

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

April 8, 2022

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Centers for Medicare & Medicaid Services
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Submitted Online via Medicaid.gov

Re: New Jersey 1115 FamilyCare Comprehensive Demonstration Proposal

Greetings:

Justice in Aging appreciates the opportunity to comment on New Jersey's Section 1115 Medicaid demonstration renewal proposal. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults in New Jersey and older adults nationwide. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources, particularly populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicaid and working with advocates who represent low-income older adults in New Jersey.

We applaud New Jersey for advancing health equity in their proposal. As acknowledged in their proposal, systemic barriers to health based on age, race, ethnicity, sex, sexual identity, disability, socioeconomic status, and geographic location are all contributors to health disparities.¹ However, while New Jersey has worked to make its Medicaid system more equitable, more can be done to advance equity in their current proposal as prioritized by the

¹ N.J. Dept. of Human Serv. Div. of Med. Assistance & Health Serv., *NJ FamilyCare Comprehensive Demonstration Renewal Proposal* (Feb. 28, 2022), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-ext-req-pa.pdf>, at 7 [hereinafter *NJ 1115 Demonstration Renewal Proposal*].

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Centers for Medicare & Medicaid Services (CMS).² Our comments accordingly focus on ensuring that equity is centered throughout the proposal's initiatives specifically for older adults.

Eligibility & Enrollment Flexibilities

New Jersey has implemented a number of initiatives that we believe will be beneficial in expanding eligibility and enrollment in Medicaid for older adults. We support, for example, the elimination of the five-year look back for MLTSS applicants who have income at or below 100 percent of the federal poverty level.

Continuous Eligibility

We also support the extension of continuous eligibility to adults;³ however, we are concerned that it is limited only to adults who qualify for Medicaid based on Modified Adjusted Gross Income (MAGI) eligibility. We believe continuous eligibility should be expanded to apply to adults of all ages, including those enrolled in Medicaid LTSS. We understand that income changes for the MLTSS population arise less often, however, they do occur and termination of coverage can cause disruption in access to essential Medicaid benefits and also can result in disenrollment from integrated plans like Medicare Duals Special Needs Plans. Further, a consistent policy of continuous eligibility for all enrollees reduces confusion among enrollees and stakeholders and minimizes administrative complexity and burden on Medicaid agency staff.⁴

Retroactive Coverage and Presumptive Eligibility

In addition to continuous eligibility, we also urge CMS to extend retroactive coverage for Home and Community Based Services (HCBS) to mirror retroactive coverage in Medicaid for other services. Today, CMS allows Medicaid services to be covered up to three months prior to the month in which Medicaid coverage is requested, for any month in which the person met eligibility standards. As a result, a person can enter a nursing facility in September and not file a Medicaid application until December, but still receive Medicaid coverage beginning retroactively in September. However, CMS guidance for HCBS forbids any retroactive coverage of HCBS and only allows for payment after a Medicaid HCBS service plan is approved. The consequences of this policy discrepancy are clear: low-income persons are forced to move into nursing facilities unnecessarily.⁵ We accordingly urge CMS to update this

² See *id.*; Chiquita Brooks-LaSure, *My First 100 Days and Where We Go From Here: A Strategic Vision for CMS*, CTR. FOR MEDICARE & MEDICAID SERV.: BLOG (SEPT. 9, 2014), <https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms>.

³ *NJ 1115 Demonstration Renewal Proposal*, *supra* note 1, at 39.

⁴ *NJ 1115 Demonstration Renewal Proposal*, *supra* note 1, at 39.

⁵ Eric Carlson, *Medicaid's Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today*, JUSTICE IN AGING, Sept. 2021, <https://justiceinaging.org/wp-content/uploads/2021/09/Medicoids-Unfair-Choice.pdf>.

policy to provide retroactive coverage for HCBS as provided for all other covered Medicaid services as a means of addressing the institutional bias.

We also urge CMS to work with New Jersey to put in place presumptive eligibility for MLTSS. Even if retroactive coverage is offered and even if it is not, unlike nursing facilities, many HCBS providers do not have the financial ability to render services unpaid until a Medicaid application is ultimately approved. Having both retroactive coverage and presumptive eligibility in place would allow enrollees to access HCBS immediately and prevent unnecessary admissions to nursing facilities.

Qualified Income Trust

We appreciate that New Jersey has committed to continue stakeholder conversations to improve the Qualified Income Trust (QIT) route to eligibility. In addition to ongoing engagement, we also believe it is imperative for New Jersey to collect and report data on who is able to utilize the QIT. The QIT process is overly complex and administratively burdensome for enrollees making it ripe for inequities in who is able to utilize the QIT based on age, race/ethnicity, disability, sexual orientation and gender identity (SOGI). It is well-documented that administrative burdens disproportionately impede health access for marginalized populations.⁶ Data collection and reporting is therefore essential to informing the state's efforts to evaluate the QIT policy. In addition to the QIT, CMS should provide technical assistance and support to New Jersey to use Section 1902(r)(2) to expand financial eligibility for MLTSS.⁷

Managed LTSS Benefits

New Jersey has taken significant steps to expand access to Medicaid HCBS for older adults through MLTSS; however, we are concerned that services available through MLTSS are more medicalized and fewer services are available to ensure older adults are connected to their communities. New Jersey has indicated that it does not intend to make changes to its benefit package for specific populations from the current proposal. However, failure to do so for older adults increases their risk for institutionalization and poor health outcomes. For example, adjunct services outlined in the proposal (pp. 17-18) for individuals with intellectual and developmental disabilities (I/DD) including art therapy, aquatic therapy, and music therapy would be equally beneficial for older adults in MLTSS. Similarly, older adults are at high risk for isolation⁸ and therefore could equally benefit from community inclusion

⁶ Pamela Herd & Donald Moynihan, *How Administrative Burdens Can Harm Health*, HEALTH AFFAIRS Health Policy Brief, October 2, 2020, <https://www.healthaffairs.org/doi/10.1377/hpb20200904.405159/full/>.

⁷ Ctr. for Medicaid & CHIP Serv., Dept. of Health & Human Serv., *CMCS Informational Bulletin, Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees*, (Jan. 23, 2015), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-23-2015.pdf>.

⁸ Ctr. for Disease Control & Prevention, *Loneliness and Social Isolation Linked to Serious Health Conditions*, (last reviewed Apr. 29, 2021), <https://www.cdc.gov/aging/publications/features/lonely-older-adults.html>.

services and support coordination services provided to individuals with I/DD through the supports program (pp. 18-22).

MCO Oversight

We also strongly urge stronger CMS oversight of MLTSS in New Jersey. In its June 2020 report, the Office of Inspector General found that New Jersey is not ensuring that MCOs are adequately providing for enrollees' needs for long-term services and supports.⁹ In the absence of conflict free case management in MLTSS, there is significant risk for MCOs to improperly reduce services and fail to adequately coordinate or monitor quality of care. Ineffective care management can result in or perpetuate disparities in access and health outcomes based on age, disability, race, SOGI, and geographic location.

Increased oversight should include at a minimum tracking and publicly reporting the number of MLTSS enrollees whose services are decreased (including by age, disability, race/ethnicity, SOGI, and geographic location) as well as publicly reporting on the entirety of the state's monitoring and evaluation of MLTSS plans on a consistent basis (e.g. annually). We also encourage the state to continue strengthening care management requirements in its contracts with managed care organizations to improve person-centeredness in MLTSS. For example, considering the disparities in access to HCBS and high risk of institutionalization for individuals with Alzheimer's and dementia, MLTSS contracts should require designated care coordination staff in dementia care management.¹⁰

As suggested in the OIG report, New Jersey should impose fines on MCOs that do not abide by the MCO contract. It is estimated that New Jersey paid non-compliant MCOs up to \$721 million in capitation payments during 2016.¹¹ Allowing MCOs to keep this money without repercussions will only encourage their failure to provide beneficiaries with the required services. Imposing a penalty for failure to meet requirements would ensure that the bottom line of the MCOs is not placed above the needs of Medicaid beneficiaries.

⁹ Off. of Inspector Gen., Dept. of Health & Human Res., *N.J. Did Not Ensure That its Managed Care Org. Adequately Assessed and Covered Medicaid Beneficiaries' Needs for Long-term Services & Supports*, Jun. 2022 [hereinafter *OIG Report*].

¹⁰ See, for example, California's Financial Alignment Initiative three-way contract between its managed care organizations, state Medicaid agency, and the Ctr. for Medicare & Medicaid Serv. available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract.pdf>. The contract requires MCOs to employ specially designated Care Coordination staff in dementia care management including but not limited to: understanding dementia; symptoms and progression; understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and, community resources for Enrollees and Caregivers.

¹¹ *OIG Report*, *supra* note 9 at 4-5.

Rebalancing MLTSS and HCBS Spending

Available data shows that there is still much room to improve rebalancing for older adults in New Jersey.¹² New Jersey's proposal indicates that the nursing facility census declined by 5% between 2014 and 2019 while New Jersey's older adult population grew by 12%. Yet, the latest federal LTSS expenditure data for older adults from FY 2018 indicates that New Jersey is spending 21% on HCBS for older adults versus 79% on institutional care for older adults.¹³ This raises the question whether the census decline is in fact a result of older adults being diverted or transitioned out of these facilities. New Jersey should collect and report intersectional rebalancing data including age, disability, race/ethnicity, SOGI, and geographic location to both identify disparities in rebalancing among populations and to inform policies to address those disparities.

New Jersey should also set annual rebalancing targets for all populations based on age, disability, race, ethnicity, and other factors.

Nursing Facility Quality

New Jersey's current proposal fails to address the quality of care in nursing facilities. The COVID-19 pandemic acted to highlight long-standing quality of care deficiencies in New Jersey's nursing facilities as outlined extensively in the 2020 report from Manatt Health.¹⁴ It is also well documented that prior to the pandemic and during the pandemic nursing facilities that have higher proportions of residents of color provide poorer quality of care.¹⁵ The 1115 waiver presents New Jersey with an opportunity to put in place value-based incentives in its MCO contracts to equitably improve nursing facility quality in accordance with the Administration's priorities of increasing staffing ratios, transparency, and oversight.

¹² Damon Terzaghi, *State Survey Demonstrates Rebalancing Successes and What Remains to be Done*, AARP, Apr. 23, 2020 <https://www.longtermscorecard.org/blog/2020/04/state-survey-demonstrates-rebalancing-successes-and-what-remains-to-be-done>.

¹³ Caitlin Murray et al., *Medicaid Long-Term Services & Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018*, MATHEMATICA, Jan. 7, 2021, <https://www.medicaid.gov/sites/default/files/2021-01/Itssexpenditures-2017-2018.pdf>.

¹⁴ Manatt Health, *Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19*, Jun. 2, 2020, <https://www.manatt.com/Manatt/media/Documents/NJ-LTC-Report.pdf>.

¹⁵ See, for example, Maricruz Rivera-Hernandez, *Quality of Post-Acute Care in Skilled Nursing Facilities that Disproportionately Serve Black and Hispanic Patients*, J. GERONTOL. A. BIOL. SCI. MED. SCI., Vol. 74, No. 5, at 689, 691-94 (2018); Yue Li et al., *Racial Disparities in Rehospitalization Among Medicare Patients in Skilled Nursing Facilities*, AM. J. PUBLIC HEALTH, Vol. 101, No. 5, at 875, 878, 881 (May 2011); Priya Chidambaram et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, KFF (Oct. 27, 2020); Rebecca Gorges & Tamara Konezka, *Factors Associated with Racial Differences in Deaths Among Nursing Home Residents with COVID-19 Infection in the U.S.*, JAMA NETWORK OPEN, Vol. 4, No. 2 (2021); Yue Li et al., *Racial and Ethnic Disparities in COVID-19 Infections and Deaths Across U.S. Nursing Homes*, J. AM. GERIATRICS SOC'Y, Vol. 68, No. 11, at 2454-2461 (Nov. 2020); Robert Weech-Maldonado et al., *High-Minority Nursing Homes Disproportionately Affected by COVID-19 Deaths*, FRONT. PUBLIC HEALTH, Vol. 9, Mar. 22, 2021.

CMS should encourage the state to amend its waiver proposal to better address quality of care in nursing facilities.

Housing Supports

We strongly support New Jersey's inclusion of housing supports in the waiver proposal. Without housing, HCBS cannot be delivered. Older adults are severely rent burdened and that burden increases with age and by race. Such instability is driving a surge in homelessness among older adults and particularly older adults of color. In many parts of the United States, older adults represent the fastest growing age segment of the homeless population with nearly half becoming homeless for the first time after age 50.¹⁶ We support New Jersey's proposal to include additional contractual requirements for MCO housing specialists and standards as well as the creation of a state Medicaid housing unit with a commitment to enhance engagement between Medicaid and housing stakeholders.

Assessments

We support that assessments be conducted and initiated by MCOs at transitions (out of incarceration; into and out of nursing facilities and other institutional settings) to determine whether an individual is eligible for targeted housing-related services (pp. 37-39). The burden to request an assessment should not be on the beneficiary or their case manager during a period of particularly high disruption and health uncertainty. We support at least two yearly assessments for all MLTSS members to advance rebalancing goals. MCOs should be evaluated on how they are meeting this requirement and whether there are disparities in who is receiving assessments based on age, race, disability, SOGI, and geographic location; and then implementing targeted interventions to address the disparities.

Assisted Living Programs

We applaud New Jersey's innovative use of Assisted Living Programs (ALPs). ALPs provide comprehensive care throughout the day to beneficiaries within their own homes.¹⁷ This expands care options for beneficiaries who prefer to receive care in the home, require intermittent care throughout the day, and cannot afford an assisted living facility. An expansion of ALPs in New Jersey could greatly improve equity in HCBS, however, the route to partnership between ALPs and housing providers is not simple. The Medicaid housing unit

¹⁶ Patti Prunhuber & Vivian Kwok, *Low-Income Older Adults Face Unaffordable Rents, Driving Housing Instability and Homelessness*, JUSTICE IN AGING (Feb. 2021), <https://justiceinaging.org/wp-content/uploads/2021/02/Older-Adults-Rental-Housing-Burdens.pdf>.

¹⁷ N.J. Assisted Living Program Provider Coalition, *Breaking the Long-Term-Care Mold to Fill in the System's Gaps*, <https://www.capitalimpact.org/wp-content/uploads/2022/02/New-Jersey-Assisted-Living-Program-ALP-Primer-10-2021.pdf>.

could be an ideal intermediary between housing providers and ALPs to expand the accessibility of ALPs for beneficiaries.¹⁸

Data Collection

It is critical that New Jersey evaluate how equitably available the housing and tenancy supports are to all Medicaid beneficiaries with robust data collection and reporting. Likewise, data collection and reporting on the availability of rental units through the Healthy Homes Initiative is needed to ensure access is equitable. Lastly, it is vital that MCOs ensure that enrollees know they have access to these services and programs through strong education and outreach initiatives.

Nursing Home Diversion and Transition

We want to ensure that nursing home diversion and transition programs are equitably available to older adults. New Jersey's MFP program has demonstrated marked success; however, the majority of transitions have been for individuals with I/DD or physical disabilities, which is necessary and commendable. Older adults, however, have been transitioned out of facilities at lower rates. For example, as of 2019, 997 older adults, 987 people with physical disabilities, and 959 people with I/DD transitioned out of New Jersey facilities despite the higher number of older adults in institutional settings.¹⁹

Accordingly, we recommend that New Jersey be required to collect and report robust demographic data on who the transition and diversion programs are serving to identify disparities based on intersecting identities including age, race, disability, SOGI, and geographic location. For example, individuals with Alzheimer's or dementia are at particularly high risk for institutionalization.²⁰ New Jersey could employ targeted diversion and transition strategies that address this disparity. Such a strategy could, for example, include far more robust supports for unpaid family caregivers including assessment questions during the care plan process for caregivers on what they need and connecting them to supports that are culturally competent. Research demonstrates that individuals with dementia and Alzheimer's are far more likely to avoid institutionalization when they have a family caregiver.²¹ "Family" however should be defined broadly to include friends and other relationships. This is particularly important for the LGBTQ population who are less likely to have children caregivers. Transition strategies for this population could resemble the

¹⁸ *Id.* at 17.

¹⁹ Kristie Liao & Victoria Peebles, *Money Follows the Person: State Transitions as of December 31, 2019*, MATHEMATICA, at 6 <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf>.

²¹ National Institute on Aging, *Family member availability predicts likelihood of unpaid care for people living with dementia*, November 16, 2021, <https://www.nia.nih.gov/news/family-member-availability-predicts-likelihood-unpaid-care-people-living-dementia>.

Olmstead resource team that provides intensive supports to people with intellectual disabilities during their first days back in the community from a facility in place today, but trained specifically in Alzheimer's and dementia.

We are supportive of the efforts to improve nursing home diversion and transition outlined in the proposal including nutritional supports and increased respite to caregivers. Again, we encourage data collection and reporting on who receives these services. We also encourage New Jersey to analyze who is able to utilize the short-term stay provisions that allow nursing home residents to retain their income to pay towards housing while in a nursing facility or institutional setting. Equitable access to this program ensures that nursing facility residents are able to retain housing to return to.

Data Strategy

We support New Jersey introducing new performance measures to consider equity and access in MCOs provision of behavioral health services (p. 10). We also encourage New Jersey to consider equity and access in all of its performance metrics. Data collection for all of these initiatives is critical to ensuring the demonstration equitably provides benefits and services, and reduces health disparities.

It is vital to evaluate impact by race and ethnicity, and it is equally important to collect and report data employing an intersectional analysis of age, disability, SOGI, geographic location in addition to race and ethnicity. Without collecting this data, it is impossible to ensure equitable access to the Medicaid program and its benefits. Data collection for limited English proficiency enrollees in New Jersey is especially important. New Jersey has an immigrant population of nearly two million people and over 5% of the population has limited English proficiency.²² Data must also be publicly reported to ensure transparency and accountability.

Workforce

Lastly, we encourage CMS to work with New Jersey to ensure an adequate workforce to provide long-term services and supports. Currently there is a significant workforce shortage that is driven in large part by inadequate compensation and advancement opportunities.²³ CMS and the Administration for Community Living (ACL) have identified the workforce shortage as a crisis and accordingly should provide technical assistance and guidance to New

²² See Minority & Multicultural Health, *Language Access*, NJ DEPT. OF HEALTH (last reviewed Jun. 11, 2021), <https://www.nj.gov/health/ommh/resources/language-access/>. The top five languages spoken at home in New Jersey, other than English are Spanish, Filipino, Chinese, Hindi, and Korean.

²³ PHI, *Crisis on the Frontline: New Jersey's Direct Care Workforce*, November 10, 2021, <https://phinational.org/resource/crisis-on-the-frontline-new-jerseys-direct-care-workforce/>.

Jersey on how to recruit and maintain an adequate workforce that is valued for the essential services they provide to MLTSS enrollees.

Thank you again for the opportunity to provide feedback on New Jersey's 1115 proposal. Please feel free to reach out to Valencia Sherman-Greenup with any questions regarding our comments at vshermangreenup@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Amber C. Christ". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

Amber C. Christ
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