disability for them to be able to be covered into adulthood so they could get DDD services.

Thank you.

MS. GRANT: I think your concerns, Bev, are absolutely on the money. The thing is they're challenging but they are duly noted. And I think that's something we're going to have to consider as we go forward. I don't know that we have an answer today.

MS. ROBERTS: No, I didn't expect an answer, but I just wanted to put it on the record.

MS. GRANT: You've put a plug in, and we heard it.

MS. ROBERTS: Thank you very much.

DR. SPITALNIK: Thank you, Bev.

Other comments or questions from members of the MAAC?

Hearing or seeing none, I'll thank you, Carol.

And we turn back to Jennifer Langer Jacobs and Greg Woods to speak with us about the end of the Federal Public Health Emergency. Jen and Greg.

MR. WOODS: Thanks, Dr. Spitalnik. I think I'm going to start this off and then I'm going to hand off to Jen for the second part of this topic.

You may be sick of hearing us talking about this and it's part of sort of the never-ending pandemic that we're still talking about it, but I did just want to take a minute before we dive into some details and level set on what we're talking about here. Just as a reminder, the COVID-19 Federal Public Health Emergency, or PHE for short, was declared by the Federal Secretary of Health and Human Services way back in March of 2020 when the pandemic began. This is an authority that the Federal HHS Secretary has to declare a public health emergency. And then critically shortly thereafter there was federal legislation enacted that, in effect, said so long as the federal government says a PHE remains in place, Medicaid members who have coverage would keep that Medicaid coverage even if they experience changes in circumstance that would in ordinary times have resulted in them losing coverage, such as changes in income, such that they're over the income threshold. But those members would remain enrolled and would remain enrolled as long as the PHE continued. And so for the last 2 and a half years, that has remained the status quo. We have now had multiple HHS secretaries who have

extended the Public Health Emergency numerous times. And as we speak today, it remains in place.

The most recent extension took place a couple of weeks ago earlier this month, and that extension extended the Public Health Emergency an additional 90 days until mid-January of next year.

The federal government has promised that states will be given at least -- and the public will be given at least 60 days' notice before the Public Health Emergency ends. So right now we were extended through the middle of January. I think, given that the federal government has made that 60-day promise, we should know by November whether that will actually be the end of the Public Health Emergency in January or whether we should expect yet another extension. And I will just note that based on what we are hearing, it appears to be a live possibility that the PHE may actually end in January. But I'll also acknowledge that this is not the first time we have thought that it's a live possibility. And, obviously, in previous instances, the Public Health Emergency did not, in fact, end. So I think what we can just say is we just genuinely don't know, but our approach has been to remain prepared for all eventualities. So that's where we are in terms of federal Public Health Emergency.

As we've discussed with the MAAC before, once the PHE does end, per federal guidance, we will have 12 months to reprocess eligibility for all of our more than 2 million members. And just to reemphasize, all members will individually have their eligibility reassessed after the PHE ends so everyone will go through a redetermination process to confirm whether they are eligible before anyone's coverage would potentially end. Needless to say, this is a major undertaking and we are intensively preparing for this across several different fronts.

So I'm going to take a minute today. I'm going to talk through some of our thinking around the timeline and the logistics of that massive effort to redetermine the eligibility of all of our members over that 12-month period and then I'm going to hand it back to Jen who is going to talk about some of our outreach and messaging efforts in this space.

So if we could go to the next slide. So this is an updated version of a slide that we shared with the MAAC before. This is showing a hypothetical timeline of how the unwinding period would look if the PHE did, in fact, end in January, which, again, we don't know whether it will or not. But if that were the case, as I said before, we would expect that the federal

government would let us know that the PHE was ending in November. We would then sort of press go, actively ramp up, and we would expect the first post-PHE member renewal mailings to go into the mail in February of next year, in February of 2023, so the month after the Public Health Emergency ends. I think the first date that we would expect to see any significant disenrollments from members who received their packets in February and were no longer eligible would be April because members would have time to respond to that and there's sort of a 2-month cycle that typically plays out. So that would be the earliest date where you would see meaningful disenrollment.

All through the rest of -- again, in this scenario, all through the rest of calendar year 2023, renewal mailings would continue to go out. They would be spaced evenly across the year -- and I'm going to talk about that in some more detail in just a moment -- and they would finish going out 12 months later. So in this scenario, that would mean January of 2024. And then there would be a couple of more months again because there's a couple month process once a renewal package goes out where we would need to process and review, but nearly all determinations initiated under the unwinding period we would expect in this scenario

would be complete by the end of March of 2024. So again, this is a hypothetical timeline. It's based on if the PHE ends in January. If that's not the case, if it doesn't happen then and it gets pushed back further, the timeline would look broadly similar, but all of the dates that I just talked through would be pushed back further.

So now I do want to turn to how we're planning to sequence the redeterminations and importantly how to spread them evenly over the 12-month period after the end of the Public Health Emergency. We've attempted here to strike a thoughtful balance in order to carefully manage the bandwidth of our eligibility workers, both county workers and at our enrollment vendor and ensure that all of our members have the opportunity to complete the eligibility renewal process. So there are a few key elements here. I will note this is a little technical. I wanted to give some transparency into what we're thinking here. So forgive me for diving a little bit into the weeds just a moment.

First, one key element. For members who have successfully demonstrated their eligibility in the 12 months before the end of the PHE, so this could be either members who first enrolled in Medicaid for the first time in the last 12 months prior to the end of the

PHE, or those who had successfully completed a renewal during that period. They will stay on their normal timeline. So, for instance, if a member first applied and was determined to be eligible in July of 2022 and then if the PHE does, in fact, end in January of 2023, that member stays on their normal 12-month cycle. They would renew in July of 2023, 12 months after their initial application just as would have been the case absent the Public Health Emergency. The same situation would apply if a member successfully completed a renewal in July of 2022. So for members who are on track in that way, nothing is going to change. They're going to keep their renewal dates.

Second, for all of our remaining members -- so, for instance, this encompasses a couple of different groups. These could be members who haven't responded to our renewal request during the Public Health Emergency. It could also be members who have responded but at the time they responded were found to be over income or otherwise no longer meet eligibility criteria. We will be spreading those members evenly across the 12 months of the post-PHE period. So each month will account for one-twelfth of the renewals so as to be really intentional and not overload our eligibility workers.

And when I say they will be spread evenly, I

just want to note this means not only that we will spread them evenly in the aggregate across the state, though that will be true; but also that we will spread them evenly within each county and within our enrollment vendor.

In addition to that, we will also be pulling out extra focus groups -- and these are shown on the right side of this slide -- that we expect may require extra effort and attention from eligibility staff. And we're going to make sure that those cases as well within each county or within our enrollment vendor are evenly distributed across the year. So we're slicing this a bunch of different ways really to make sure we have the bandwidth to address all of the cases that we need to renew.

So just to talk to you very quickly, those special focus groups, I'm just going to run through them. One, one focus group is members who receive services from the Division of Developmental Disabilities and we know there are -- this is to address the special needs of that population and intended also to allow for even spacing for our DDD care coordinator as well as eligibility staff who will assist with that process.

Another special focus group is other members who qualified on Medicaid on the basis of age or

disability, and that's several discreet eligibility groups. As many of you will know, those redeterminations, there may be more complex eligibility rules. It may involve looking at assets or resources and may require extra time or effort to complete. So that's going to be a focus group where we're going to make sure that those cases are distributed evenly.

A third focus group is members who have turned 65 or otherwise qualified for Medicare on the basis of disability during the Public Health Emergency. Again, there's some more complexity here because often when a member becomes eligible -- when one of our members becomes eligible for Medicare, they may no longer qualify for Medicaid under the eligibility category they were in previously, but they may qualify under a new category or they also may qualify for what's known as a Medicare Savings Program which offers a more limited set of benefits around -- assuming some of the Medicare cost-sharing responsibilities. So that's another group where we expect there's more complexity and we're going to pull them out and make sure they're evenly distributed.

And then our last special focus group is members who have not received any Medicaid services in the six months leading up to the end of the PHE. That

can mean a number of things but, in general, we're expecting those members may be more challenging to contact and maybe less responsive to our initial outreach. So that's a lot of detail I know. I know that not everyone may want to follow all of that nuance, but I think the main takeaway I would want everyone to take from this is that in spreading member redeterminations, we are really doing our best to spread not just the number of members but the work even across the 12 months. We know this redetermine process is going to be on a larger scale than anything we've done before. And to make sure we have the bandwidth and we're able to keep that moving in a timely way, we're really planning to slice our members several different ways very intentionally, by county, by eligibility group. And, again, the end goal is to ensure the system doesn't become overwhelmed and that we are able to manage the unprecedented volume of renewals that we're expecting.

Then lastly, and this is tying back to something that Jen mentioned earlier but I just want to reiterate here and just to add a bit more complexity, so I'm sorry for that. There's one group of members for whom everything I just said does not apply, and those are the 6,000 members who are currently enrolled in the

WorkAbility program. For those members, we are going to push renewals, as Jen said, to the last three months of the 12-month unwinding period. And, again, that's to ensure that we have time to fully implement the changes associated with S3455, the legislation which expands eligibility for WorkAbility and that until those new eligibility rules are fully in place, we won't complete those redeterminations for members in WorkAbility. So that's one small but very important exception to the general process that I just discussed.

So with that, I think I'm going to hand off to Jen who's going to talk a little bit about some of the outreach and messaging that we've been doing around the end of the Public Health Emergency.

DR. SPITALNIK: Greg, can I just add? When you're talking focus groups, you're talking about the groups you're focusing on, not that you're planning focus groups. Is that correct?

MR. WOODS: That is correct. We are not planning any particular focus groups. And I would say, just to be clear, we are focusing -- we view all of our redeterminations as important. When I say focus groups, I think what we mean there is groups that expect or will require extra focus or attention or complexity when we're doing the redeterminations so that we wanted to

pull out and treat differently.

DR. SPITALNIK: Thank you. And I appreciate your ability to make this complexity accessible to us. Thank you.

Jen.

MS. JACOBS: Thanks, Greg. And thanks, Dr. Spitalnik. I want to pause for a minute and say I have been increasingly struck by the experience of moving around in the world again without a mask. Not every time. Sometimes I'm still wearing my mask and I know sometimes many of you are still wearing your masks. But it certainly feels like we have reached a new chapter in this thing and that, of course, is joyful and also feels sort of deeply meaningful in lots of ways.

Hearing Greg talk through a minute ago, I sort of took a step back from all the work that we've been doing to reflect on that in the same way. And I do want to point out everything changed in March of 2020. The work that we needed to do around the pandemic in 2020 originally, obviously, the shutdowns that were occurring and concerns about impact disruptions for our members; 2021 rollout of vaccine strategy where we wanted to make sure that our members had access to those vaccines equitably with other New Jersey residents; and now preparing for the end of the PHE. This thing has

been an enormous project for our team, requiring all of this intellectual effort that you heard Greg, a piece of which you heard Greg describing here. And I am excited that as a human being in the world, I get to walk around without my mask more. I get to see people and hug them again. I am also struck that here at Medicaid, we still have one very intense chapter left in our pandemic life, and that is this unwinding process. So what Greg described to you is just a glimpse of all of the work that's going on on our team among our eligibility policy leaders and all of the people who are involved in processing Medicaid eligibility being prepared for what's coming soon, having our systems significantly updated since the start of the PHE all throughout this period, our legal team deeply engaged to make sure that we're doing this correctly in the first place, and also that our members have all of the rights that are afforded to them under the program, our managed care oversight team making sure that we're working closely with our MCO partners, lots of clinicians really paying a lot of attention to making sure that the flexibilities that we accessed during the Public Health Emergency are properly transitioned. So it really has been a tremendous exercise for this organization, one that folks have rallied around. And as I feel that relief as

a human that we're coming out of the pandemic period and we can theoretically put a lot of that behind us, I'm also just acknowledging the tremendous level of effort that is still going on inside this organization to make sure that we are implementing this last phase the best way possible. So just a great "thank you" to my team and all of our partners in the community.

I want to talk a little bit here about the community engagement and the help that we need from you all to make sure that New Jersey does this the best way possible. We have prepared for you and for our members materials that provide information about the end of the Public Health Emergency, and we're hoping that you will help us get that last word out during this last chapter of the pandemic.

We have talked to you before, certainly in July, and to many of you in between about key messages. They are here on the page. The first message is make sure that we have your updated contact information. That's really important for mail that might be coming to your house related to redetermination of eligibility. And then second, when that mail comes to your house, we need you to pay attention to it, make sure to reply on time so we don't end up with any kind of gap of coverage for folks who remain eligible.

I have emphasized before to you and I want to say it again because I noticed it last night, I am number one guilty of having unopened mail on my kitchen table. And so I see this as just a characteristic of human beings, and we need to be mindful about it in this process that we need folks to watch for that mail and reply to that mail so that we can make sure we complete that redetermination for them.

We have sent out the materials we've prepared on paper to 6,000 community organizations during this month of October. That was a large project that folks were working on within our team, and we're excited that it's out the door. We also have a live landing page, Stay Covered NJ, and we're hoping that you will go there and visit. So I want to take you on a little virtual ride so you can get a sense of what that page looks like.

This is a new format, so if you were to look at our DMAHS website, we are in an older format. Other divisions within the Department of Human Services have moved their websites over to this new format. So Stay Covered NJ is our first go at the new format that will eventually be moving all pages. We're excited about that because it brings us some functionality, and it's just more user-friendly than the old format. So we're

real excited about this. You're seeing here the scrollers that are visible on that website. The blue bar gives you some navigation options. And then on the right, if you have your phone handy, you can scan that QR code and it will take you right to our website which looks as nice on the phone as it does on the screen.

On this site, if you see the yellow circle on this page -- that is not a circle. If you see the yellow ellipse on this page, there's a translation function that's available on this site like other DHS sites that operate on this platform. And we also have PDF versions of our communications around the unwinding which have been translated into all the languages you see in the drop-down menu here. So a huge thanks to the team that made sure this got done so that we could communicate across our communities the best way possible.

And here's an example of what some of those communications look like. We have 21 languages in PDF available on the Stay Covered NJ site. So we hope that you will visit and tap into those translations so that we're sure we're getting the word out to all of the people that we serve regardless of the language that they are speaking at home.

And then finally, we are also live on social

media, and we hope that you will join us there. We're looking to make sure that we're spreading the message. And so if you can follow us on social, we hope that you will re-share our messages to the communities that you serve. And here, you have the QR codes for each. Pick your social media for each of the social media feeds from the Department of Human Services. I think our first round of unwinding posts, Sam Krause came out yesterday. Many thanks to you and central office team for getting those out on social, and we will continue to keep folks updated as new materials are developed. And then to the point that Greg was discussing earlier, once we know the end date for the Public Health Emergency formally coming to a conclusion, obviously, that's when communication becomes all the more important, and we'll be evolving our messages appropriately, obviously. So Please join us out there in the world of social media and continue to stay involved with us as a community ambassador. Take a good look at the website that we've shared, Stay Covered NJ, where you'll find all those materials.

DR. SPITALNIK: Jen and Greg, thank you so much. I think it should be noted that this is probably the first time in New Jersey history "Join us on social media" related to Medicaid has been uttered publicly.

So we're at a new pivotal point in history. And thank you so much, and we appreciate that this is, as they say, a moving target in terms of decisions being made by the federal government.

With that, I want to call on Theresa Edelstein who has point, Mary Coogan, in that order. Please unmute and make your comments or ask questions.

MS. EDELSTEIN: Thanks very much. Jen, thank you for all this information. The website looks great.

Just a quick question. In the 6,000 or so mailings that went out, were hospitals included in that mailing? And if not, can they be? And I guess I would have the same question about any other institutional providers that have Medicaid enrollees in their seating.

MS. JACOB: Yes, thanks, Theresa. I know we have hospitals on our list for mailing. I don't know if they were including in the first 6,000, but I can certainly find out from the team where we are with them.

DR. SPITALNIK: I'd also encourage you to reach out to the Department of Health's programs, the WIC Program, Early Intervention, and other services. And WIC, I know with DFD.

Mary Coogan, please.

MS. COOGAN: Thank you, Dr. Spitalnik.

First of all, this is terrific. I mean, the materials look very vibrant. Clearly, a lot of time was spent. Thank you for all translations. And I know people are anxious as to when all this is going to actually roll out.

Also, I think, Dr. Spitalnik, you should acknowledge that Medicare is using QR codes which would be a first in the history.

MS. JACOBS: Are we cool? We hired cool people to do that for us because Greg and I aren't that cool.

DR. SPITALNIK: We always thought you were cool.

MS. COOGAN: In terms of the materials, so if somebody wants to get, like, posters or flyers or something, is the Department going to be printing those? Or are people expected to sort of download them and them go get stuff printed? How is that working?

MS. JACOBS: You can do it either way. So you can download them straight off the site, but there is also a "contact us" button and you can request copies of the materials that way.

And I just want to come back to Theresa's question real quick because I realized one of the advantages of Zoom is I am sitting at my desk and I can

see things that are on my desk. So, Theresa, we did include long-term care providers in that mailing, lots of child care centers, ESL adult classes, some contacts through our Office of New Americans. Dr. Spitalnik family planning centers, family success centers, food pantries, immigration advocacy organizations, laundromats and libraries, local Departments of Health, and WIC locations. So that was that first round of 6,000, and we will greatly appreciate your feedback as we're continuing additional rounds including providers.

DR. SPITALNIK: Thanks, Mary.

Thanks, Jen.

Beverly.

MS. ROBERTS: Thank you. I just want to add my appreciation to Jen and Greg for all the work that's been done and for the presentation this morning. And there were 2 points I wanted to bring up.

The first is when the PHE ends and the renewal packets are sent out, is there a plan to use a brightly colored envelope, orange or blue or something with something printed on it that says "Important" in capital letters? Because when we do our advocacy, if we know it's going to be a bright blue envelope, we can say, "Please be on the lookout for this bright blue envelope, it's going to be really important." So if

that can be done, I think that would be helpful for people.

MS. JACOBS: Yes. In fact, we intended to share with you today a visual of the envelope that we have planned, but we had a slight change. One of the interesting aspect of this whole experience has been a nationwide paper shortage. So the availability of colored paper has not been quite as reliable as you would like it to be. We want to make sure that we nail down exactly what the envelope is going to look like. The current plan, though, is to have bold letters that say, "Renewal enclosed," so that it's clear what's inside that envelope without, obviously, sharing anything that's HIPAA protected.

MS. ROBERTS: Thank you.

And then my second point has to do with the training of the staff at all the Medicaid offices. And I know there has been training that's been ongoing. I also know there's a lot of new staff. So especially leading up to when this is going to happen, and obviously, as you know, I'm concerned about folks that get DDD services, but more broadly even for the entire ABD population who might have more issues than other people for the staff training to be ongoing, repeat, repeat, repeat. Just as an example of something that I

know has happened in the past. I haven't heard about it recently, but I had heard in the past. So when staff at the local Medicaid office didn't really know about the DDD waiver unit which has the higher income. And they saw somebody come in who they wanted to try to help, they really wanted to help, they didn't know DDD waiver unit so they were going to try to get them approved under MLTSS, which shows a good heart, but it also shows that they don't know what they should be doing. And if, in fact, the person did get approved for MLTSS, then they couldn't have DDD services because you cannot have both simultaneously. So there were times where there are good intentions but lack of knowledge ended up causing more problems. So, again, for that training to be ongoing as much as possible. Thanks.

MS. JACOBS: Thank you, Bev.

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

Anything else in summary, either Jen or Greg, that you want to add about the Public Health Emergency?

MR. WOODS: I did see one thing in the Q&A, and we can follow up. There's a question about online versus mail redeterminations. And, Jen, you might want to speak to this also. But I would just say we're

looking to maximize the number of different ways that people can successfully renew and we expect that there will be both online and mail opportunities. And that's something we can provide some more detail on in a future meeting but did just want to acknowledge that point, and that's something we very much planned for.

DR. SPITALNIK: Thank you so much.

Our next and final agenda item is planning for our next meeting, which is January 25, 2023. I think we can stop the screen-sharing with slides and bring everybody on the MAAC back to the gallery view. And I want to acknowledge Sherl Brand perseverance in being on the phone so she's not visible. So if MAAC members, I would ask you to unmute your video so people can see.

And it is our custom at the end of every meeting to review the -- well, first, I'll ask generally, are there any comments or statements that anyone on the MAAC would like to make at this time? If so, I would ask you just to unmute and make comments.

MS. EDELSTEIN: Dr. Spitalnik, it's Theresa Edelstein.

Just a quick question. I know the virtual listening session on the budget is coming up next week. Does the Department have any specific comments about the

Fiscal '24 budget, areas of priority or focus that they'd like to comment on at this point?

DR. SPITALNIK: I would turn to the Department and whether you'd like to decline at this time or --

MS. JACOBS: I think our focus for next week is really listening, and so we don't have any messages to share at this time. Our intention is to hear what our stakeholders are telling us that day.

DR. SPITALNIK: Thank you, Theresa.

Thank you, Jen.

Any other general comments?

So let's turn to planning for our next meeting. We enter a new calendar year, and I'll just review, and this will also be on the website as the PowerPoint is, that our meetings next year in 2023 are scheduled for Wednesday, January 25th; Wednesday, April 26th; Wednesday, July 19th, and Wednesday, October 25th, 363 days from today. But our immediate planning is for our next meeting, and I will reiterate what I have garnered from our conversation, which is certainly not complete, but go through it.

Even though it was the last item, we'll, as we say as in the disability field, backward chain, and say that the Public Health Emergency and ending of that

would be one of the first items which also is germane to enrollment.

The issues in WorkAbility implementation remain a front-and-center concern. And we would ask that you consider their suggestion of engaging the community in developing a person-directed communication strategy around the decisions and eligibility and people being able to join WorkAbility.

Under the Home and Community Based Settings Rule, there were questions on individuals' rights and role.

And under Cover All Kids, I think there were questions around adulthood, which are beyond what can be described.

From the MAAC members or the members of the Division, what other things would we like to raise?

Mary, please unmute.

MS. COOGAN: I'm thinking we could get an update on the Waiver Renewal, the 1115, because that should be approved by then and that would be January so that probably would work well.

And then also the behavioral health analysis that had to get postponed, can we put that on for the next agenda, the next meeting?

DR. SPITALNIK: Thank you.

Other items?

Beverly, are you unmuted to comment?

MS. COOGAN: I unmuted, but Mary beat me to it.

DR. SPITALNIK: Very Rogerian.

Other comments or questions?

Again, I want to reiterate that the slides are posted on the Division's website. There is a transcript that is made of the meeting which the basis by which we approve minutes. And I want to thank --

MR. VIVIAN: Dr. Spitalnik, I hate to interrupt. I'm sorry for interrupting.

DR. SPITALNIK: You're not interrupting. You're not interrupting.

MR. VIVIAN: I didn't unmute fast enough.

I had raised at the last meeting about abortion and who would pay; even though it's accessible, who would actually pay for consumers. We have mental health consumers that do get pregnant. And many people with disabilities get pregnant. And, unfortunately, they have to make decisions. And I don't know what Medicaid's plans are regarding, like, paying for somebody for an abortion in New Jersey. So maybe that could be on the agenda.

MS. JACOBS: I can answer that question for

you, Wayne, and I'll be happy to follow up with you. We do cover abortion in New Jersey. We cover it with state-only dollars, but nothing has changed in our policy.

MR. VIVIAN: Okay, great. Because like I said, unfortunately, we do have people who do get pregnant. And it has been an issue.

MS. JACOBS: We want people to have access to the care they need, right?

MR. VIVIAN: Exactly. For them to make their own decisions, of course.

MS. JACOBS: Thanks, Wayne.

DR. SPITALNIK: Thank you for bringing that up.

Are there other comments? And I hope I didn't ride roughshod over anyone's interest in raising anything. And I thank people for their body language. It's a hard medium to ensure that we're all in touch.

As I said, the PowerPoints are posted. The dates for our next meeting in January, January 25th, is posted and the rest of the year so you can plan accordingly.

I want to thank everyone in the Division of Medical Assistance and Health Services for the effort that so many different programs provide to making sure

that we have this information available to the public.

And in addition to moving into the 21st Century and even further than social media and QR codes, I am pleased to announce that we are ending 17 minutes early. So I'm thinking of that as another contribution to public health and wellbeing.

We wish everybody good health, safe holidays, and look forward to seeing you in the new year. And to Jennifer Langer Jacobs and Greg Woods, Carol Grant, Shanique McGowan, Joe Bongiovanni, thank you all for your presentations. And to the 244 people who joined us this morning, thank you so much. Be we will everyone, and we'll look forward to seeing you in the new year. Thank you.

(Meeting adjourned at 11:43 a.m.)

CERTIFICATION

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

Lisa C. Bradley

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The Scribe