MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
Via Cisco Webex

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FINAL
MEETING SUMMARY

Members Present:
Deborah Spitalnik, PhD, Chair
Theresa Edelstein
Beverly Roberts
Mary Pat Angelini
Mary Coogan
Sherl Brand
Wayne Vivian

State Representatives:
Carole Johnson, Commissioner
Jennifer Langer Jacobs, Assistant Commissioner

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CHAIRWOMAN SPITALNIK: Good morning. I'm Deborah Spitalnik, the Chair of the Medical Assistance Advisory Committee, and it's my pleasure to welcome all of you fanned out through New Jersey to the first virtual meeting of the MAAC.

As is our practice, in addition to the notification through the Open Public Meetings Act, with which we have complied, a notice of public meeting has been sent out to indicate that due to the COVID pandemic that we have moved to a virtual format.

I thank everyone for participating today. And I want to, on behalf of the MAAC and all of us invested in the Medicaid program, to thank Commissioner Johnson and all of the Department of Human Services, Assistant Commissioner Jen Jacobs of DMAHS and her whole staff, Deputy Commissioner Sarah Adelman for the time and effort they've put in to ensure that we have this opportunity for stakeholder input.

I also want to express our appreciation to the New Jersey Hospital Association for providing us with this platform.

Today's agenda will start with remarks from Commissioner Johnson. After her remarks, we'll have updates on initiatives and planning and implementation,

autism services, electronic visit verification, and then we will have a focus on COVID-19.

Due to our format today, you will be hearing from both the speakers and the leadership of the Department as well as the members of the MAAC, but you won't be able to see us, but we will do our best to bring the questions that people have e-mailed in to both the Commissioner and other speakers.

I now turn to Commissioner Johnson for her remarks and our appreciation for her leadership, always and particularly through this difficult time and her willingness to spend time with us this morning despite her myriad demands.

Welcome, Commissioner Johnson.

COMMISSIONER JOHNSON: Thank you, Deb. Thank you to the members of the MAAC for finding a way to hold this meeting virtually when we are all working so hard to maintain social distancing and not congregate but have important work to do and so need to have a venue to do that in. I know it's not easy to put this together, but I'm grateful for you all having worked to do that.

I wanted to start today -- I'll be brief, but I wanted to have the opportunity to thank all of you for the work you're doing every day; frankly, the work you do every day all the time all year long, but particularly in

this pandemic environment where everyone has had to adapt quickly to continue to ensure that services are provided to some of the most vulnerable residents in our state, both the residents we have always served and then a growing population of individuals who now need our services who may not have a month or so ago. It is challenging and there are many barriers, and you all have been so creative and responsive to the many needs that have arisen. And so we're really grateful to you for your work.

I also want to highlight how much we appreciate the partnership that we have with our colleagues in the counties when it comes to eligibility and enrollment. We do a significant amount of that on the Medicaid side here in Trenton, but we depend on our partners across the counties for eligibility enrollment processes for Medicaid, SNAP, our TANF program, our General Assistance Program, our Emergency Assistance Program. And the volume of incoming over the last couple of weeks has been, as you might imagine, substantial. While those county partners have worked hard to try to figure out how to restructure their business process and move people to whole and ensure that they are appropriately practicing social distancing and how they're providing a service that for a very long time had been face-to-face in a way that ensures that people can get access to our benefits in a

timely way. So it may not be visible to you, but an incredible amount of work has gone on both with our Medicaid team here in Trenton and with our CFE team and then our partners across the counties who are just seeing a substantial influx of new applications and are moving very quickly to process them.

Jen will take some time to talk about all the various policy changes that we've made in Medicaid to try to get services to people as quickly as possible and ensure the continuity of our provider community. I'll just briefly mention a couple of other things that are happening across the Department. The list is long and so I won't take all your time but just highlight a few.

Food is a critical issue at this time. We have in the last three weeks or so moved $75 million in additional SNAP benefits out to our enrollees to ensure that our individuals who are SNAP participants had the resources and capacity to be able to comply with the CDC recommendation to have two weeks' worth of food on hand as we move into an isolation period for our stay-at-home order. So it was a fast and quick move to be able to get more money to folks. And we are going to continue to look for opportunity to ensure that people have the food that they need.

We also have worked with the Feds. We have

asked for any number of waivers on the SNAP side to make the application process easier, meaning that we've gotten waivers related to the interview process, to having to have a physical signature, to extending enrollment times in our SNAP Program, and to extending the timeframes for redeterminations, because we want to ensure that during this difficult time people have as much access to food as possible.

Similarly, we are laser-focused on food in our Aging Services Program. We have been working with the county Offices on Aging, which is the network that our Aging Office helps coordinate. They have seen an incredible amount of incoming related to the food needs of older residents. Both the residents that we've known for years, those who have participated in aging programs for a very long time, those who we know are homebound or socially isolated or who participate in congregate senior dining, which is no longer available because of that social distancing guideline, and so serving those folks is something that is very important to our aging partners. But making sure that we're helping those seniors who find the need for assistance with grocery shopping is another initiative our aging team is working on with our volunteer partners across the State. So those are very important ways that we're helping to adjust food needs. We are in

close contact with both our food pantry network, our foodbank network, the Food Council that represents the grocery stores. They are constantly taking the pulse of where we are with food. Then we'll talk a little bit about how our health plans are working on food needs as well. But food is a very important part of the work we're doing.

Similarly, so is shelter. And so we have been working with partners across the State to make sure they have resources. Many of them have had to staff up because individuals who are spending time in the shelter now have to spend more time in the shelter than they might otherwise have because they need to be there during the day and it might have been a night shelter. That involves more food and more staffing. Also, the shelters are doing the work to try to comply with the CDC recommendations for shelters being able to facilitate social distancing, which, again, spreads their population out and requires more staffing. So we have been directing more resources in the shelter direction and then working with our federal partners through FEMA to get approval for federal support to help do non-congregate sheltering. So we are working with counties across the State on options that the counties are building -- some have already built and some are in development -- to ensure that there are opportunities for non-congregate sheltering for individuals who may be

experiencing homelessness and have health-related issues or otherwise need to be in a different place from where they might normally shelter.

We also, as many of you on this call will know, have taken a number of steps in our Division of Developmental Disability to support the developmental disability community as the pandemic has evolved. Early on, folks have told us -- we don't have documented evidence to prove this -- but folks have told us that we were one of the first states if not the first state to close our day congregate day programs for DDD because we were very concerned about people being in congregate settings as this process was evolving. So as part of that, we shifted individuals to their group homes. We recognize that that is very challenging. It is challenging for all of us to be at home right now for long periods of time without having the opportunity to congregate with our friends and other things like that. It is particularly hard for individuals with IDD who value that routine and value their connections to their peers and friends. So we have tried to do everything we can to be as supportive as possible in this environment, recognizing that it is challenging but it is what has to happen to ensure the safety of as many folks as we can in this challenging time. So we redirected resources to our group homes.

We also at the same time recognized that we were going need more opportunities for families who were now going to have their adult child who has IDD at home because of this change because they won't be able to go to their day program. So we changed our policies with respect to who you can hire as staff and allowed families to be able to become the support staff for their family member and be paid through our programs to be able to get that kind of support. Again, that's a very challenging environment, having individuals at home when they value their day program so much is a real challenge for individuals and families, but we're trying to support folks as much as we can and ensure as much safety as we possibly can at this challenging time.

We also have made a number of policy changes related to child care. So one of the critical issues the Governor was focused on from the early days of this crisis has been ensuring that first responders and essential employees have access to child care so that they can do the work they do with confidence that their children are in safe, affordable child care. So the Governor moved to close child care centers and only reopen those that would serve essential workers. And then we were able to use subsidy dollars to support families for all or portions of that cost so that they could access child care at this

critical time.

There are a number of other things that are happening across our Division. We have also launched a reinvigorated and expanded New Jersey mental health care hotline that is taking calls from 8 to 8 every day to be emotional support for individuals during this challenging time. And we are continuing to work with our partners and FEMA, crisis counseling, and other emergency response strategies related to mental health services. We expect to have approval for our plan there very shortly.

So there are many things that are happening. I appreciate the opportunity to join you today -- the things that are happening across the Department. As I mentioned, Jen will talk in detail about the Medicaid changes, but I wanted to really particularly join just to thank you for the work you're doing and for all of your support at this very unprecedented and challenging time in our State. We all get through this together, and I know that that's true because I know all of you and your commitment to the individuals that we serve. So thank you so much.

Back to you, Deb.

CHAIRWOMAN SPITALNIK: Commissioner, thank you so much, as always, for your leadership and never more than now. My understanding is that you might have time

for a few questions.

If members of the MAAC want to ask a question, please indicate that in the chat box, and I will call on you and ask you to unmute yourself.

The pauses that we have when we can make eye contact with each other don't translate well virtually. I am not seeing any questions at this time.

Commissioner, I think that is a reflection of the scope and the thoroughness with which you spoke with us this morning and your compassion. I know that you have many, many demands on your time. And, again, our appreciation for being with us today and for everything that you and the entire Department and the Administration is doing.

COMMISSIONER JOHNSON: Thank you so much, Deb. I also want to be sure to thank our Deputy Commissioner, who has done yeoman's work in the last several weeks to move federal policy, state policy. She's done an incredible amount of work, and we wouldn't be where we are without her work. So thank you.

CHAIRWOMAN SPITALNIK: Thank you again.

I'd ask to go to the previous slide which has our agenda and to walk through that with you.

We will now have a series of presentations and the opportunity for -- at the end of each section, I will

call for questions from the members of the MAAC. As always in our process, the slides from the MAAC meeting will be posted on DMAHS's website. This Webex is being recorded. And as always, we thank Lisa Bradley, our court reporter, for the minutes that she creates. As a point of process, we will be addressing the minutes from our previous meetings through e-mail.

And it is now my pleasure to turn to Jennifer Langer Jacobs, Assistant Commissioner, for the Division of Medical Assistance and Health Services, to bring us greetings and to launch us into the initiative section of our webinar. I know how much in contact she has been with so many of us today. And I will, in turning it over, also recognize that we have 266 people on our meeting today. So thank you all for being here.

And Jen Jacobs, please bring us greetings and start us.

ASSISTANT COMMISSIONER JACOBS: Thank you, Dr. Spitalnik. It's good to talk with all you this morning. Thank you for joining us in this new format which we're getting adjusted to. We have so appreciated your input through this process. As the Commissioner said, we're reminded every day of the importance of the community connections that we have, your coming to us with the issues you're seeing, and the opportunities that are presenting

themselves, and we are all working through this together.

We're excited to be here with you today. We tried to stay in touch with you in every other way, through e-mail, through text messages, through website updates, meetings, and conversations, but the MAAC meeting is a time when we bring the Medicaid community together as a whole. So today's meeting feels very different, but we appreciate that that dialog has continued with all of you, and it was important to us to get together with you here in this new way.

And so we will present to you today on a couple of topics that we have spoken to you about in the past. These are topics that are on a certain time line: Autism services, which launched on April 1st; and the EVV, Electronic Visit Verification, mandate that's coming for January 1st. We felt it was important to address each of those topics as timely issues that are moving at the same time that we are managing the greatest public health crisis of our lifetimes. So, obviously, the bulk of our discussion today will be focused on COVID-19, New Jersey's response, the response of the community that we work so closely with, but we did feel that we wanted to touch on autism and EVV so that you had information on that as well.

So I will go ahead and take us to the next slide. And I think Carol Grant will be able to unmute herself and

share with you a little bit of information on the launch of autism services for April 1st.

Carol, can I ask you to let me know if you're out there and can speak to the group? I think we need to make sure that you're off mute on the Webex and on your cell phone. Carol?

MS. GRANT: Yeah.

ASSISTANT COMMISSIONER JACOBS: There you are.

MS. GRANT: Okay. It's really difficult working in this virtual environment.

ASSISTANT COMMISSIONER JACOBS: It sure is. And you've done such a great job of it, and thank you for your leadership inside our organization and outside.

Would you talk with us a little bit about the launch of autism services on April 1st?

MS. GRANT: I certainly can.

I wanted to make a couple of comments first before I actually launch into the slides.

A study recently done by the Centers for Disease Control reported in *Science Daily* on April 11th that 1 in 59 children had autism. The New Jersey rate was the highest of the states studied, 1 in 35. That puts the rate of autism at 1.7 percent nationally and in New Jersey at 3 percent. So it was important to have a Medicaid

autism benefit in this State.

We set a goal implementing an enhanced autism benefit package for children with Medicaid delivered by the managed care plans with an April 1 start. I really am pleased to say that with the support and assistance of many people, including our sister department and Division of Children and Families and the Children System of Care, that we've met that goal even in the midst of the COVID-19 emergency.

The first aim was to enable the seamless transition of children from, again, the Children System of Care and the Department of Children and Families where autism services, including Applied Behavioral Analysis for children up to age 13, were provided as a small waiver benefit, moving to an EPSDT entitlement, really, for children up to age 21 with an autism spectrum diagnosis. I am happy to update you on the status of this benefit as of April 1st.

So there were a series of services that were available even before April 1st launched on January 1 of 2020, including physical therapy, occupational therapy, and speech therapy, alternative communication assessment and devices, and sensory integration.

The services launched on April 1st included Applied Behavioral Analysis. And additional services in

this benefit will be available as of July 1, 2020, including DIR Floortime, which is Developmental, Individual Difference, Relationship-based Model; Developmental Models in Autism Intervention; Early Start Denver Model; and Certified Autism Specialist.

One of our principal goals here was to work hand-in-glove with our Managed Care Organizations. Beginning in January, we really began biweekly meetings with all five Managed Care Organizations. A primary focus was to make sure that there was network adequacy and the development of network; continuity of care with Children System of Care providers; provider education through MCO webinars; care coordination with existing care management entities, including CMOs and our managed health care plan; customer service training for call center staff; member engagement, which is MCO communication with beneficiaries via mail, website, and handbook; and monitoring and evaluation tracking issues and complaints as we roll this benefit forward.

So the autism actions to date, we had a goal for the seamless transition for families served in the Division of Children and Families to our Managed Care Organizations. That has happened for 400 children and without disruption of care. We have had no reports of inability to staff on transition cases.

One of the benefits of Managed Care is flexibility in being able to effectively use providers to deliver this benefit, the flexibility in provider certification requirements, the use of telehealth, and assistance and some hand-holding around provider registration and enrollment for those not used to the Medicaid system.

We've had regular meetings with sister divisions and others involved in the delivery of services to individuals with autism, joint preparatory meetings with MCOs, Children's System of Care, or Care Management Organizations, and PerformCare where points of contact were established and exchanged.

And then we have ongoing communications. Managed Care Organization meeting with Autism New Jersey, Managed Care webinars, Department of Children and Family letters to family members and providers, a provider newsletter, and we are planning a virtual stakeholder meeting for May. This is something that would have happened much earlier in our rollout, but it has been impeded by COVID-19 and the stay-at-home order. And we have every intent of having regular and productive communication with stakeholders around this benefit to deliver it effectively and to improve it as we go along.

So I look forward to working with many of you

on this benefit, and that concludes my presentation.

CHAIRWOMAN SPITALNIK: Carol, thank you so much.

At this point, I will open this to questions to the members of the MAAC, but I also want to recognize the efforts of Division of Medical Assistance and the Children's System of Care in having planned these services in consultation with an Autism Executive Steering Planning Committee and the two opportunities that were presented for stakeholder input before the program was put together at the MAAC and other meetings.

So thank you for this excellent update. I am not seeing any questions from members of the MAAC at this point. And I just paused to see if the technology hasn't caught up yet. It seems that there are no questions at this point.

Again, Carol, thank you. And as we all sharpen our virtual skills, we'll look forward to opportunities for stakeholder input and to echo what the Commissioner said. There can be no more important time to give support and relief to families who are now providing 24/7 support to their children and emerging adults. So thank you again to everyone involved.

I now turn back to Jennifer Jacobs and ask that the slide be advanced to her presentation on Electronic

Visit Verification.

Jen.

ASSISTANT COMMISSIONER JACOBS: Thank you, Deborah.

And, Carol, thank you for your leadership on the autism rollout.

With respect to electronic visit verification, we wanted to have a brief update conversation to let you know that this federal mandate which we have spoken about in past meetings of the MAAC, this federal mandate is still in place. New Jersey is required to implement Electronic Visit Verification for home health services. We have an extension, but we must implement by January 1, 2021. It's our understanding from CMS that they do not have statutory authority to give any further extensions beyond January 1, 2021. And certainly, no one anticipated that we would have a global pandemic during this rollout time.

Importantly, our contract award for the EVV vendor moves through a competitive process that's run by our Department of Treasury, and that contract has not yet been awarded to a vendor. We told you that we would report to you when it was. And once it is awarded, the launch of the program will occur six months after the award.

Our vision, which we've shared with you before, is to implement a system and an operation that meets all

the requirements and to do it with broad public support and a strong stakeholder process. So it's important us to even during this time to continue the discussion about EVV so that as we are moving forward towards the deadline, we are all working together to implement this federal mandate. We've had stakeholder meetings in the past, but we haven't had sufficient opportunity at this stage to really meaningfully engage our community in an interactive dialog and in particular to do that with the awarded vendor. So we're expecting that award to come very soon. And then over the next few months, we will conduct what will now be exclusively online community forum, where previously we had planned on bringing folks together for more sort of comfortable human interaction in real life. We'll now have to move those community forums online, but we'll be really focused on making sure that we're reaching out across our community as broadly as possible. And we do have an upcoming meeting with our self-directing families for our members with developmental disabilities.

So the conversations are continuing. It's not front and center in the way that COVID-19 is -- and we will spend the rest of this meeting on COVID-19 -- but it was very important for us to share with you that the deadline has not shifted. It is our understanding currently that we will be required to implement Electronic Visit

Verification by January 1st.

Dr. Spitalnik, I think we may have members of the MAAC who would like to engage in some dialog on this subject.

CHAIRWOMAN SPITALNIK: Thank you, Jen.

May I ask that the slide go back to Slide 3, as Sherl Brand unmutes herself and poses a question. Thank you.

Sherl, please ask your question.

MS. BRAND: Thank you, Deborah. And thank you, Jen, for the updates.

My question is I'm aware that the vast majority of states that have already implemented EVV or are close to doing so have elected to go with an open model whereby the State establishes the requirements for whatever vendor and then as long as the vendor that organizations are working with meet those requirements, they can move forward with that process. What that does is certainly mitigates the burden on the provider community to shift to a new vendor. So I'm curious about the decision to go with one versus that open concept. And is that set in stone, or is there an opportunity for organizations to perhaps talk with State about the open model?

ASSISTANT COMMISSIONER JACOBS: Thanks for that question, Sherl. And I appreciate the opportunity

to kind of level set with folks.

The State has contracted or has issued the RFP for our own vendor to accept the data that will be sent by health plan and provider vendors. So we did adopt an open model like other states did. And exactly as you described, the vendor that our providers are using will be able to plug into the vendor that the State will be using for this purpose.

MS. BRAND: Oh, okay, great. When I saw the vendor, I thought that it was closed. Thank you for the clarification.

ASSISTANT COMMISSIONER JACOBS: I appreciate the question. Thanks.

CHAIRWOMAN SPITALNIK: I'm not seeing any other questions about Electronic Visit Verification, so that I will now ask to have the slides advance to COVID-19, that which has caused us to gather in this virtual format. I also want to let you know that these slides are already posted on the DMAHS website.

We turn to Jennifer Jacobs.

ASSISTANT COMMISSIONER JACOBS: Thank you, Dr. Spitalnik.

So here we are, everybody. We are ready to talk to you today about the work that our team has been doing with respect to this health emergency, and we truly

do see that the work happening on our end is in support of more than a million and a half New Jerseyans who are having this experience and being impacted in a lot of different ways. So we appreciate the opportunity to talk to you about this today. It certainly feels like the most important discussion that we could be having among the members of the MAAC. And so we would like to talk with you very transparently to give you a sense of the work that we're doing and the ways that we're thinking about it. I want you to have a window into our organization. Many of you have worked with us for many, many years, and you know how the Division of Medical Assistance and Health Services operates under normal circumstances. These are certainly not normal circumstances. And so we just wanted to open all the windows and show you the ways that we are managing this work and holding our team together and sustaining the energy of the community to the greatest extent possible, pulling in all the connections, and making sure that we're addressing issues that you're describing to us as happening and that we know are happening on the ground.

So I would like to begin by talking to you a little bit about how we started this calendar year. We had a vision for 2020, and it looked like these four goals with a whole lot of work that we were going to do under each one of the four. I wanted to share this with you

because it remains important to us. It turns out that life is what happens when you're making other plans, but if you've set your goals the right way, then as life is happening it falls into maybe the vision you originally had.

And so our first goal for 2020 was to serve people the best way possible. We were thinking about health equity and quality improvements. We were rolling out new benefits and services and all of the work that we needed to do around those priorities was lined up under goal number one.

In the same way, we knew that, goal number two, we needed to experiment with new ways to solve problems. We had a bunch of innovations that we were working on, new technology rolling out, and a lot of troubleshooting going on, which is always the case. We are never bored in the Medicaid world. But it turned out that there was a lot of new problem-solving that we would be doing this year that we did not anticipate.

Goal number three was to focus on integrity and real outcomes. That means operational accountability inside our own organization and also with our partner organizations. It means a focus on compliance with state and federal requirements. And for us, looking at what we call true-true metrics, the ones that tell us the real

story, and making sure that we're managing to that.

Under goal four, which we think of our culture goal, we wanted to make sure that with everything we did in 2020, we were showing people that we care. And for us, that means compassionate service. It means developing our leaders and it means managing through change. And we certainly have an opportunity to do that here.

So we were working on this vision in December and January. In February, we were finalizing it and working with individual team members across the Department so that everyone understood how they plugged into all four goals with the work that they were doing and really understanding how our key initiatives and innovations and implementation were each a part of this vision. And then we planned on presenting this to you with all of the individual pieces and parts at our April MAAC meeting, which is the very conversation we're having today.

Of course, you all know what happened next. And it has certainly changed the game. It's changed the game for every sector of the New Jersey economy and all the people who work in those sectors. And there are frontline staff in every sector who are impacted by this in the most serious ways. And we recognize that those are people we serve, and we have a role in making this work better for them. It's impacted every community in the

State of New Jersey, and we understand that we serve those communities, too.

For New Jersey, it started on March 4th with a 32-year-old doctor in North Jersey. And since then, as human beings, we've had this common experience and we've all had unique experiences.

As an organization, we had to reorient ourselves because our journey for 2020 would not look anything like we had planned. Our Medicaid team swung into action with what seems like 22,000 new moving parts, which I'll tell you about at a high level today. But I want you to know that I'm honored to represent them.

One thing we knew, as folks were just beginning to do all of these new things and address this new reality, one thing we knew was that we needed to think about the principles under which we would operation because this is not the usual work that we're accustomed to and our normal processes would not serve the purpose. We said we need to make sure that we're philosophically aligned as we address the challenges that we will face. And we really felt this acutely in the first couple of weeks because everything was changing every minute and we wanted to do as much as we could as fast as we could. So established five North Star principles. And it's important to me to share this with you today because I want you to see how

they flow through all the work I'm about to describe happening.

The first point on the five-point star is, again, going back to our original vision, we will serve people the best way possible through this emergency. And we recognize that that means supporting their eligibility for the program and ensuring that services are available in unprecedented times, not just services related to COVID but services unrelated to COVID where we might experience, for example, workforce shortages. We were acutely aware of this. You were bringing this to our attention early on, and we have been focused on that together. Serving people the best way possible is absolutely critical to our organization and all the people in it.

We also recognize that we need to keep our communication clear and simple, and we need to be more focused on that than we have ever been before because we cannot assume that people have a base of understanding. In changing times, there is no common base of understanding that we can rely on. Everything is a little bit different than it was before. So we agreed that every communication needs to have the intent of building understanding as we're rethinking and managing new issues.

We also recognize that we need to experiment with new ways to solve problems. Innovation was part of

our vision for 2020. But now we have to innovate fast and smart. And so we wanted to make sure that we were considering bold, creative, and inclusive solutions and that we were making good, smart decisions, thinking strategically and thinking proactively. We've set up infrastructure inside our organization, which I'll describe to you, to make sure that we're doing that the best way we can.

Showing people that we care is as important or more important than ever. So we wanted to make sure that our hallmark included empathy, positive energy, and collaborative focus across our community.

And then finally, we recognize that there is sacrifice and loss across the State of New Jersey. And we wanted to make sure that we are showing gratitude for one another all the time. We're doing as much as we can as fast as we can, and we need to make sure that we're pausing to recognize the experience that we're all having.

And I really do want to take a moment to pause here and say that the COVID response team across our entire Division has pulled together to get this work done and to continue this work and to be as strategic and thoughtful as we can be. We are counting our blessings. We are managing through illness, through anxiety, and through grief. And, again, I'm honored to work with these people

and I'm channeling their energy and their passion as I'm sharing with you today updates on the work that we're doing.

I want you to know that we have a team of 40 leaders inside DMAHS who are meeting every single morning. And every morning, we are looking at these North Star principles. And next to them, we're looking at our priorities for the week. We also have a tracking document that we're using to make sure that we actually know where all the 22,000 moving parts are. And people have been very focused on making sure that that document is reflective of the feedback we're hearing from you. So that gives us a sense of organization and a sense of groundedness in this new reality. It identifies the responsibilities that we've identified for serving people the best way possible. And I want to give you a little bit of what sense what that looks like to us.

We know that there's rapid response work we need to be doing. We're very focused on that, ensuring access to testing and treatment, making sure that our high-risk members are protected, that we're not seeing gaps in services, people have continuity and stability that they need during scary times. We're supporting social distancing in new ways. And then we're addressing the changing needs on the ground as they're presented to

us. So there's a piece of this that is very much happening in real-time. But then there is also a piece of this where responsively we need to be planning for the future. So we can't spend all of our time focused on the realtime firefighting. We need to also be thinking about enrollment growth that we're expecting to see. We need to be thinking about the way health care will change going forward. And we need to be thinking about the needs of our members post-COVID. That gets us thinking a lot about -- you know, we've talked in the past about social determinants of health and, certainly, we're thinking differently about that now.

That leads into innovation. We're solving problems in new ways every day and for the long-term. So we're using new approaches, new partnerships, and new technology. We're looking at doing things better, smarter, faster more efficiently. We want to stabilize the system, and we want to transform the system so that it's ready for what's coming.

Our operational focus, then. Every single day, we're doing these three things. We're making sure right now that we're taking steps, bold steps, to protect and extend access to Medicaid coverage to the greatest extent possible, that we're helping our members get the care they need, and that we're working creatively with our

providers to solve problems. Those three focus points will carry us through the rest of this COVID-19 discussion today.

It's really important to recognize as we're working on protecting and extending access, as we're working on helping our members get care, and as we're working to solve problems, it's very important to recognize that we're part of a broad ecosystem that supports our New Jersey FamilyCare members and includes a lot of organizations that we have tried to represent on this slide. These organizations are essential for us. You are our community partners. Many of you are on the phone with us today. I was really excited to hear we have as many people as we have dialed in. I think that's a wonderful outcome of doing a meeting by phone even if we don't get to appreciate the in-person interaction we're accustomed to.

The interaction we're having with you, the communication, the dialog, the problem-solving, this is incredibly important to enabling us to do our job the best way possible and serve our community. We really want to point out that the relationships we have with our sister agencies, with our operational partners, advocates, and community organizations, the provider associations, even the Department of Corrections and funeral directors, there

are 22,000 moving parts here and each of you have your own moving parts and so the connections that we've made with you to make sure that we're serving people the best way possible, you will see those connections through the rest of this discussion here today. And we want you to know we are more appreciative than ever of the working relationships that we have across organizations.

So I mentioned three points that we want to focus on operationally. This is the first one. We need to make sure that we're protecting and extending access to Medicaid coverage. And of course, the first step in that journey is to get folks applying for the coverage. And so we want to remind you, although we are very accustomed to walk-in service in our counties and in our regional offices, during a time of social distancing and stay-home orders, online applications are really the best way to help people apply for our program. And so we are recommending that they apply online, but they can also access phone support which is available at our 800 number, and local organizations across the State are still supporting folks. So when they go to our website and they look help for applying, all those local organizations are listed.

There are three ways to apply online. Many of you know this very well, but I just wanted to mention it.

Certainly, one way is through our NJ FamilyCare site directly. But you could also suggest that people go to NJHelps which includes an assessment for food assistance and cash assistance in addition to health care coverage. It will lead them -- if they are appropriate for New Jersey FamilyCare, it will lead them to the New Jersey FamilyCare site. So there's no delay in that application. It's really just giving them the additional assessment for food and cash assistance.

And then similarly, the Get Covered New Jersey site is really the place to go for marketplace health insurance options. And this may be the default go-to for people who have recently lost a job, for example. And that site will connect them to healthcare.gov. It will also connect them back to our New Jersey FamilyCare site. So no wrong door, but we did want to emphasize online applications during this time.

I also wanted to mention to you that some flexibility has become available to us through the federal government during an emergency period. And you could spend probably six or eight years getting a Ph.D. in all the different levers and waivers and flexibilities that are available through the federal government when an emergency happens. They have worked hard to be good partners to us as we move through this process.

I'm not going to focus on the 1135 waiver versus the 1115 versus the state plan amendment. I don't think that's what's critical for purposes of this conversation. What I want to focus on is what we're achieving with those things.

So one thing we're doing is accessing emergency flexibility that will enable us to enroll people in the program faster and easier. They will be able to self-attest to income and assets that lets us move through the process more quickly. People have asked a lot of questions about income related to federal stimulus payments and also the emergency increases for unemployment insurance. Those federal income sources will not count as income for purposes of Medicaid eligibility determinations, and that's important. We have also made some behind-the-scenes technical changes, probably a little too in-the-weeds to go into today. But those technical changes will allow us to move applications through the process on a more expedited basis. So we have what's called the federal authority to be able to take those steps.

And then I also wanted to mention to you that we have ads running on television, radio, streaming media, social media, and online search. So we're trying to get the word out that Medicaid is certainly available to

families, but also that anyone has lost coverage as a result of the emergency or any other reason would be able to go through Get Covered New Jersey and seek coverage in the marketplace.

Here, I wanted to describe to you a little bit about continuing coverage through the emergency period. This is a requirement that came from the federal government attached to enhanced matching funds. So we were very excited to be able to extend coverage for our Medicaid and CHIP members entirely through the emergency period. And one thing that you really need to know is that this required extensive overriding of scheduled disenrollment. And I wanted to give you a little bit of detail on that because we had to work through the technical aspects of making this real. We found out in mid-March that we would be continuing coverage for Medicaid and CHIP members through the period, and we have systems that run every single month that handle the enrollment and disenrollment of our membership. The systems were already in motion for April. And so we could not pull it back fast enough to be able to prevent the technical systemic disenrollment of members who were scheduled for disenrollment on April 1. But we could put a fix in place as quickly as possible. And so there were about 50,000 people who have would have dis-enrolled for the end of March and been ineligible on

April 1st. We put our system's override in place, and by April 13th, we had everybody back in and eligible with April 1st as their eligibility date. That is because the March system had already run and we had to pull it back. So we've done that and we've got everybody eligible again for April 1st. We will have that override process running throughout this emergency. So that means we're already working through the May 1st group to make sure that they don't lose eligibility, and we are in a very good place for that based on the lessons learned with the April group. So this will continue to be a manual override of scheduled disenrollment, but we think that our technical team has their arms around this and we will not see disruption for May.

We also wanted to share with you that the Governor decided he would suspend New Jersey FamilyCare premiums. So families that normally pay premiums for the CHIP children population received zero dollar statements starting in March. So they know that they will not need to pay premiums during the emergency period.

When it comes to protecting and extending access to coverage, we have had some increased calls related to eligibility. "Will my eligibility continue?" We certainly had some calls when we were doing the system overrides for the April group, and I wanted to express

appreciation to those of you who reached out to us and said, "Hey, we're hearing an issue. Here's a specific case." And we have been able to fix those cases as we've learned about them same day. So hopefully, anyone who experienced any issue in early April -- for the most part, people have not been going out and seeking health care services. Many people are staying home. But anybody who did need to go out for health care services, we hope that we were able to catch them and fix any issues that they experienced that same day. And I really want to say thank you to our hotline workers, the folks who are picking up the phones all day every day helping us recognize what's going on out there, address systemic issues and also address those one-by-one issues and make sure that nobody's having gap in care.

The second operational focus I mentioned to you was helping our members get the care they need. It's important that you know very early on we put out a statement that there would be no co-pays for COVID testing and office visits. The federal requirements have followed that as well. And we're finding that health care is adapting quickly to support social distancing. Here are a few things that are going on that we wanted to share with you.

For one, we immediately set up so that members could refill their prescriptions early and they could get a 90-day supply so there's not a need to return to the

pharmacy immediately.

We also saw dramatic steps to relax telehealth rules in the State of New Jersey. And we are seeing our members accessing telehealth, which is really exciting. What this means is that they can receive care from health care providers. They can be in their home or anywhere else. They can be using a regular phone or a smartphone app or encrypted telehealth software. Wherein the past, that encrypted software was really the only way to go with telehealth. We now have flexibility to just use whatever device you have to communicate with the doctor or other health care provider. We're sure to include treatment for mental health and substance abuse. We didn't want there to be any barriers to telehealth there. And the visits would be paid the same as an in-person visit.

For some services, for telehealth, there's a little bit of complexity to defining what can be done over the phone. An example of that would be certain forms of therapies. But we've been working through those technical details with the provider community and putting out guidance as we need to to give folks a sense of stability that they know our expectations and we've all agreed and we're on the same page.

I also wanted to mention to you that transportation is running as you would expect it to.

LogistiCare is our contractor for transportation, and they're maintaining their service level. They have appropriate clinical protocols in place to protect the safety of our members and their drivers. And we've definitely seen a reduction in trip volume. Like I said, people are avoiding going out for services if they can. But we have essential trips that continue. An example of that is dialysis. There's no reduction in dialysis trips. People need to go out for that service, and they're doing that.

I would also mention to you that transportation is available for individuals when they have symptoms and when they have a positive test for COVID-19. These members still need to get where they need to get to for medical care. And so LogistiCare has the right protocols in place to handle those cases, and they've been doing a good job of that for us.

Also on the subject of helping people getting care, we have flexibility from the federal government right now on Fair Hearing deadlines. This is to allow for the possibility that someone doesn't -- because of the emergency, someone does not immediately apply for the Fair Hearing that they have a right to, and so this extends the deadline so that they have a little bit more time to apply, depending on what their needs are.

And I should also mention to you that we're working with the Office of Administrative Law. We need to reestablish the hearing process which is normally an in-person process. We need to reestablish that in a way that will be compliant with social distancing, so we're working through that with them.

And then I really wanted to get to here. This is a slide that we use. The pictures at the bottom are pictures that we use internally sometimes when we feel like we want to make sure we're focused. An example is we have a major IT project that's running. And when those IT team members are working on their project, they have these pictures in front of them so that they remember this isn't just any IT project; we've serving these people. And so when I was putting this slide together and the ones that follow, I wanted to make sure that you saw these examples.

We are providing support broadly for COVID-related needs, but I wanted to talk to you a little bit about the work that our Managed Care Organizations are doing to reach out to our high-risk members and coordinate their services and address everything that is happening to them right now. We polled the CEOs and clinical leaders of the Managed Care Organizations together at the beginning of March. And with the Commissioner, we made sure that we were all aligned on this set of guiding

principles and really understood what our strategy was going to be so that we knew that we were being thoughtful and collaborative to work through this the best way possible. And so the Managed Care Organizations identified their high-risk members, and they have made thousands of outbound calls. I'm going to share some of those with you today because I want you to see both the kinds of intervention that the Managed Care Organizations are having clinically with our members and also the coordination across this community. And so I'll walk you through a few of those stories. And I also want you to know that we have applied for federal emergency authority that will allow the Managed Care Organizations to put some additional services for members who may need them during this emergency period even if they don't need them in general.

So we have a program called MLTSS which provides home and community-based services like home-delivered meals, and that's a special program. You have to be enrolled in it, but for purposes of this federal emergency, we've asked the federal government to allow us to provide some additional services even to members who are not enrolled in MLTSS.

So I want to walk you through some of the stories because I think they're really important as an

indicator of what's going on out there. They're all involving care managers who are reaching out to our members and then coordinating with community resources or internal resources at their own organizations. Every health plan does this differently, but you'll see how these interactions work.

The first example is a care manager who contacted a member and learned that this member had suddenly relocated. She needed infusion supplies, and the care manager helped connect her to a new provider for infusion supplies, one who could deliver to her new home. And this is an example of a need that was not COVID-related specifically, but the member's sudden relocation made it an urgent need, and the care manager was in touch with her because she had been identified as high-risk.

Another high-risk member was 16 weeks post kidney transplant. And when we reached him, the care manager learned that he had tested positive for COVID-19 and was home but with a very high fever. So she connected right away to his transplant team and to emergency services.

We had another example of a mom with a child with complex care needs identified as high-need by the health plan, and the care manager learned from mom that they had run out of Pediasure. And the care manager

coordinated with the family doc who provided samples while that care manager got expedited delivery of the Pediasure for the family.

Another kind of member who is identified as high-risk is one who lives alone and they have other high-risk identifiers. So the next example was a cancer survivor and someone who was using personal care assistance services for help with activities of daily living. The aide stopped coming to her home for a couple of days. And when the care manager called, the member said that the aide had not been there. So the care manager reached out to our home health agency and got services started again that same day.

Another example came in of a special needs plan member. That's a member who has the same Managed Care Organization covering their Medicare and Medicaid on a coordinated basis. This member had chronic illness. She lives alone. She does not speak English. And the care manager connected with her, made sure that she had food that she needed. She actually brought it from the food pantry at her church and then set up three-way communication to coordinate with the member's friend who speaks her language and supports her. And to this care manager, that was serving this member the best way possible; let me pull in this person's support in the

community and we will work together to support the member.

Another example of a high-risk member who didn't want to go to their doctor, "I'm scared to go out, but I really need to talk to my doctor," she didn't know about telehealth. And so the care manager coordinated a telehealth visit so now she could meet with her doctor in her own home. And those visits can continue once somebody is set up and understands how to do it.

Most of the other examples I have for you fall into the category of social determinants of health. And like I said earlier, we're really thinking about this urgently and differently than we ever have before, but you can see the strength of the community connections that exists for our care management teams.

So just quickly going through these examples:

A woman who needed safe drinking water, the care manager knew about a local church and a volunteer from the city delivered to the member on a Friday night.

Another example of a member who was emotional because he had no food left in his home, he was looking specifically for an Indian vegetarian diet. The care manager was able to connect to a local community organization and to a food pantry and she authorized home-delivered meals for that member going forward.

Other examples, there was a group of members

all in the same city who the care manager was contacting. She recognized that they all had food insecurity issues. Food was available at the local food pantries, but these folks didn't have the ability to go get it. So she made a connection to the city's Office on Aging. They arranged for a driver to pick up the packages and deliver to the member.

And then another case of a man on dialysis living with his young son but no other adults in the household, and the care manager again was able to arrange for delivery of prepared meals and groceries culturally appropriate for that member.

And then finally, this was another example of a member who was food insecure without family support. She was afraid to leave her home. The care management staff arranged for grocery delivery to a local organization and also connected with her on SNAP eligibility and talked about a long-term plan for resources and support.

That takes us right back to that community ecosystem that we recognize is so important for us.

The third operational focus that I mentioned to you earlier was working creatively with our providers to solve problems. This has required us to think differently and stretch and use the emergency

flexibilities we have, but also technology and innovation and just getting outside the box as much as possible. We are using some emergency flexibility on site of service so that we're enabling home-based care as often as possible when that's appropriate. An example of that, we had to close at adult and pediatric medical daycare programs. The sites are closed, but their staff are working with us to provide check-in calls for these members that they know well that they are accustomed to seeing multiple days a week. They're delivering meals when the member's asking for that, and they are coordinating with our Managed Care Organizations to support the people that they mutually serve.

Likewise, we thought about our partnership with LogistiCare, our transportation vendor, a little bit differently. We've amended our contract with them to enable them to deliver groceries and food to our members, and they have delivered hundreds of meals just in the last couple of weeks. And we have also amended the contract to enable them to transport home health aides to members' homes. That's really important. People were very nervous. Frankly, just managing public transportation right now is stressful. And so we're going to try to home health aides with a ride straight from their home to the member's home. We think that will be a real benefit for

the public health.

We're also working with pharmacies because, as you know, investigational drugs are becoming available, and we want to make sure that we're coordinated in our response.

Doing a lot of creative work to enroll new providers in the Medicaid program. This is essential. We have some emergency flexibility provided by the federal government and some technical innovation that we're working. Folks really thought about how we could do this differently than we ever imagined and quickly, and they're working on rolling out some new solutions that will let us expedite enrollment of providers so that they can serve our Medicaid members.

And we're fast-tracking family members as providers of personal care assistance that support for activities of daily living when families say they would really prefer not to have an aide coming into the home.

We've had to take some steps to relax processes. This has been important just to make sure that people are focusing resources in the right direction which is really working to the emergency. So we've suspended Medicare provider audit, and Managed Care Organizations have lifted prior authorization requirements for inpatient services and they're extending the current

authorizations for outpatient services by 90 days to get us through this initial emergency period.

I did want to mention that by not having prior authorization requirements for inpatient services, Managed Care Organizations don't have a lot of visibility on discharge planning, so we're very attuned to making sure that as people are coming out of the hospital, the health plans have the information they need to coordinate care back in the community again. And as advocates, I want you to be aware that we're sensitive to that and that the Managed Care Organizations are really doing everything they can to make sure that we're coordinating safe discharges even where they may not have the visibility that they would have had before, so kind of working through the challenges of that and appreciating our providers who are coordinating closely with us.

And then finally -- this is my last slide, Dr. Spitalnik. I'm going hand it back to you. But I wanted to share with you that we all have the sense that there's so much more to do. So as much as we recognize that the system has completely changed and evolved faster than we ever imagined it could in this context, there's a lot more work that we have to do. And it, again, falls under those three headings of rapid response and planning and solving problems in new ways, so just a few of those things that

we wanted to draw out:

We're exploring additional federal emergency flexibilities, and that really means in the standard rule book, which is many, many thousands of pages, there are rules that can be bent or broken during emergency times. And we're working with the federal government to understand what they'll approve. And likewise, there may be some options for provider sustainability. I think you're all aware that some funding is flowing already to provide support from the federal government, but we also hope that we will get some additional flexibility that lets us provide Medicaid funds for provider sustainability.

We're planning for significant enrollment growth over the next 12 months. We're thinking about what are systems that we will need to make sure that that enrollment growth is manageable and then also where our contingencies as we might need to tap them.

We're continuing to adapt to this rapidly changing environment, and we recognize that there will likely be new protocols for prevention and testing and treatment of the virus and that our program will need to be responsive to that and prepared.

And then we're looking at how to address health equity questions as we see this impacting different communities in different ways, how to address workforce

development so that we don't experience shortages, and also thinking about social determinants of health in this new environment.

I guess I would just close my portion here by saying that we are continuously struck by the closeness of our partnerships. This is an incredibly intense and evolving situation. We're honored to be here working on it with you. And now more than ever, we're grateful for the leaders that we work with and the people who share our vision of serving people the best way possible.

Dr. Spitalnik, I will now hand it back to you for discussion among the MAAC members.

CHAIRWOMAN SPITALNIK: Thank you so much, Assistant Commissioner Jacobs for this extensive, compassionate, and informative presentation.

We'll turn to the next slide. This is an opportunity for members of the MAAC to ask questions. And I have a list, and I will start calling on people. But I also want to welcome Deputy Commissioner Sarah Adelman. She may want to respond to questions. And then before we close, I'll also turn to the Deputy Commissioner and Assistant Commissioner for any closing remarks.

The first question I have is from Beverly Roberts who I will ask to unmute herself and pose a question. Thank you.

MS. ROBERTS: Thanks so much, Deborah. Can you hear me?

CHAIRWOMAN SPITALNIK: Yes.

MS. ROBERTS: Thank you so much, Jen. This was a really, really detailed and wonderful presentation. I also want to thank you and your entire staff for all of the work that you've been doing which is just phenomenal.

I wanted to ask about the home-delivered meals that you mentioned. I know that it has been allowed in the past for MLTSS members, but only for MLTSS. So if you could talk a little bit about how that would work for somebody who's not MLTSS. And also, you mentioned about LogistiCare doing that. So that information would also be helpful. Thanks.

ASSISTANT COMMISSIONER JACOBS: Thank you, Bev. I'm happy to answer that question. I'll do the best I can with it.

The truth is there's a Medicaid piece of this, which is we've applied to the federal government to say we would like to provide these home-delivered meals and other MLTSS benefits to members who are not part of that program but who may have this need during the emergency period. And so we will be able to authorize meals through the health plans in that way as they're reaching members who express that need.

In addition, there are meal programs happening through other organizations within state government and well beyond state government, and so when we amended LogistiCare's contract, it wasn't for the home-delivered meals that our health plans would provide; those are sent through shipping companies and arrive at the member's home that way. When we amended LogistiCare's contract, we were saying we would like to be able to use you to actually pick up meals from the aging program, from community food pantries, and other sources that are not that home-delivered meal that's authorized by a health plan and so really not technically under the Medicaid umbrella but under those related human services to be able to deliver back to the people that we serve. So there are lots of ways right now that members are receiving meals at home. It includes food pantries and churches and community organizations all over the State and, additionally, that federal emergency flexibility that we've requested for the home-delivered meals through the health plan.

CHAIRWOMAN SPITALNIK: Thank you so much.

I will turn to MAAC Member Mary Pat Angelini to unmute herself and ask her question. Mary Pat.

MS. ANGELINI: Thank you very much, Deb. And thank you, Jennifer. That really was a wonderful presentation. And I want to personally thank you for the

speed at which the changes came regarding telehealth, especially as it relates to mental health and addiction services. It's really been a lifesaver. So thank you very much.

I know you mentioned that you're expecting an enrollment surge. Have you seen any drop-off of our current enrollees in Medicaid?

ASSISTANT COMMISSIONER JACOBS: Thanks, Mary Pat. I appreciate the question and also your service, your direct service, in the community.

The answer to your question is we were seeing enrollment dropping off all during 2019 and the very beginning of 2020. And I'm really talking about applications. Now we are seeing an increase in applications coming in since about the third week in March. So we're gearing up to manage that higher volume that we anticipated would come when we saw the shifting of the economy.

MS. ANGELINI: Thank you.

CHAIRWOMAN SPITALNIK: I'm not seeing any other questions, but from an earlier e-mailed question, there was a question about the expansion of telehealth to mental health services both for beneficiaries and caregivers. Is there anything that you would like to add to that, Jen or Sarah?

ASSISTANT COMMISSIONER JACOBS: So the modifications that were made to the telehealth rule really has a touch on behavioral health in a special way because there were certain limitations on where someone could be when they were receiving a telehealth visit or having a telehealth visit with their provider. We were able to lift those restrictions so that that visit could occur regardless of where the member is. We wouldn't want to ask them to go out and go to a certain office to be able to engage in a telehealth visit. The purpose of the telehealth visit during this emergency is to make sure they don't have to leave home. So we went ahead and made that change. And now across the behavioral health community, we've had some questions about how sort of the specifics of certain services. And it's really not only behavioral health. Among other providers, too, there are things that you would normally do in an office visit that you can do over the phone, discussions that you can have, observations that you could make. But then there's also a hands-on aspect sometimes to a visit that you wouldn't be able to do over the phone. So we're working through with different provider types, how they can manage a telehealth visit and feel that they are compliant and consistent with our expectation. And as we've been working through the guidance for each of those provider

types, we've been having conversation with them to make sure that the guidance we're issuing is consistent with the reality that they're experiencing.

CHAIRWOMAN SPITALNIK: Thank you.

I am not seeing any other questions in the chat box.

Wayne Vivian, if you have a question and want to unmute, this would be a good time.

I am not hearing any other questions. I will try to get us through the way that we typically close meeting in terms of our looking forward to our next opportunity, and then I want to make sure that Sarah Adelman or Jen has anything they'd like to say before we adjourn.

It's hard to believe that we met last on February 9th and had an update about preparation or anticipation from the Department of Health Emergency Response and what has transpired with the ravages of COVID and the incredible amount of work that has been done to support all of New Jersey citizens.

As our regularly scheduled agenda calls for, we are scheduled to meet on July 22nd and October 1st. We have a shared commitment to exploring whether both the feasibility for a meeting prior to the July 22nd meeting. None of us can predict that we will be able to gather in

person or to remain at a safe social distance. So that is the last update that I'll share. Again, the slides are already on the website, and we continue to invite e-mail questions and concerns.

I would now turn to Jen and Sarah, in whatever order they prefer, if there's anything they would like to say in closing to the community.

MS. ADELMAN: This is Sarah. I just will echo the comments of the Commissioner and Assistant Commissioner Jacobs throughout this MAAC meeting. We thank you all so much for your partnership and for your advocacy. We all have common goals here and know that the community remains passionate about making sure that PPE and testing are available to our workers on the frontline who serve our communities across all kinds of provider types across all the divisions in our Department, whether it be health care workers or home health aides, direct support professionals, those working in homeless shelters and at food pantries. So we continue to advocate with you all for those supplies to be available to our communities, and we'll keep you all up to date as more comes available for New Jersey and will continue to do the advocacy around flexibilities and funding wherever possible.

So, again, thank you for your partnership for all of the work that you're doing with us and in the

community on the frontlines right now. We know you've been in touch with us and we've been in touch with you, but we are open and working hard and available for you whenever you need it, so please never hesitate to reach out to us. And be well and stay safe.

CHAIRWOMAN SPITALNIK: Thank you so much.

Jen.

ASSISTANT COMMISSIONER JACOBS: I would just echo what Sarah has said. I would like to thank the members of the MAAC and especially Theresa Edelstein and Stuart Sandberg as the New Jersey Hospital Association for hosting us on this call today. You've made this possible. And folks in the community and in our ecosystem, the people who make the all happen with us, please continue talking to us and letting us know as you see individual issues or systemic issues. We are scrambling 7 days a week and, in the case of many people on my team, 24 hours a day to make sure that we're doing this the best way possible with you.

And then just finally, Dr. Spitalnik, I did want to say one more thank you to my team for the incredible work that they've been doing to bring us through this the best way possible.

CHAIRWOMAN SPITALNIK: Thank you so much.

I want to echo the thanks to Theresa Edelstein and New Jersey Hospital Association and especially Stuart

Steinberg who we now think of as our wizard behind a curtain who has really made this accessible to all of us.

And in closing, again, to express our gratitude and admiration for the incredible work that is being done with such thoroughness, generosity of spirit, and compassion. We send our heartfelt condolences and wishes to those who have suffered losses and those who are suffering with illness, and our wishes for good health and safety for everyone.

So I will adjourn with our heartfelt thanks for the opportunity to be part of this virtual caring community. Good health, everyone. Take care. Thank you for being with us today. And we will now end our meeting. We stand adjourned.

(Meeting 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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