MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

Via Zoom Videoconference
January 27, 2022
10:00 a.m.
FINAL
MEETING SUMMARY

MEMBERS PRESENT:

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

MEMBERS NOT PRESENT:

Dot Libman

ALSO PRESENT:

Jennifer Langer Jacobs, Acting Commissioner
Greg Woods, Chief Innovation Officer,
Division of Medical Assistance & Health Services

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

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, the Chair of the Medical Assistance Advisory Council (MAAC), and it is my pleasure to welcome you to our first meeting of 2022. Today is January 27th. In keeping with the New Jersey Open Public Meetings Act, notice has been posted of this meeting as well as the meetings for the rest of calendar year 2022. We will convene again on Thursday, April 28, 2022; Thursday, July 28, 2022; and Thursday, October 27, 2022.

What I will now do is first ask the members of the MAAC to unmute themselves. I'll just call three names, and then just please go in sequence and, of course, our leadership from the Division of Medical Assistance and Health Services (DMAHS). I will then review the agenda. And so I turn to our colleagues and members, Mary Pat, Chrissy, Mary Coogan, would you start us off, please?

MS. ANGELINI: Good morning everyone, Mary Pat Angelini, I'm the CEO of Preferred Behavioral Health Group and former Assemblywoman.

DR. SPITALNIK: Thank you.

MS. COOGAN: Good morning. Mary Coogan, I'm with Advocates for Children of New Jersey.

DR. SPITALNIK: Chrissy.

MS. BUTEAS: Good morning. I'm Chrissy Buteas with NJBIA (New Jersey Business and Industry Association).

DR. SPITALNIK: Thank you.

Theresa, Beverly, and Wayne.

MS. EDELSTEIN: Thanks, Dr. Spitalnik. Good morning. Theresa Edelstein, Senior Vice President at the New Jersey Hospital Association.

DR. SPITALNIK: Thank you.

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

MR. VIVIAN: Good morning, everyone. My name is Wayne Vivian. I'm President of the New Jersey Coalition of Mental Health Consumer Organizations.

DR. SPITALNIK: Has anyone else joined us?

MS. BRAND: Hi, Deborah, it's Sherl Brand.

DR. SPITALNIK: Sherl, welcome.

MS. BRAND: Good morning, everyone. Again, my name is Sherl Brand. I'm Senior Vice President of CareCentrix, and I am also a registered nurse.

DR. SPITALNIK: Thank you.

Anyone else?

Welcome to all the members and welcome, of course, to our stakeholders and members of the public.

The way that we have proceeded within this

virtual environment is that the MAAC members, after presentation, can unmute and ask a question. If members of the public would like to pose a question, you can put that in the Question and Answer box at the bottom of your screen. And if it's not something that can be responded to, I want to assure everyone that all of those questions are gathered at the end of the meeting for DMAHS.

I want to review our agenda for today and we will be able to move to approval of the minutes. We will have an NJ FamilyCare updates, federal policy implementation report, COVID-19 updates, a wrap-up and a retrospective look at 2021 as we look forward this year. And in that spirit, we will be planning for the next meeting at the end of the meeting.

I do want to acknowledge a public comment that came from the New Jersey Independent Living Council that has asked the MAAC to speak to and address, the implementation of new legislation that changes some aspects of the WorkAbility Program. I have referred that to DMAHS, and the MAAC members will all receive a copy of that right after this meeting, and then we will ensure that it's on the agenda to whatever extent it can be elaborated at our next meeting. And I want to thank Norm Smith as Chair of

the State Independent Living Council and all their members for raising this important issue.

I have the delightful duty -- and I think we all share this -- to congratulate Sarah Adelman, who has been Acting Commissioner of the Department of Human Services; and Governor Murphy this week announced his intention to nominate her as Commissioner. We are so appreciative of everything she did in her role as Deputy and in assuming a year ago the tremendous responsibility. So congratulations, and we lookforward to congratulating her in person.

With that, I will move to the approval of the minutes, and I will ask the MAAC members if there are any additions, corrections, or if I may have a motion to approve the minutes, a second, and then I'll ask for a vote.

Members, please unmute if you can speak to that.

MS. ANGELINI: This is Mary Pat Angelini. I move to accept the minutes, as presented.

DR. SPITALNIK: Thank you. Is there a second?

MS. BRAND: Sherl Brand. I second.

DR. SPITALNIK: Ask for "no" votes?

Hearing none.

Abstentions?
Hearing none.
The minutes are approved.
Thank you, colleagues. Thank you, Phyllis Melendez for overseeing that process and to Lisa Bradley who's been so important as well the other DMAHS staff.
We now turn to the substantive portions of our meeting. And I am delighted to introduce Greg Woods. Greg is the Chief Innovation Officer of the Division of Medical Assistance and Health Services. His run of presentations will start with NJ FamilyCare updates. We'll take questions at the end of that update before we move into his other presentations.
Welcome and good morning, Greg.
MR. WOODS: Thank you, Dr. Spitalnik. And good morning, everyone.
So I wanted to start by briefly providing our usual update on NJ FamilyCare enrollment. And this is a graph that I think will be familiar to those of you who have been on previous MAAC meetings; we've shown a version of this several times, but did want to just provide an update.
As the graph that you see shows, our

enrollment has continued to increase. We are as of December, which is the last full month, at around 2.08 million total members. This represents a continuation of the trend that we've seen throughout the COVID-19 Public Health Emergency, with perhaps a mild slowing in the rate growth or deceleration over time.
As I've mentioned at previous MAAC meetings, it's somewhat difficult to entangle exactly what's driving this growth upwards. There are a number of factors, both having to do with policy and program and also some underlying circumstances, economic and other circumstances in the world. That said, our best analysis is that this is primarily driven by the federal requirements that we maintain continuous enrollment of members during the Public Health Emergency. And as a reminder, what that means is that in the vast, vast majority of cases during the Federal Public Health Emergency which is ongoing, individuals are not losing coverage even if they no longer meet Medicaid eligibility criteria. So what that means is that in addition to new members continuing to enroll, as they always do each month, we are keeping the vast majority of our existing members; and the combination of those two facts leads to sustained program growth.

As I mentioned, we are still under a Federal Public Health Emergency. The federal government recently extended that. When the Federal Public Health Emergency ends we would expect this growth trend to probably begin reversing itself. However, as with all things pandemic, there's a lot of uncertainty here so that's a bit speculative, but that would be our expectation.
I'll stop there. I know, Dr. Spitalnik, you wanted to do some questions here before we moved on to the next section of the presentation.
DR. SPITALNIK: Thank you so much and thank you for this graphic; it's very helpful. Do any of the members of the MAAC have questions or comments about the enrollment update?
Hearing none and seeing none in the chat, thank you.
Greg, I'll turn to you for federal policy implementation presentation.
And I should have said at the beginning, but I just want to remind everyone that after the meeting, the slide presentation is posted on the DMAHS website at: https://www.state.nj.us/humanservices/dmahs/boards/maac/. Thank you.
Greg.

MR. WOODS: Thank you.
So turning now to federal policy implementation, I want to talk for a few minutes first about our Section 1115 Demonstration Renewal.
As a reminder, our comprehensive Section 1115 Demonstration, this is what gives us authority from the federal government to operate various parts of our program. That demonstration, our current performance period, our current approval ends in June. It's scheduled to expire. So we are currently working on renewal. As a reminder, and we talked about this at previous MAAC meetings, we had posted a comprehensive draft proposal on our website in September for public comment, and I think the link to that is both on the slide and I think is now in the chat. We had received a really robust response on that. So we received approximately 120 written public comments on that draft. We also held two public hearings during the fall where we presented on key elements of the renewal proposal, one of which was a special meeting of the MAAC, and then we also had an additional public hearing. And during those meetings, in addition to the written feedback, we also received extensive verbal feedback from members of the public.
So as a reminder, just to reorient you, as

part of this presentation, we had identified some of the major themes of our demonstration renewal. I'm just going to quickly touch on a couple of those.

One, just maintaining momentum on our existing demonstration elements, which includes various refinements and updates to existing program elements. Number two, expanding our ability to serve the whole person. And in particular here, we're focusing on integration of physical and behavioral health needs and addressing the social determinants of health with a particular focus on housing-related issues. And number three, serving our community the best way possible, which includes addressing access, quality of maternity care, and more broadly addressing inequities in access and outcomes among our beneficiaries with particular focus on historically marginalized or otherwise vulnerable communities.

So having received comments both in writing and verbally on our draft proposal, our next step is to submit our final renewal application to our federal partners at the Centers for Medicare and Medicaid Services (CMS). This final submission is undergoing the final stages of review. We had hoped it would have been submitted by today's meeting. We're not quite there yet, however, I think we are very, very close, so

please stay tuned on that front.

Once we submit and our federal partners confirm that our submission is complete meets all of their requirements, there will be a second public comment period. And this is what they call a federal public comment period. The first one was a state public comment period. So before, we were requesting members of the public to comment on our draft proposal before we finalized it, so it comes to us as the State. The second public comment period gives the public the opportunity to come to the federal government now, having received our proposal, things they should consider as they review it and move towards approval. So that will be coming up.

So with all of that context, I did want to talk about what to expect in the final submitted proposal. As I said, we're not quite ready, unfortunately, to share the proposal today, but I did want to preview some of the key things that we would expect to include.

Before I get to the substance, I do want to start by noting that we expect that our final proposal will include detailed summaries of the public comments we received and, importantly, our responses to those comments. This would be towards the end of the

proposal. It's a long document, I know, but when it is posted, please just scroll down. I want to make sure that everyone who did comment takes the time to actually look at those responses.

I just want to say, we got a tremendous amount of helpful feedback from stakeholders and from the public. And we spent much of the last several months really looking at that feedback closely, thinking through the comments, and in many cases either updating or at least clarifying our proposal in response to those comments. So we really do encourage you to look closely at our responses because we take these comments very seriously, and I think reading our responses will give you a good sense about how we're thinking about some of the major issues. Even in cases where we may have not made a specific change to our proposal, I think it really provides valuable information about how we're thinking about those areas moving forward.

So I also want to say that most of the core elements of our draft proposal we expect will be retained in our final proposal. As I said, we got many, many helpful comments, and we've updated the proposal in a bunch of different ways. But we do think the basic bones of what we're submitting are going tobe

similar to the draft proposals that we shared in September, the core things that we want to pursue again, you know, finding and improving existing programs, innovating and addressing housing and other determinants of health, integrating behavioral and physical health, improving access and quality of maternity care, addressing disparities. These things are still there, they're still our priorities, they're still in our proposal so I think the core approach that there is continuity from what we could share previously. With that general background, though, I want to give you a couple of changes that we do expect in the final proposal.

First, the proposal will be updated to reflect the fact that since September, we have received, and when we posted the draft, we have received federal approval for the extension of coverage for pregnant members to 12 months postpartum. This is something I know we've talked about a couple of times before at the MAAC. That was already part of our draft proposal, but we have reframed it since it's now no longer a new thing, but it's something that we have approval for today that we're looking to extend; and we've also changed it a bit to align with exactly what our federal partners at CMS approved back in October.

So the basic thrust there is the same, but that is a significant update to reflect events that have taken place in September.

Second, and this is a new thing that I don't think was discussed before, we are planning to introduce a new element to our proposal. And this is in direct response to multiple comments and very helpful comments that we received. And that's to propose to our federal partners that we extend 12 months of continuous eligibility to certain other adults beyond pregnant individuals. As some of you will probably know, we already have continuous eligibility in our program for children. And then as part of what was approved a couple of months ago by our federal partners, we now have continuous eligibility for pregnant members. So this proposal would go beyond that and also expand that continuous eligibility if approved; it would expand it to other groups of adults. And, obviously, once we've posted a proposal, we'll be more specific about who would be affected. But our hope is that this policy would result in greater predictability that once affected are enrolled they would have guaranteed continuous coverage for the next 12 months. We hope that would improve access for those affected groups and reduce churn in and out of the

program. And that's, again, in direct response to some comments that we received that were very helpful.

A third thing I wanted to flag, one question or concern we got from several different commenters was around our proposals on housing, specifically, how our proposal -- which, as a reminder, our draft proposal incorporate housing-related benefits into our managed care package of benefits -- how that would interact with the work that's already being done in that space by community-based organizations, by those already on the ground doing housing-related work. And I want to say it was never our intent that under our proposal that Managed Care Organizations(MCOs) would duplicate or supplant existing activities that are already taking place in our communities. The intent really was that our MCOs would support and facilitate access to housing-related services for their members, relying heavily on those existing resources and organizations. So really supporting, supplanting, but not in any way duplicating or replacing what already exists. And we got several comments, and so I think we took that as a signal there was some -- we could have made that point more clearly and really made sure our proposal reflected that. So we've made a number of changes in that section of the proposal to really reinforce that

point. We're looking to supplant and support what's already there. We're not looking to replace it or to shift it from existing organizations to our managed care plans.

So those are a few previews, but I do want to say that's not a comprehensive list. There are a number of other changes and clarifications we're working on. So I appreciate everyone's patience. Once we have submitted our final proposal to CMS, that will all be public, and we would encourage everyone to really take a close look both at the changes we've made to the main body of our proposal and also, again, to those common responses. So please stay tuned on that. And, again, we do appreciate your patience.

DR. SPITALNIK: Thank you so much, Greg. And I know the intensity of that work in terms of each comment.

At this point, does anyone have a question or a comment to Greg within the parameters that the proposal can be spoken to at this point prior to CMS's approval?

MS. ROBERTS: A very quick question. Greg, thank you so much. And I understand that you're not able to go into great detail --

DR. SPITALNIK: Beverly Roberts.

MS. ROBERTS: Thank you.

So, Greg, clearly, you didn't want to go into detail or couldn't go into detail at this point on the new proposal to implement 12 months of continuous eligibility. I would hope that people with disabilities would be part of this group. I don't know if you can make any further comment but, certainly, that would be wonderful if it is.

MR. WOODS: I don't know that we're prepared to comment on specific groups today. But we appreciate that feedback, and I think we can circle back with you once we have the final proposal out.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Thank you. Any other comments or questions at this point?

Seeing and hearing none, thank you for that, Greg. And we'll turn to the other policy issue, the American Rescue Plan.

MR. WOODS: Thank you. Thanks again, Dr. Spitalnik. So I am now going to turn a different topic. This is the enhanced funding for home and community-based services that we received under the American Rescue Plan. So just to orient everyone to this, and I know we've talked about this topic before as well with the MAAC, as a reminder, under the

American Rescue Plan (ARP), which was federal legislation enacted last year, that legislation provided enhanced federal funding to all state Medicaid programs for home and community-based services, but required as a condition of accepting that money that the State reinvest those dollars in strengthening or expanding services in this space. And so as part of the process of receiving those extra dollars, all states were required to submit a spend plan to CMS demonstrating that we were, in fact, reinvesting those dollars on appropriating Home and Community Based Services (HCBS) purposes and really expanding and strengthening our HCBS programs.

So as part of that process, we submitted a spend plan back in July for about $800 million worth of total investments over the next several years, and that spend plan is available on our website. I believe the link just got put in the chat, and it's also here in the slide when those are posted. So that is spend plan we sent to CMS in July of 2021.

In September of 2021, CMS came back to us and granted us partial approval for that spend plan, which is to say they approved many of the items that were included, but not everything. And for those that they didn't approve, they asked us for some additional

information or clarification. We then subsequently provided that and had a number of follow-up conversations with CMS.

We have actually just received about an hour ago some follow-up responses from CMS. It's not reflected in the slides that we have today and wasn't really reflected in our preparation for this meeting, and I will say that I, at least, have not had a chance to review that in detail yet. But based on a very quick glance, it looks like CMS is going to be approving some of the additional items that we are waiting for. I apologize that I don't have more detail on that. But as I said, that actually came in at 9 a.m. this morning. So that's good news. So I apologize this part of the presentation may be a bit obsolete, but once we have the opportunity to review what CMS has sent to us, we will provide more information on the details there and I also assume that CMS will put it up on their website at medicaid.gov.

So that said, with that caveat that we have some breaking news here that we haven't had a chance to really process yet, I did want to, as a high-level overview, remind everyone of what the elements of our spend plan were and provide a status update on each. To do that, we've organized our spend plan items into

three categories, and these categories reflect where things stood, you know, 24 hours ago when we were finalizing this data. But I'll still go through them because it provides helpful orientation on what the state of play is.

So the first category is things where CMS has approved the activity and have already as of today begun implementation. And as you'll see from the slide, this primarily consist of provider rate increases, including for personal care, support coordination, and assisted living. The items in this category total $591 million, and that obviously represents the majority of our projected total spend plan expenditures. To be clear, that doesn't mean $591 million has gone out the door yet. That's an ongoing process. But it does mean that all of these items are in place and those dollars are beginning to flow out. So that's the first category. And as I said, that really does represent the largest lion's share of the total spent.

The second category are activities that CMS have approved as of yesterday but where we are still working on finalizing some of the implementation details, so they haven't gone live yet. In dollar terms, this is a much smaller category, about

$42 million. In general, I would say these are things where it may be a bit more complex to implement than, for instance, a simple rate increase, so it's taking a bit longer. However, we're working extensively on all of these items and expect to, on a rolling basis, begin implementation in the coming months.

And then the third and last categories are things that CMS had not as of 24 hours ago given approval to, and this category represents $145 million. And here, too, this tends to be somewhat more complex where CMS had relatively more questions to address before approving.

So as I mentioned earlier, it looks like CMS has, in fact, approved a number of these items. So many of these items, I think, will be moving from Category 3 on this slide into Category 2. Again, we'll provide updates on that front as soon we've had a chance to review and process what CMS has done here. And then, of course, our work will be to move all of the items in Category 2 into Category 1, actually to get everything live and implemented, so everything is sort of moving leftward on this slide as we move forward. So lots of work still to come here, many updates, but I think we'll be able to provide both in the near future and in the coming months.

DR. SPITALNIK: Thank you so much.
Members of the MAAC, any comments on either the increased FMAP or that you thought of related to the comprehensive waiver renewal?
Hearing none.
While stakeholders can only ask questions through the Question and Answer, the history of the Comprehensive Medicaid Waiver Renewal is posted on the chat which you can access. And thank you Sam and Karen for your help with this technology.
There was a question about whether the final draft is posted or whether that is a confidential document to CMS.
MR. WOODS: The 1115 submission to CMS? It is very much a public document and it will be posted.
DR. SPITALNIK: Okay. In what is submitted what is received back?
MR. WOODS: I'm sorry, Dr. Spitalnik, the question is?
DR. SPITALNIK: The question is what was sent to CMS that you are waiting to hear from, is that a public document, or what is returned a public document?
MR. WOODS: So we have, as part of the enhanced FMAP spend plan process, there is a

requirement states provide quarterly updates, and those are public documents. And we can probably find the link to the quarterly update we provided in the fall that updated the July version, and that included responses to CMS's initial partial approval. And then subsequently, we will continue to -- we have another quarterly update coming in a couple weeks, and that will also be public, so all of those documents are public.
DR. SPITALNIK: And is that also the case for the 1115 Renewal?
MR. WOODS: For the 1115 Renewal, we will submit -- I apologize if I'm misunderstanding the question.
DR. SPITALNIK: I may be confabulating.
MR. WOODS: Just to restate, for the 1115 Renewal, when we submit our final proposal to CMS, they do a quick review to ensure that it's complete then that is posted. We would post it on website. It is posted on medicaid.gov federally so that all of that is public.
DR. SPITALNIK: Great. Thank you so much.
Any other comments or questions from the MAAC?
Greg, thank you for all this information,

especially for the tremendous amount of work that underlies it.
We will now turn to Assistant Commissioner Jennifer Jacobs, and we'll have COVID-19 updates, at which point we will open to questions and comments from the MAAC.
Assistant Commissioner, good morning.
MS. JACOBS: Good morning, Dr. Spitalnik. Thank you so much. It is great to be with you all again today. We look forward to this opportunity. This is a section we've had to add to our agenda for the last couple of years now, so a little outreach to you all to say, my goodness, I can't believe we've been doing this for two years and thank you for all that you are doing to help our community find our way through this.
We have a number of updates for you today related to COVID-19. The first one is about vaccine counseling. You may have seen recent updates from our federal partners at CMS with respect to coverage of vaccine counseling. As you know, people do often trust their health care providers for advice on preventative care, decisions that they should be making, and we want to continue to support that.
Vaccine counseling has been covered in New

Jersey prior to COVID. It is covered in New Jersey now. But what we are really focused on is making sure that our providers are aware that they can, in fact, bill for this. And CMS has really specifically put some parameters around their expectations. So what we're talking about here is very specific to COVID-19, and we appreciate your help sharing this information throughout our community.
So we try to give you here the what, the who, the where, the when. The "what" is our providers can offer that trusted support and help us build understanding to increase vaccination rates in our community. Vaccine counseling is available for children under age 21 and their parents and caregivers. The child does not have to be present. This could be, for example, a phone call between the pediatrician and the parent. But in any event, the counseling is covered and can be provided by any NJ FamilyCare provider who is qualified to administer a COVID-19 vaccine.
The question of where, everybody always wants to know do we have telehealth access. We talk about that more than we ever did before. And the answer here is yes, vaccine counseling can be provided face-to-face or by telephone or a telehealth platform.

The question of when, vaccine counseling can be provided at any time. That includes during a well child visit, and there's not a requirement that the vaccine be administered on the day that the counseling occurs.

So there's more information available about this through CMS's website and through the Managed Care Organizations who are our partners. We are really happy to help providers do more of the counseling that we think will be helpful as our members are making their decisions about getting vaccinated.

And so I'll pause here for just a moment, Dr. Spitalnik, in case there are any questions.

DR. SPITALNIK: Thank you so much.

Any questions from members of the MAAC?

Thank you for that opportunity. I think we can proceed.

MS. JACOBS: I will move on then.

Now, there's a lot of talk in the world today about at-home testing for COVID-19. You've probably all asked your own questions in your own households about accessing these tests. We're here today to talk about the Medicaid policy around these tests. I'm sure that you know there is a supply challenge, to some extent, and really that that has, I

think, has been improving over the past few weeks. So as these tests are now available in pharmacies, we want to be clear about the coverage under the Medicaid program.

So COVID-19 at-home tests are covered, whether they are provided by a health care provider or picked up at a pharmacy. This includes the at-home tests that you see at the right there on the slide, but tests that require submission to a lab or rapid tests that are completed at home. So we have put out a Medicaid newsletter with respect to the covered tests. You can see the current brands there. We will add additional types over time as they become available. And the only limits that we've put in place due to the scarcity challenge is you can pick up two kits, two boxes, a day. That includes four tests with an overall limit of four boxes, which would be eight tests in a month. And this is pretty standard to what we're seeing in retail locations.

So the policy, I hope, there is very clear. I do expect that more tests will become available and we will adjust our coverage. And certainly, if we need to take another look at the quantity limits, we will; but this is what seemed appropriate, given the circumstances that we're managing today. So more

information is available on that at the link that we've included on the page. And as we said, we will be putting these slides out online as soon as the meeting is over. They may be there already.

Next, we wanted to talk about the vaccine mandate for health care workers. You've probably heard a little bit about the federal mandate. For purposes of this discussion, I'm going to be focused on the state mandate, which is Executive Order 283. That requires covered workers at health care facilities and high-risk congregate settings to be up-to-date with their COVID vaccinations, including boosters. And do we want to make sure that all of our provider community is paying attention to this.

The Executive Order requires covered workers to be fully vaccinated by March 30, 2022. There are some workers, hospitals and long-term care facilities, home health notably, who are required to be vaccinated sooner by federal rules, but really all of our health care workers will need to be fully vaccinated by March 30th; and then when they become eligible for a booster shot, are required to submit proof the booster shot within three weeks of becoming eligible.

As you know, we had previously had the opportunity for folks to do testing in lieu of

vaccination. Testing now will be available as an alternative only for medical or religious exemptions. We've had questions about what workers are included, and the short answer to that is all of them. All of the health care workers, full time, part time, contractors, whether they're front of the house or back of the house. So it's really a broad-reaching policy, and we encourage you to take a look at the Executive Order if you are one of our providers. And we're happy to take questions, but please do take a look at that Executive Order, as it's fairly detailed.

Next up, speaking of vaccination, I wanted to talk to you a little bit about the vaccination rates of our Medicaid population, and we want to be very transparent with you about the analytics that we have been able to do, the effort that we have put in. We've talked to you a little bit about that before, but here, we're going to dive into the data in a way that we did not do in past discussions. And so come with me with a little ride here. We've got three slides that contain data we're hoping that you'll be able to digest with us here today.

The first slide here is about cross-state comparison. We were at the National Association of Medicaid Directors (NAMD) meeting in the fall, and lots

of discussion about the challenges of measuring vaccination rates and in particular the challenges of measuring vaccination rates Medicaid population and understanding what we see here on this page in front of us, which is the comparatively lower vaccination rates among the Medicaid population than we see among general statewide numbers, and there are lots of reasons for that. Certainly, within our communities, we have experienced folks being hesitant. Early on, we certainly experienced access challenges, and we were trying to tackle that. There's also an important discussion to have around the data and reporting challenges that states are experiencing as they try to line up Medicaid against overall state data. Those fall into a couple of categories.

It's challenging to look at the general statewide vaccination rates against Medicaid; for one, because of the challenge of uniquely identifying individuals. So if you look, for example, at California's blue line, they are estimating 74 percent of their statewide population has been vaccinated. What they're doing there is they're using the number of shots that have been given to individuals as far as they can tell in their data, and sometimes that is even tricky. Two shots can look like one person, or two

shots can look like two people. But they're trying that sort of unique we think 74 percent of our population uniquely has been vaccinated.

Then with that yellow bar, we are trying to say within that we think we've identified the percentage that is Medicaid. And there is complexity in making those two things match. That's sort of the numerator, right?

As you think about the way that states are looking at the denominator, in general, for public health purposes, your denominator here is going to be based on census data and updates to census data. States are in different places on that, but it's roughly where it is. For Medicaid, it is strictly the number of eligible enrollees, so there's challenge to doing this measurement.

And then even looking across states, California and DC are probably not running their numbers the same. Utah and Louisiana are not probably not using the same methodology. So being able to get to apples to apples has been certainly a challenge across the nation and within the state.

The next slide will show you that challenge here at home in New Jersey. So here we are looking at our Medicaid vaccination rate, the light blue bar.

We've broken this out by age for you, compared to the statewide vaccination, the dark blue bar. You see the same challenges here within our Medicaid numbers that we see at the national level and some more data and reporting challenges that we just want to be very clear about. We have limited visibility from members who may have been vaccinated by a third party, and that includes many of our members who were vaccinated by Medicare, many of our members who have over coverage or who got vaccinated at work in the early days before everybody was reporting the data. So that's a challenge.

When you walk into your vaccine site, you will get vaccinated whether or not you provide health insurance information. So sometimes the vaccine site just doesn't know, particularly in the early days of the megasites, did not who your insurer was. We're not always able to get the data because of that.

And then finally, as I described a little bit on the national slide, matching our individual Medicaid members to the vaccinated individuals that are recorded by the Department of Health is also challenging. So no doubt that there's hesitancy in the community. No doubt that in the early days, folks were having a hard time accessing, and we were really

scrambling around that. These data challenges still exist, and they're unlikely to go away. So we just wanted to be very transparent in presenting that to you.

And then my next slide, this is the last data slide, I think, in this section, so thanks for bearing with me. Folks had asked us again and again what are the Managed Care Organizations doing to support vaccination rates in New Jersey. We've talked to you about this before so I don't want to dive too deep into details, but we started our MCO strategy in January of 2021. If you have feelings like I do about January of 2022, you just need to remind yourself that in January of 2021 none of us had vaccines. We have come a long way, and this is all going in the right direction. So just a reminder on that if it feels like sometimes this thing is never going to end.

In January of 2021, the vaccines were rolling out. We set up a strategy with the clinicians and that operators at our Managed Care Organizations. We used the red, orange, yellow triangle you see on this slide which you've seen before if you've been to prior meetings. And we started mailing and calling and partnering with our community to make sure that we were doing everything to could to build bridges, to break

down barriers, and to ensure that everyone had access to the vaccine. Our partnership with the Department of Health on that has been unprecedented. We have worked really closely with their team, their leadership, their call centers, to make sure that our Medicaid members had all the access that everybody had and to ensure that our high-risk members were getting that vaccine. So a lot of partnership has gone on here, and I would add that several of our Managed Care Organizations are partnering with CMS to try to get visibility on some of that Medicaid data I mentioned a minute ago where we may have members who are vaccinated by Medicare and we don't know it.

So data-sharing is the new challenge of the day, and we've been working on that actively across all of the different relationships that we have. But here on the bottom right of this slide, you will see vaccination status by MCO and by priority group. That is the red, yellow, orange triangle that you see there. The red being our highest risk group, orange being moderate risk, and yellow now being all eligible members five and up. So here you see that United and Wellcare were really neck and neck for first and second place in our vaccination rate chart here, and Wellcare really came out on top. So we congratulate them for 6

putting up the strongest numbers on the board.

DR. SPITALNIK: Assistant Commissioner, could we go back to the slide on vaccination?

My question was about children five and up, and the data here understandably is members age 12 and up in terms of the lag between eligibility. So I don't know if there's any anecdotal or issues that have risen to the surface. We're very concerned about not as many children becoming vaccinated as eligible and also some teenagers who've expressed, even while in the hospital with COVID, that they wanted to be vaccinated but their parents were not supportive of that. So I don't know what the churn is looking like around adolescents and also the 5 to 11-year-olds.

MS. JACOBS: Just going back here, you can see where we are with the adolescents; definitely room to grow here. We are still validating the 5 to 11 data, so we weren't able to present that to you today. It's newer data. And this has really been an interesting exercise in making sure that what we're presenting is clear and complete. So we hope to have the five-plus data for you soon, but we definitely agree that there's work to do in our community building acceptance among parents and adolescents. There are adolescents who want to get vaccinated, but their

parents don't want them to. And there are adolescents whose parents want them to get vaccinated, and they are choosing not to. So it cuts both ways there. And I think this is so common across state public health programs, never mind state Medicaid programs, that it's part of virtually every conversation we're having.

DR. SPITALNIK: Thank you so much.

At this point, any other questions or comments from the MAAC about vaccines? It's a larger approach to COVID in your next set of slides.

MS. ROBERTS: Hi Deborah. This is Bev.

First of all, thank you for all of this great information.

So I have a question about the recent release about the eight free at-home COVID tests, which is absolutely wonderful news. So it's a two-part question. The first part is so you've got an NJ FamilyCare member. Let's just say it's the parent of somebody with Intellectual/Developmental Disabilities (I/DD) who has NJ FamilyCare. And the parent goes into the pharmacy with their son or daughter's NJ FamilyCare card, so that the person that is the member does not have to be there, correct, as long as you have the card? And you just show the card upon check out, right?

MS. JACOBS: It would be at the pharmacy counter. So it's not at the -- I think of a Walgreen's or a CVS as having two counters. You would need to go through the pharmacy counter because they will be processing it like a pharmacy claim.

MS. ROBERTS: Okay. But you don't have to have any documentation from a doctor or anything, it's just you've got NJ FamilyCare card and you can, up to eight per month you go to the pharmacy counter?

MS. JACOBS: That's right. And ideally, if you're going to a pharmacy where you've already given them your card, they know who you are or your child is. They would treat it like filling any other prescription except that you don't need that piece of paper for the doctor.

MS. ROBERTS: Also, for the pharmacies, we know about the big ones, the CVS's and Walgreen's. Is a list of other pharmacies, do we know, that are participating in this? Or any pharmacy that deals with Medicaid?

MS. JACOBS: Each Managed Care Organization has a pharmacy network for their members. And Fee for Service has a pharmacy network, as you know. So it would be any participating provider, essentially.

MS. ROBERTS: Okay, great. Thank you.

Thank you very much.

MS. JACOBS: Sure.

DR. SPITALNIK: Other questions or comments?

Thank you for letting us take this stop because we know how challenging it is to amass the data and the commitment to the accuracy and efficacy of it. So, thank you.

MS. JACOBS: Thank you, Dr. Spitalnik. I do want to shout our teams that have been working on this, between Human Services and Health. It's been a tremendous collaboration and a real effort when you're doing data analysis like this. You have years to validate and get it right, and this partnership with the MCOs and Department of Health and moving numbers around as much as we can and know where we are has been quite an adventure and everybody's been up for it.

Let me just tell you one more thing about vaccines and COVID generally. There's a little bit of a "So what? Here's the data. What do you do with it?"

We think there's three important things that we want you to be aware we're focused on. For one thing, it's important that we continue our community outreach. That means being aligned with Department of Health's county ambassadors and the community organizations that are doing this work. We are not,

just as Greg described with the 1115 and housing, we are not trying to do something solo. We're trying to do something in partnership with the community with the ecosystem that is already out there. So we will continue that work. And we need to expand, as you mention, Dr. Spitalnik, outreach to parents of young children. That's going to be very important in months ahead. And we need to support access to booster shots. So all three of those things feel important in the outreach zone. As I mentioned the data changes, so exploring additional ways to leverage our data and put appropriate interventions in place to increase vaccination rates, and that includes working with NJII, the Innovation Institute to improve our race and ethnicity data sharing so that we can have eyes on health equity.

And then finally, December was the month a hundred new policies, and I'm sure that will continue over time. We have new guidance coming from federal partners, from state partners, and we've got to continue adapting to that. Some of the topics we already discussed today are examples of that, but also changing circumstances around treatment of COVID, treatment inpatient, outpatient, different kinds of drug administration. So we are working through all of

that with our clinicians and then monitoring new trends and troubleshooting as we need to, and we do appreciate the partnership of our stakeholders as we're doing that.

So I think that's a wrap for COVID-19 today, Dr. Spitalnik. And if it's okay with you, I'll move on to 2021 wrap-up.

DR. SPITALNIK: That would be great unless there are any burning questions from the members of the MAAC. Thank you. And we appreciate wrapping up 2021 and all the presentations that have us looking forward to what we hope is a brighter, healthier future. So thank you so much.

And I want to acknowledge that Theresa Edelstein had to leave our meeting for another meeting, but we appreciate her being there.

Please wrap up 2021 with us.

MS. JACOBS: I'm happy to do that. I always like when I have the opportunity to pause on this slide because I love this little kid and I just want to snuggle him very much, but I will focus.

Let me talk to you a little bit about the goals that we set for ourselves in 2021. If you remember this time last year, I did a walkthrough of 2020. I feel that it's important that we do this. As

we are running our program day to day, I tend to be thinking about two things a lot. One is velocity and the other is stability. So velocity is where are we going, what direction is it, how fast is it, is high priority or low priority, it's really thinking through all of that momentum and motion that is part of our day, the velocity side. And then the stability is we have to get there in one piece. We have to be clear with the team about the work we're going to do today, the work we're going to do this year, and then we all feel a little bit comfortable with the move forward and addressing any change that we bump up against.

So when we're planning for the year and we're talking about the work we're going to get done, it falls in these three categories that you're looking at on this slide. There's an alphabetical helper there for anybody who has memory challenges like I do. So first is the A's and B's, action on basics. It's the stuff that we know we need to get done in a year no matter what. And what falls in that category is members have to get services. Providers have to get paid; reports have to get submitted to CMS; eligibility and enrollment has to be on track; the budget has to happen. So all of those block and tackle, like it's got to happen topics sort of fall into our goals. But

they're not the only thing that we're thinking about as we're planning for a year, because we also know next step that we will face change and disruption. And some of that will be exciting change in the form of new policies, like Greg spoke about the HCBS spend plan. That wasn't part of our 2021 planning. We didn't know that that would come down the pike, but we knew there would be some change that would be positive and we planned for it; we were ready. There's going to be some change and we will tackle it. And we were really specific about how to go about that. So when that change came and it was good, we were ready. There will also be new problems, and so we're planning for those. And occasionally there's a new variant.

And then finally, we know that we have to make time for evaluation and enhancement. So we're doing all the things, we're dealing with the change. We also need to pause for the ease, make sure that we are looking at our program, measuring the things that matter, and then improving on them. So we're going to talk to you about a lot that were going on in 2021 falls in three categories. I'm not going to put these categories up again, but you'll see a little bit of each of three zones, if that makes sense, as we're walking through the work that we did in 2020.

So we set a few goals. One of them was we will serve people the best way possible and then we laid out what we think that looks like and the work that we needed to do in 2021 around it. One of the things we knew was that we need to improve maternal-child outcomes.

You are certainly familiar Nurture NJ, the First Lady's maternal health initiative, and a lot of this work falls under Nurture NJ strategy. So these are things we got done in 2021.

We implemented quality-driven changes to maternity payment policy. There, we are really talking about changing our payment policy around early elective deliveries and requiring providers to submit the pregnancy risk assessment when billing for prenatal care.

And we launched our community doula program back in January 2021 and made process on that across the course of the year so that now members are getting services, providers are getting paid, and the workforce is growing.

We got federal approval, second state in the nation, to expand eligibility for our members to 12 months postpartum, and we're in the process of implementing that now.

We modernized our coverage of equipment to support lactation, and there's a lot of other lactation work that's still going on behind the scenes.

We discontinued premium and waiting periods in order to support the Cover All Kids Initiative.

And we expanded our coverage for prenatal care for undocumented women and built systems to support contraceptive care coverage for them as well.

So when I look at this slide, of course I think about all the things that aren't done yet, but I tell myself this is a significant list and it's really only maybe half of the list. If we shared the whole list with you, your eyes would glaze over and you'd be done forever. But it's an important part of our maternal child health accomplishments in 2021 and lots more work underway in 2022.

The second thing we think about when serving people the best way possible is making sure that our members with physical, cognitive, or behavioral health challenges are getting better coordinated care. That meant a focus on expanding access to autism services and a real partnership with our stakeholders in order to tackle some of the challenges that we ran into in implementing that benefit.

We launched a DHS website to support

telehealth access through the free smartphone program. Folks asked us about that. It's a federal program; it's not a state program, but not as easy to access over the Internet as you would hope it would be, so we created our own website to help guide folks through that process.

We augmented systems and provider incentives to improve interoperability between provider types, including really leading the way nationally and improving behavioral health connections, data connections in order to better serve the people who are coming into one provider's office and then another and connecting their systems. So a lot of work went on behind the scenes from an information technology (IT) point of view. That is an example.

And then from an operational point of view, also, we've been working with partners, payers and providers, to improve transitions of care between settings, and so a lot of work, obviously, went on in that area as well.

And then the third piece under serving people the best way possible is making sure that we're supporting independence for older adults and people with disabilities. Here, we had a significant project around implementing the federal mandate to use

electronic visit verification for delivery of personal care services. This was a huge undertaking that our team needed to partner with payers and providers and multiple Electronic Visit Verification (EVV) vendors on. And I want to say a big thank you to everyone who was part of that process because the stakeholder effort there was really incredibly collaborative. This is a federal mandate, but our goal was to go live with broad public support and enthusiasm, understanding among our stakeholder community, and people just muscled through the challenges of that together. And I'm really proud of the way New Jersey providers and payers have worked with the state to get that done.

We certainly had new health care workforce dynamics this year or 2021, which included staffing challenges which we had to address with rates and with some improved processes that would actually ease access on this end. So there were concrete steps that were taken there to address that.

We expanded the integration of Medicare and Medicaid coverage for our members so we are now up to 62,000 members who are covered for both their Medicare and Medicaid benefits by the same health plan. And that was an increase of about 4,000 in 2021. So we want to continue moving towards integration because we

believe that having better coordination of Medicare and Medicaid services is the right way to help people get the best health outcomes.

We also supported self-directed personal care expansion through our Personal Preference Program. We are now 24,000 members as of December, and that was an increase of almost 4,000 in 2021. I think a significant part of that is response, obviously, to the dynamics of the pandemic, but it's a growing program and we're proud of the work that's being done there.

And then finally, we are in process, talking with stakeholders and the Center for Health Care Strategies (CHCS) and experts from other states of reviewing our qualified income trusts. We have heard stakeholders say there are different experiences that folks have. It can be really challenging to get through that process, and we want to understand what we can to improve that from our end to think about it differently, let's get outside of the box. And so that is very much a live conversation, but a lot of stakeholder discussion went on there during 2021.

Goal two really captures thinking about new ways to solve problems. And when we were planning 2021, I will tell you a lot of our focus was in goal one, a lot of the programmatic stuff we just talked

through. And so we had a number of things going on in goal two. But it also evolved significantly over the course of the year. For one thing, we had been working on the Perinatal Episode of Care, and that has now launched. It is a quality-driven episode. It's unique in the nation, will engage payers and providers in addressing some of the challenges that we see in the delivery of care in the prenatal, postpartum, labor and delivery period, and we're very excited about that. So we hope that all of the providers who are serving our members who are delivering little baby New Jerseyians are working with us as we move forward with that Episode of Care model.

And speaking of putting incentives in place around quality, we included in our doula reimbursement a quality incentive that links back to those OBs and midwives who are working with our pregnant members. So we really want to encourage partnership between doulas and the clinicians who are working with those members. And one way to do that is to say to our doulas, "We ask you to help us encourage members to go back for that postpartum visit that nobody wants to go to." And so there's an incentive in place in the doula's reimbursement for when the member goes to the postpartum visit with their obstetrician or midwife,

the doula gets an incentive for helping us to coordinate that visit, so really trying just to make sure that we're 7 thinking about that value-based payment.

And we also kicked off Integrated Care For Kids (InCK) this year. This is an innovation model that is supported by CMS. We are testing it out with providers in Monmouth and Ocean County. And here, we're really talking about an assessment which enables better support for at-risk kids. So if the provider does the assessment and sees that this family has some specific needs, there's an opportunity to kick in some additional attention to that family's needs and partnership with community organizations who can help. So that is really an interesting innovation.

Here are the two big things that Greg talked about a few minutes ago, really making sure that our 1115 is getting us to the next level, into the next generation of thinking about person-centeredness and social drivers of health. And so we hope that you have a chance to take a look at that. We're really particularly excited about the work we can do around housing and better coordination across physical and behavioral health.

And then finally, that HCBS spending plan

opportunity that snuck up on us this year. This was one of those sort of change things where we weren't expecting it, but here it was. And because we were ready for change, we were able to take all of the priorities that folks have talked to us about, right, we got together with our stakeholders and said, "What is it that we can do to strengthen our HCBS infrastructure?" And then we wrote all of that into the spending plan that Greg talked about a few minutes ago. We're really excited to be in implementation mode with that and maybe more than we knew since we got some updates early this morning. So this is all work that is partly done. We launched it. We're implementing it. We proposed it and then continues forward into 2022.

We also have been working very hard to use new systems and technology to make our program more efficient, more effective, and we're excited about that. The table on the chart on the slide here that we wanted to share with you shows that improved turnaround time around application processing. So if you're not familiar with Medicaid acronyms, MAGI and non-MAGI is meaningless to you, and that is fine. But what you want to know there is that MAGI applications are much less detailed. They're easier to process. The

non-MAGI applications have a lot more to review. In any case, we have improved the turnaround time from 2019 to have 2020 to 2021, and that is largely due to systems that we have implemented that enable our county workers to do their work more efficiently and more effectively. And the partnership between the folks who design and develop those systems behind the scenes and the endusers of those systems has been pretty amazing to watch, and you see the result of it here. So same workers doing the work are able to move through it more efficiently, and we're really excited about that and we continue to improve. So that has been an important development for us and is contributing to the quality of the work that we do.

Likewise, we've improved data sharing with sister agencies this year, and that is helping us to do our work more efficiently. And we have a very close partnership with Get Covered NJ and the Department of Baking and Insurance. This is important especially as we start to prepare for the end of the Public Health Emergency. As Greg mentioned early on, we do expect that the Public Health Emergency will end in 2022. I think we all hope the Public Health Emergency will end in 2022. When it does, we'll have to start doing redetermination of eligibility again. And we will be

working with our stakeholders to make sure that we are communicating broadly to the community as much as possible about the need to be responsive to any mailings they get from NJ FamilyCare and keep your contact information up to date with NJ FamilyCare.

And then any time that someone seems to be income ineligible for Medicaid and they are disenrolling, we want to smooth that transition over to the state-base exchange, and we will be working closely with Get Covered NJ to do that.

The final part of experimenting with new ways to solve problems was around that vaccine outreach strategy and the work we did in 2021 in partnership with Managed Care and our sister agencies, which I spoke to you about a little bit earlier. It does amaze me that a year ago none of this had happened in terms of vaccine outreach. And it was really something that was evolving over the course of 2021, but here we are and we will continue to move forward. As we discussed earlier, we have a real focus now on child and adolescents and boosters, making sure that as the vaccines are available, folks are building understanding and going out and accessing them. And then also in the course of that, we had the provider relief funding that needed to be distributed by the

federal government. They needed to know from us who the eligible providers were. And that was something that was going on behind the scenes. You never needed to know, but we were letting the federal government administrators who were working on that provider relief funding know our Medicaid providers were so that when they applied for the relief funding, they were validated as eligible, and there's a team behind the scenes making all that happen.

And then finally, the responsiveness to the changing of logistics of delivery of care. We talk a lot about telehealth now, hybrid delivery of services, providers reopening, and we just spoke about access to over-the-counter COVID testing, so all of those sort of pieces that have been changing and we've needed to adapt and issue new policies, new guidance, new 20 expectations around them.

The third kind of overarching goal was around focusing on the integrity of our program and real outcomes, you know, measuring what matters and making sure that we're taking action on it. And this is stuff that you'll see fewer are hyperlinks in this section because a lot of it is just work that needs to happen in our organization to help us improve, to help us view what is going on in our community and take the

steps that will get better results.

I want to talk to you about some of this today even though it's not necessarily on your radar in general because we feel accountable to you for it. So for one thing, we continued to develop our MCO performance accountability series. These are what you might think of as 360 reviews that highlight the strengths and address the deficiencies of each of our MCOs individually. Every organization has strengths and weaknesses, and we just think it's important to be very upfront about that and work with them on improving where they need to. So that has been going on.

We also, sort of on that note, developed our COVID-19 vaccination dashboard to drive the MCO outreach. As I said, ideally, you have years or at least months to put together data reports that are thoroughly vetted and validated, and we didn't have that kind of time. Not only that, but the scene was changing from who was eligible to what was being provided and so we had to adapt each step of the way there. But we've had this vaccination dashboard that I showed you that helped the MCOs kind of recognize where they were doing well and where they needed to improve.

We have been working on this eligibility processing the chart I showed you a minute ago with our

county directors, and I just wanted to call that out for a moment to say a lot of new meeting cadences started up during the pandemic, and this was one of them where we said to the counties, "Hey, you're dealing with the pandemic like everybody else and yet we need you to keep eligibility on track; and not only that, we need you to improve the rate of eligibility processing and the quality of the work that's being done. And so we're going to meet a lot." And we got together with the county directors. We've maintained that cadence so that everybody knows what's going on, everybody's looking at the numbers. We know the oldest case in any county at any time and we're talking about what do we need to do to move that case along? What kind of information does the family need to provide? How come that's stuck? And we've seen that improvement come from those discussions. Directors are asking us questions. They're saying their staff are running into issues. We're able to tackle that stuff together. So that has been important. There is accountability on both side there. We need the counties to work with us on eligibility processing, they need us to give them clear answers, and those conversations are a way to make that happen.

And then finally, we also have put in place

dashboard upgrades for transportation and for IT systems where we have seen some issues. So it is no secret to anyone that we struggle to make our non-emergency medical transportation benefit one that members can smoothly access. And as you can imagine, transportation is not exempt from the workforce challenges that every provider and business is experiencing. So we've been working closely with our transportation vendor to address the challenges that they're seeing out there. And I was very encouraged that they maintained stability of the service throughout the Omicron surge. And that gave me a good feeling about where they're going in 2022, so something that we've had eyes on, we are keeping eyes on because we recognize that although transportation and IT systems are not exciting things that folks love to talk about, they are really critically important to giving our members a stable and secure Medicaid program.

Program integrity and compliance are part of our everyday. There are some important points to mention here. We began to phase our MCOs back into field-based care management and face-to-face assessments. That phase-in has been a little bit affected by the Omicron surge, but they got back out there to our members because we know we have members

who do not have frequent visits from families who are relying on that visit from the care manager, and we wanted to get them back out in the field. So we've been doing that work together with the goal of getting all of our members their visits in the first half of 2022.

As I mentioned before, that partnership with the counties, we have now, every single one of the 21 counties, signed onto a memorandum of understanding that lays out performance standards for the eligibility work and includes incentives and penalties, just as we have for managed care, just as we have for transportation, and they have stepped up to that task.

Dr. Spitalnik, this is most behind-the-scenes item on this list, but one that I wanted to mention because it's a big deal. We closed out what are called data quality issues in our statistical information system. For lots of folks, that doesn't sound exciting, and I get it, but it's important in our partnership with the federal government that we are giving them data in the format they want and needed, and we had some issues that we needed to straighten out. The team worked really hard on those this year, and getting 12 of them closed out was a big deal to us and a big deal to our federal

partners so I wanted to take a moment to point that out.

And then speaking of federal partners, the deployment of new data security measures in 2021 has been important for security reasons. And then we continued our partnership with the Medicaid Fraud 10 Division on some of the new initiatives that they're working on there.

Just wrapping up goal three then around fiscal accountability and managing risk, we implemented the County Option Hospital Fee Pilot Program. This brought $400 million in funding to hospitals that are serving our community. So that was a tremendously heavy lift for our legal team, our fiscal team, and provider partners, and it was an important accomplishment in 2021.

We also addressed some of the budget neutrality discrepancies that we were running into in our conversations with our federal partners about the 1115 Waiver Renewal. We maintained the federally required audit and recovery processes. There are quite a few of those and just another thing that doesn't hit the radar, but it's a requirement and work that is important for us to be doing. It falls in the action on the basics category; it's got to happen, and

everybody kept those trains on the tracks.

And then something new in 2021 in partnership with our Federally Qualified Health Centers (FQHC) providers, we developed a billing manual and conducted wraparound training to address some long-standing challenges in that working relationship. So we're in a new place, we're in a new 10 chapter there, and we're pretty excited about it.

The last thing I wanted to mention to you on the subject of wrapping up 2021, we have a fourth goal that we think of as our culture goal. It's important in the sense that it defines how we work together and how we work with our stakeholders. And it's very simple to just sort of say show people we care. In the work that we are doing, it is important that we show people we care. And here are three ways that we think in a very Medicaid specific way about that statement.

First, we are always focused on collaborating inside our organization and outside our organization with positive energy and with compassion for each other and the people that we mutually serve. And I would point to all of the stakeholder dialogs that were going on this year around EVV and doulas and the 1115 and the home and community-based services and autism services. There's a group of legal stakeholders

who get together and aging stakeholders. Across our community, there are folks engaging with us regularly in compassionate and collaborative ways, and that is an important thing that we stand for within our organization.

The second thing I wanted to mention is our intention always to try to simplify and clarify. We need to build understanding and we need to solve problems. But the way you get there is by simplifying and clarifying what is complex state or federal law, rules and regulations, a pandemic, but we get there through clarity and communication.

And then the last piece, and this is really, I think, where the magic is, we always want to make sure that we are advancing the truth, what we call the true-true, which is what is really going on. So not just saying, for example, that we have a vaccine outreach strategy, but being able to talk in detail about how we have designed that strategy, the clinical orientation to focus on the highest risk members, transparency around the data challenges. That's just one example. Another example is not just that we got our doula program approved, but here's what it looks like, here the specific details, members are getting services, providers are getting paid, being able to

speak to what is actually going on the ground and asking ourselves the hard questions about that. It's much easier to say, "Yep, we did it," than to show it. And we're really focused on showing it, what is really going on out there. That's how we think of the true-true.

So that is our culture goal. There's a lot more to it inside our organization, but just wanted to be able to share that last piece with you as well.

So, Dr. Spitalnik, I'll hand it back to you now. If there are questions, I'm very happy to take them, and Greg and Carol and Heidi are also available.

DR. SPITALNIK: Thank you so much, but we can't even move to questions without thanking you and everyone in the Division for the incredible efforts over the last year, making them accessible to all of us and the ways that you show people that you care by building viable systems, responding to circumstances, and really giving everyone an understanding of the complexity and the burdens that you've all been shouldering with grace, compassion, and skill. So I couldn't move to informational questions until I expressed all of our regard on that.

Members of the MAAC, comments or questions on what the Commissioner has just presented?

MS. ROBERTS: Hi, Deborah. It's Bev.

I want to echo everything that she said to Jennifer and your entire team. You're doing great work. It was an excellent, excellent presentation. I want to especially say that we are thrilled with the improvement in the processing time which you highlighted, which is really good news. And also just to say -- and you mentioned about working with stakeholders at whatever point the pandemic looks like it's going to end to see what comes next. Is anybody talking about a target for when that pandemic might end.

MS. JACOBS: Tomorrow? I think every conversation we have with our partners at CMS, whatever the topic is supposed to be starts with, "Have you heard anything about the end of the Public Health Emergency (PHE)?"

So everybody wants to know. We don't have a clear sense of it. They have told us that we'll have at least 60 days notice. I think we've mentioned that to you before. We don't know anything more except that we need to be getting ready now. We need to be working with our stakeholders now and communicating to the community. It's not going to go on forever and so having a good strategy for when it does end is

something we can do right now while we're waiting.

MS. ROBERTS: I'm certainly happy to work with you any time, any place. Let me know; I'll be there.

MS. JACOBS: Thanks, Bev. We appreciate it.

DR. SPITALNIK: Thank you, Bev.

Other questions or comments from members of the MAAC.

Thank you again.

This brings us to what we do at the end of each meaning and also some at the beginning of planning for the next meeting. And so our next meeting is Thursday, April 28th. I'm going to assume, which is always a dangerous practice, that we will still be in remote mode at that point. I think in trying to soothsay about what things will look like, the priority will be to implement the changes on behalf of beneficiaries rather than trying to find the equivalent of Giant Stadium for us to be able to meet as a stakeholder group. We aspire to that. So we will remain in virtual mode, and I really want to acknowledge that even through the limitations of this technology as information is presented we include the links in the chat so that everyone has access to this information.

So I welcome, of course, input from members and, of course, the leadership of the Division.

So far what I have garnered from our conversation this morning is an update on the 1115 Demonstration Waiver; an update on the American Rescue Plan and the movement things from column two and column three as close to column one; an update on vaccines.

I was wondering if it would be timely to include an update or presentation on Cover All Kids or whether that was still in the works; and the question that was raised by the state Independent Living Council on the implementation or the impact of the new legislation on the WorkAbility Program.

Other thoughts? Questions?

MS. COOGAN: Deborah, this is Mary Coogan.

Just in terms of where we are with the Public Health Emergency and redetermination of eligibility at that point. But all the things you just mentioned, I think make a lot of sense. And I also just want to express my kudos to DMAHS, but also all your colleagues at Health and stakeholders and MCOs. It's clear from what you indicated, Jennifer, during today's meeting that there's a been tremendous amount of collaboration between everyone and great success because of that collaboration.

MS. JACOBS: Thanks, Mary.

DR. SPITALNIK: For this sort of closing part of our agenda, as we're building the agenda or summing up, I think we can stop screen-sharing and maybe bring people into gallery view. Thank you.

Other comments or questions at this point?

Again, thank you.

In addition to all the work that you've heard about, the planning for of the MAAC meetings are also quite an extensive effort in addition to all the work that you've heard about, but amassing the material, assimilating the material so that NJ FamilyCare really lives up to the Medicaid requirements for stakeholder input and transparency, so our thanks for that.

Another way that we want to express, again, our thanks to the leadership, our congratulations to soon-to-be Commissioner Adelman. And another way that we're demonstrating our caring is giving you back 25 minutes of your day because we've proceeded in such an efficient way. So in that spirit, do I have a motion from the MAAC to adjourn?

So moved.

DR. SPITALNIK: A second.

MS. ROBERTS: Second.

DR. SPITALNIK: Adjournment doesn't require a vote. So thanks, everyone, for your presence, your participation. Stay well, stay warm this weekend, and we look forward to hearing about the fruition of many of the things that are pending. Thank you all for 8 participating.

Again, a reminder that the slides that you've seen are posted on the DMAHS website at: https://www.state.nj.us/humanservices/dmahs/boards/maac/ as well as a history of these meetings where you can find the documents. And again, appreciation for all the linkages in the chat.

Thank you, everyone. We look forward to seeing you in the spring in warmer times and hopefully well times. Thanks, everyone.

(Proceeding adjourned at 11:40 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 as recorded.

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Lisa C. Bradley, CCR

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