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# Building an Equitable Medicaid HCBS Infrastructure in New Jersey for Older Adults

JUNE 2022

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## INTRODUCTION

New Jersey's Medicaid program plays an essential role in helping older adults remain living in their homes and connected to their communities by providing coverage for supports known as Home- and Community-Based Services (HCBS). New Jersey offers a wide array of HCBS including personal care, adult-day services, and assisted living, to name just a few. However, equitable access to HCBS remains a challenge in New Jersey and across the country.

This paper is aimed at supporting New Jersey policymakers, state staff, HCBS providers, and aging and disability advocates in developing an equitable Medicaid HCBS infrastructure. This paper will provide a brief overview of New Jersey's Medicaid HCBS infrastructure for older adults, identify where there are opportunities to advance equity in the HCBS infrastructure, and recommend policy solutions leveraging those opportunities to build an equitable HCBS infrastructure in New Jersey.

The inequities in access to Medicaid HCBS arise out of discriminatory views of individuals with disabilities of all ages, including older adults, being less valuable to society, and society's desire to isolate them into isolated and confined settings.<sup>1</sup> That discrimination has been preserved by federal law, which requires states to cover care provided in institutional settings but makes coverage for most HCBS optional. While New Jersey has made notable progress to address the institutional bias, dedicated and intentional targeted strategies and resources are required to eradicate racism, ageism, ableism, sexism, homophobia, and transphobia entrenched in the HCBS and long-term care infrastructure.

The state has set the goal to enable older adults to remain living in their homes and communities in the State Strategic Plan on Aging.<sup>2</sup> To fully realize that goal requires New Jersey's Division of Medical Assistance and Health Services (DMAHS) in coordination with other state departments to leverage initiatives already underway and create new opportunities to disrupt the status quo and design an HCBS infrastructure that ensures older adults and people with disabilities have equal access to HCBS, regardless of age, disability, race, sex, sexual orientation, and other factors. This is particularly urgent in light of the COVID-19 pandemic that has disproportionately killed residents in institutional settings at much higher rates, especially in facilities with a greater percentage of residents of color.<sup>3</sup>

## NEW JERSEY INITIATIVES

There are currently a number of initiatives underway in New Jersey that the state can leverage to build an equitable Medicaid HCBS infrastructure.

### New Jersey State Strategic Plan on Aging

In 2021, New Jersey released its State Strategic Plan on Aging for 2021-2025. The plan includes seven goals including increasing access to HCBS.<sup>4</sup>

### New Jersey Age-Friendly Communities and State Advisory Council

On March 2, 2021, Governor Murphy issued an Executive Order establishing an Age Friendly State Advisory Council to 1) identify opportunities and barriers to the creation of livable communities; 2) recommend best practices for age-friendly employment and civic engagement; and 3) promote age-friendly community inclusion and equitable outcomes by examining programs and practices to ensure they address disparities experienced by older adults of every race, color, religion, gender, disability, sexual orientation, gender identity or expression, national origin, or ethnicity.<sup>5</sup>

### New Jersey's Medicaid 1115 Renewal

DMAHS submitted its proposed application to renew its 1115 waiver, New Jersey FamilyCare Comprehensive Demonstration, on February 28, 2022.<sup>6</sup> The applications include proposals to improve access to home- and community-based services through Managed Long-Term Services and Supports.

### New Jersey's HCBS Spending Plan

The federal American Rescue Plan Act provided states with a ten percent increase in federal funding specifically to expand and strengthen Medicaid HCBS.<sup>7</sup> New Jersey received final approval for its HCBS spending plan in February 2022, which includes 16 initiatives to expand and strengthen HCBS in the state.<sup>8</sup>

## ACKNOWLEDGMENTS

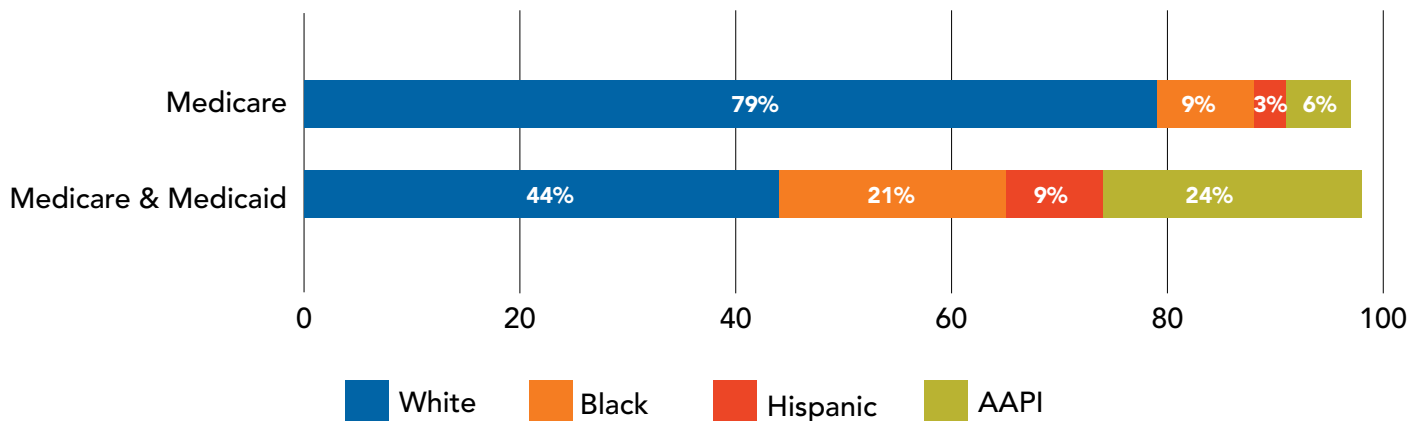
The development of this paper was made possible through funding from the [Henry & Marilyn Taub Foundation](#). To inform this paper, Justice in Aging interviewed HCBS program staff, HCBS providers, and other key state stakeholders. We would like to specifically acknowledge and thank Age Friendly New Jersey, Bergen County Division of Senior Services, Brightside Manor, Capital Impact Fund, Corporation for Supportive Housing, New Jersey AARP, New Jersey Disability Rights, New Jersey Long Term Care Ombudsman Office, and Rutgers University School of Social Work.

## MEDICAID HCBS FOR OLDER ADULTS: AN OVERVIEW

New Jersey is home to 217,000 older adults and people with disabilities who are dually eligible for both Medicare and Medicaid.<sup>9</sup> Of this total, 65% are age 65 and over, representing approximately 141,000 older adults.<sup>10</sup> These individuals are eligible for Medicare because of their age or disability and they are also low-income and with low assets in order to qualify for Medicaid. Individuals dually eligible for Medicare and Medicaid are disproportionately communities of color. In New Jersey, 44% of individuals dually eligible are white, 21% are Black, 9% are Hispanic, and 24% are Asian American or Pacific Islander. For comparison, of individuals who are eligible just for Medicare, 79% are white, 9% are Black, 3% are Hispanic, and 6% are Asian American or Pacific Islander (See Figure 1).<sup>11</sup>

New Jersey is also the home of 41,000 older undocumented immigrants age 55 and over. Today, these individuals are not eligible for Medicaid and have no coverage for HCBS.<sup>12</sup>

FIGURE 1  
Coverage Type, New Jersey's Medicare Enrollees



Source: Centers for Medicare & Medicaid Services (CMS), "MMCO Statistical & Analytic Reports," PUF\_2012 tab in Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012) (02/2020).

New Jersey's Medicaid program is known as NJ FamilyCare and provides multiple Aged, Blind, and Disabled (ABD) enrollment pathways for older adults including, SSI, Medicaid Only, NJ Care, and Managed Long-Term Services and Supports (LTSS).<sup>13</sup> New Jersey also offers two enrollment options as an alternative to MLTSS enrollment for Medicaid-eligible older adults: Program for All-Inclusive Care for the Elderly (PACE) and Fully Integrated Duals Special Needs Plans (FIDE-SNPs).

## NJ FAMILYCARE SSI, MEDICAID ONLY, AND NJ CARE AGED, BLIND, DISABLED

Individuals who are eligible for the federal Supplemental Security Income (SSI) program are automatically eligible for enrollment in NJ FamilyCare. Individuals who do not qualify for SSI, but who have income and resources at or below the SSI limits and are determined aged, blind, or disabled can enroll in the Medicaid Only program. For both of these enrollment options, individuals must have income below at or below \$841 in 2022 and resources below \$2,000 (for an individual).

Older adults also have the option to enroll through the NJ Care eligibility pathway if they are aged, blind, or disabled and have income up to 100% of the federal poverty limit and resources below \$4,000 for an individual.

Under these enrollment options, covered services include medical benefits as well as three HCBS benefits through New Jersey's state plan: home health care, Medical Day Care (Adult Day Health Services) and the Personal Care Assistant (PCA) Services benefit that allows individuals who qualify to receive assistance with activities of daily living and household chores.<sup>14</sup>

## NJ FAMILYCARE MLTSS

To access Medicaid long-term care beyond the state plan benefits, older adults must be enrolled in a NJ FamilyCare MLTSS plan. The five MLTSS plans—Aetna, Amerigroup, Horizon Blue Cross Blue Shield, United Healthcare Community Plan, and WellCare of New Jersey—offer a wide array of HCBS programs, supports, and services (See Appendix A). To be eligible for MLTSS enrollment, individuals must meet clinical eligibility (nursing facility level of care), have income below 300% the SSI limit (\$2,523 in 2022), and resources below \$2,000 for an individual.



Individuals who have income above the limit can establish a Qualified Income Trust (QIT) to place excess income.<sup>15</sup> In assessing eligibility, there is also a five-year lookback of an individual's resources to determine if there have been any assets transferred for less than fair market value.

As of March 2022, a total of 44,750 older adults were enrolled in an MLTSS plan to receive long-term care.<sup>16</sup> An additional 2,391 older adults who reside in a nursing facility remain in Medicaid fee-for-service, but are currently being transitioned into health plans.<sup>17</sup> Of older adults receiving long-term care through an MLTSS plan (and transitioning to an MLTSS plan from fee-for-service), 39% (18,287) reside in a nursing facility and 61% (28,854) are receiving HCBS.<sup>18</sup> (See Appendix B, Table 1).

**39%** of older adults enrolled in NJ FamilyCare MLTSS plans reside in a nursing facility and **61%** receive HCBS.

## PACE

PACE is an enrollment option for Medicare and Medicaid eligible individuals 55 and over who have a nursing facility level of care and need services and supports to remain living at home. Six PACE agencies operate in New Jersey within specific counties and within certain zip codes.<sup>19</sup> As of March 2022, 1,148 individuals were enrolled in PACE.<sup>20</sup> (Appendix B, Table 2).

## FIDE-SNPS

FIDE-SNPs are a specific type of integrated Medicare and Medicaid managed care plan for individuals dually enrolled in Medicare and Medicaid. These plans are tasked with delivering and coordinating an enrollee's Medicare and MLTSS benefits. As of April 2022, there are six FIDE-SNPs available in New Jersey with a total enrollment of 71,302 (which includes dually eligible individuals both who are age 65 and over and those under age 65).<sup>21</sup> (Appendix B, Table 3).

# OPPORTUNITIES TO ADDRESS EQUITY IN NEW JERSEY'S MEDICAID HCBS INFRASTRUCTURE

DMAHS has made notable progress in making Medicaid HCBS more widely available. The most recent available data from 2019 shows that of its total expenditures for LTSS across all populations, New Jersey spent 48% on HCBS and 52% on institutional care, compared to spending 41% for HCBS and 60% for institutional care in 2014, the first year the state implemented MLTSS.<sup>22</sup> New Jersey has also made progress to increase person-centered HCBS options. Between 2017 and 2020 New Jersey increased the proportion of personal care assistance delivered through self-direction from 33% to 42%.<sup>23</sup>

However, much progress remains – particularly for ensuring HCBS is made equitably available based on age, disability, race, and other factors. New Jersey is currently ranked 35th in the country for rebalancing its spending on HCBS. As noted previously, New Jersey spent approximately 48% on HCBS and 52% on institutional care in 2019. For comparison, Oregon, which is ranked first in the country, spent 83% of its total LTSS expenditures on HCBS. When looking at how well New Jersey is making access to HCBS more widely available for older adults specifically, spending for HCBS is just 21% for older

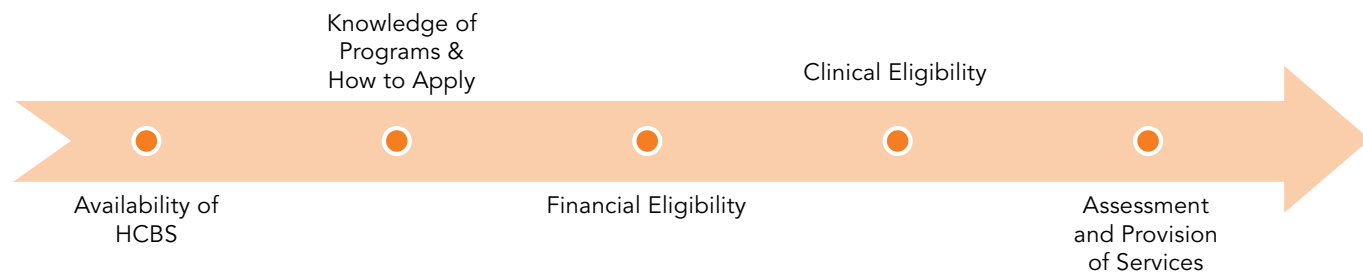
New Jersey is ranked **35<sup>th</sup>** nationally for rebalancing the provision of care from institutional to HCBS settings. **79% of spending** for older adults and people with physical disabilities goes to **institutional care**.

adults and people with physical disabilities.<sup>24</sup> In other words, 79% of New Jersey’s Medicaid LTSS spending for older adults and people with physical disabilities goes to institutional care.

To start to address these inequities in access to HCBS, it is necessary to evaluate the long-term care infrastructure at every stage of design and implementation including, for example, the availability and adequacy of Medicaid HCBS, knowledge of programs and application process for HCBS, determination of financial eligibility for HCBS, assessment of functional eligibility for HCBS, quality and amount of services, and data collection and reporting.

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### Inequities in Access and Utilization of HCBS Can Arise at Every Stage of Design & Implementation



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## DATA COLLECTION AND REPORTING

Building an equitable Medicaid HCBS infrastructure demands robust data collection and reporting. Today, however, publicly available data is limited. For example, NJ FamilyCare long-term care dashboard provides enrollment data that is only sortable by age. The enrollment dashboard does not include enrollment data for either HCBS or institutional care by demographic factors, including race, ethnicity, disability, language spoken, sexual orientation, gender identity (SOGI), or geographic location. The dashboard also does not include measures of access to HCBS including, for example, the number of hours authorized for personal care services, authorized benefits, and appeals and grievances. Data is also not publicly available on how equitably available HCBS is for New Jerseyans enrolled in PACE or FIDE-SNPs. Robust, intersectional, and transparent data is critical in identifying disparities in access to HCBS and formulating solutions to address those disparities, evaluating the state’s successes and its failures in advancing equity, and in promoting accountability.

### Recommendations: Data Collection and Reporting

- 1. Establish a uniform set of demographic elements that must be collected and reported by NJ FamilyCare and health plans across all HCBS and long-term care, for applicants, users, and providers.***

Demographic elements must include, at minimum, race, ethnicity, language spoken, age, disability, immigration status, SOGI, and geographic location (e.g., county and zip code) and be consistently collected and reported across all HCBS and long-term care programs, supports and services.

- 2. Collect and report across HCBS delivery models including MLTSS plans, PACE, and FIDE-SNPs.***

To effectively evaluate the extent HCBS is equitably available, data must be collected and reported consistently across all delivery models. While some data is publicly available regarding enrollment in MLTSS, little data is available for the over 71,000 individuals enrolled in FIDE-SNPs and 1,100 individuals enrolled in PACE

including who is enrolled, who is receiving services, and how well these plans are enabling enrollees to receive the services and supports they need to remain living at home and connected to their communities. Nor is data available regarding who is enrolled in and receiving only PCA services and other HCBS state plan benefits outside of MLTSS plans.

### 3. *Establish data access and utilization measures for HCBS.*

Several access and utilization measures can be implemented across all HCBS and long-term care types to identify disparities, including, for example, the number of approvals, denials, and terminations for HCBS and long-term care as well grievance data (stratified by demographic data) are key in identifying disparities. It is also key to collect and report on measures specific to HCBS benefits. For example, for personal care it is necessary to collect and report the number of hours authorized stratified by demographic data. For the Money Follows the Person program known as “I Choose Home” in New Jersey, the access measures should include at a minimum who is receiving transition services stratified by demographic data and where in the state these transitions are occurring.

### 4. *Report rebalancing data and establish equitable rebalancing goals.*

Available data shows that there is still much room to improve rebalancing for older adults in New Jersey. The state should collect and report intersectional rebalancing data including age, disability, race, ethnicity, SOGI, and geographic location to both identify disparities in rebalancing among populations, to inform policies to address those disparities, and establish rebalancing goals that will yield equitable results.

## AVAILABILITY AND ADEQUACY OF HCBS FOR OLDER ADULTS

In an equitable HCBS infrastructure, individuals eligible for programs would have access to comparable levels and quality of services and supports regardless of where they live in the state, age, race, language preference, and the extent of disability and need. However, that is not always the case. For example, today 3,104 MLTSS enrollees are eligible for the assisted living residence (ALR) benefit. When looking at where in the state ALR benefit is most utilized, residents in less racially diverse counties have more access to the benefit. The six counties with the most older residents in New Jersey are Bergen, Ocean, Middlesex, Essex, Monmouth, and Morris (in that order). Ocean, Monmouth, and Morris are the least racially diverse but account for 34% of MLTSS enrollees residing in assisted living facilities. On the other hand, Bergen, Middlesex, and Essex counties are more racially diverse with a higher older adult population than Ocean, Monmouth, and Morris, but account for just 18% percent of individuals receiving the assisted living benefit.<sup>25</sup> Similarly, Assisted Living Programs (ALPs), which provide a range of services to individuals residing in subsidized senior housing allowing them to remain living independently, are not available in every county; within counties, ALPs are not operating in all zip codes or communities.<sup>26</sup>

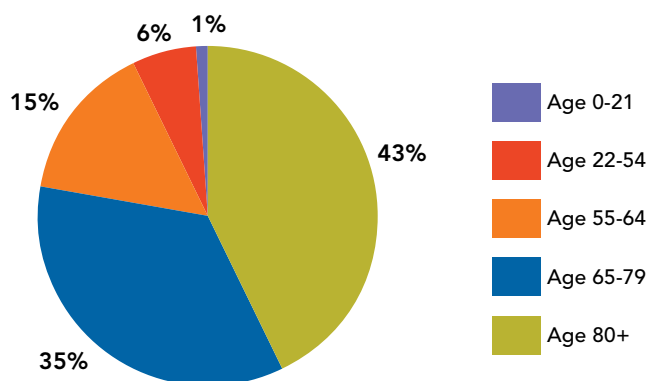
New Jersey’s Money Follows the Person program, I Choose Home, the program ranks 5th in the country for the number of transitions from institutions it has accomplished in the program’s history. This is a remarkable achievement. Yet, data demonstrates that transitions are disproportionate across populations. While transition data based on race, disability, and geographic location are not publicly available,

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age data demonstrates that individuals over age 65 are transitioned out of facilities at lower rates than individuals under age 65. The available data shows that since its inception through 2019, I Choose Home has transitioned 2,943 individuals out of nursing facilities including 997 older adults, 987 individuals with physical disabilities, and 959 individuals with intellectual and developmental disabilities.<sup>27</sup> However, older adults constitute a higher proportion of individuals residing in nursing facilities—78% of MLTSS enrollees in nursing facilities are older adults age 65 and over.<sup>28</sup> One would expect the rate of transitions to keep up with the proportion of residents in facilities, yet the rate of transitions for older adults have been markedly less.

New Jersey stakeholders have also reported that HCBS provided to older adults in MLTSS plans are more medicalized and less robust than HCBS that have historically been delivered through waivers for individuals with intellectual and developmental disabilities that aim to increase self-direction and community engagement. Instead, the HCBS benefits authorized for older adults are more constrained (e.g., assessed 10 minutes for toileting; 15 minutes for dressing, etc.). These reports are consistent with New Jersey’s 1115 draft proposal which would require MLTSS plans to offer community inclusion services for individuals with intellectual and developmental disabilities.<sup>29</sup> Yet, no such benefits are proposed for older adults—particularly older adults with cognitive impairments like dementia and Alzheimer’s who are disproportionately people of color—who also face high rates of isolation and would equally benefit from services that enhance community inclusion.

**FIGURE 2**  
NJ FamilyCare, MLTSS Nursing Facility  
Benefit Utilization, by Age, March 2022



Source: NJ FamilyCare, “Long-Term Care at a Glance,” (Mar. 2022) accessed May 16, 2022, available at [http://www.njfamilycare.org/analytics/LTC\\_explorer.html](http://www.njfamilycare.org/analytics/LTC_explorer.html).

## Recommendations: Availability and Adequacy of HCBS for Older Adults

### 5. Conduct an equity analysis of the availability and adequacy of HCBS for older adults.

The above examples represent how inequities in access to Medicaid HCBS arise in a sampling of specific HCBS programs and services for older adults. DMAHS should conduct a comprehensive equity analysis to identify the gaps in access to all HCBS programs and service types for older adults and all other enrolled populations stratified by demographic data and geographic location. Such an analysis must also examine who is currently residing in institutional settings like nursing facilities to identify whether there are disparities in who is residing in facilities.

### 6. Employ targeted strategies and interventions to improve equitable access to HCBS for older adults.

Identifying inequities in access to Medicaid HCBS is just the first step. The next essential step is addressing those disparities and to do so in a way that takes into consideration the ways in which intersecting and compounding forms of discrimination impact access.

As noted above, the I Choose Home Program has achieved high numbers of transitions out of institutional settings for individuals with intellectual and developmental disabilities. This is attributable to innovative targeted strategies the state employed for this population including the provision of intensive transition

supports, creation of an Olmstead resource team, and strategic coordination across multiple divisions and programs including the Division of Developmental Disabilities, the Division of Aging Services, and the ombudsman's office.<sup>30</sup> Targeted strategies could similarly be developed and implemented to address the significant barriers older adults face in transitioning out facilities—especially for older adults with cognitive impairments, including Alzheimer's and dementia; who have complex care needs; and who lack familial supports.

Similarly, targeted strategies and coordination are required to make assisted living more widely available in the state, especially ALPs. When someone living in subsidized housing goes into a nursing facility—even for a short stay, they are at high risk for losing their housing. With such a significant shortage of affordable housing options for older adults, the ability to find housing again is limited. ALPs accordingly are essential in helping older adults maintain housing and avoid institutionalization. It is important for DMAHS to work with ALPs to address barriers in provider participation in the program including, for example, improving and streamlining the approval process for providers and evaluating the adequacy of reimbursement rates.<sup>31</sup>

Targeted strategies should also be employed when evaluating nursing facility and hospital policies. For example, the state should employ targeted strategies to address the hospital to nursing facility pipeline and when considering reforms to nursing facility quality and payment.<sup>32</sup>

## **7. Increase equitable access to housing.**

A prerequisite to accessing HCBS is having a home, however, affordable housing is hard to find in New Jersey. It is estimated that New Jersey has a shortage of over 200,000 rental units and over 17,000 new units in supportive housing are needed specifically for older adults.<sup>33</sup> The state has a number of opportunities to increase equitable access to housing specifically for low-income older adults enrolled in MLTSS. For example, DMAHS should ensure that the 100 accessible and rental units being developed under New Jersey's federally approved HCBS spending plan are equitably distributed throughout New Jersey, in locations where there is the greatest need for affordable housing.<sup>34</sup> DMAHS should also leverage the Medicaid housing unit proposed in the state's 1115 waiver to strengthen ALP provider relationships with subsidized housing sites.<sup>35</sup> Cross-sector collaboration among DMAHS, health plans, PACE, and FIDE-SNPs with housing providers and housing and homelessness agencies could also help to connect older adults with affordable housing.<sup>36</sup> DMAHS should also take advantage of the recently announced expansion of the Money Follows the Person Program supplemental services that federal dollars will fully fund, including up to 6-months of short-term rental assistance and associated utility expenses, and other tenancy and food security supports.<sup>37</sup>

## **8. Increase MLTSS community inclusion benefits for older adults.**

Older adults' access to services that enhance inclusion in the community are critical to addressing isolation, improving health outcomes, and preventing institutionalization. MLTSS plans should be required to provide services such as supports to engage in spiritual/religious activities, recreation, volunteering, and civic engagement, for example to all enrolled members including older adults.

DMAHS should also require MLTSS plans to partner with organizations serving individuals with Alzheimer's and dementia to improve screening, case management, and develop and deliver community inclusion benefits specifically targeted at this population who are particularly at high risk for institutionalization<sup>38</sup>—at age 80, 75% of people with dementia live in a nursing facility compared to 4% of the general population.<sup>39</sup> This inequity compounds other race-based inequities because rates of dementia are two times higher among Black and Hispanic older adults compared to white older adults.<sup>40</sup>



DMAHS should create focus groups and engage directly with Medicaid enrollees to hear first-hand what their needs are and what benefits are needed to ensure their community inclusion. This is particularly important in addressing the unmet needs of marginalized communities including communities of color, LGBTQ+ seniors, older adults with cognitive impairments, and older adults living with HIV/AIDS.

#### **9. *Invest in New Jersey's direct care workforce.***

Equitable access to HCBS is contingent on having a diverse, qualified, and adequately compensated workforce who can meet the needs of New Jersey's diverse Medicaid population. New Jersey must commit to developing a statewide workforce development program to increase compensation, provide enhanced training and career advancement, improve cultural competency, and address the discrimination based on race, gender, and immigration status this workforce experiences.<sup>41</sup>

#### **10. *Establish and implement a quality strategy for HCBS.***

In addition to identifying who is enrolled in programs and what services they are accessing, it is also key to measure and monitor the quality of the services individuals are receiving to identify whether there are disparities in the adequacy of HCBS. A quality strategy should evaluate structures (e.g., staffing ratios), processes (e.g., completion of assessments and care plans), and outcomes (including functional outcomes of HCBS users and their consumer experience).<sup>42</sup>

## **KNOWLEDGE OF PROGRAMS AND HOW TO APPLY FOR AND MAINTAIN SERVICES**

A significant barrier to equitable access to HCBS is whether older adults have knowledge of HCBS programs and services, and are able to navigate the application and approval processes. Stakeholders report that the application process is complex and that many resources regarding the application and MLTSS benefits are available only online. Older adults who have limited English proficiency (LEP) face additional barriers in both accessing information in their primary language and understanding the programs. In addition, MLTSS program rules can impede access to HCBS, especially immediate access placing individuals unnecessarily at risk for institutionalization.

### **Recommendations: Knowledge of Programs and How to Apply for Services**

#### **11. *Continue efforts to improve the availability of information through multiple information channels and in languages other than English.***

It is critical that DMAHS continue education and outreach efforts to guarantee that all individuals who qualify for MLTSS and who need HCBS know about the program and understand how to enroll. Targeted strategies are especially important for individuals experiencing homelessness and to reach enrollees with LEP and communities of color. Recent research on PACE, for example, revealed that Black and Latino older adults were less aware of the program because they did not receive information about it from trusted sources like their primary care providers.<sup>43</sup> Additional methods and collaborations DMAHS could employ include radio and TV ads with in-language stations, disseminating information through meal delivery programs like Meals on Wheels, housing coordinators, homeless shelters, senior centers, and cultural centers.

#### **12. *Improve enrollment of justice-involved older adults into MLTSS.***

There are enormous racial disparities in New Jersey's prisons and jails. Sixty-one percent of individuals incarcerated in New Jersey are Black, despite Black individuals representing just 14% of the state's

population.<sup>44</sup> In 2021, New Jersey enacted a new law that expanded and improved reentry assistance to ensure justice-involved individuals are able to obtain Medicaid coverage and other public benefits upon release from incarceration.<sup>45</sup> DMAHS is also seeking approval in its 1115 waiver to include pre-release services for incarcerated individuals including up to four behavioral health care management visits to stabilize their needs prior to release.<sup>46</sup> DMHAS should expand on this initiative to engage with older adults and people with disabilities pre-release who have chronic conditions and cognitive impairments to stabilize their health, ensure enrollment in MLTSS plans, and access for health, HCBS, social, and economic needs.<sup>47</sup>

### **13. Implement presumptive eligibility for MLTSS.**

New Jersey should expand presumptive eligibility to older adults and people with disabilities enrolled in ABD programs including MLTSS. Presumptive eligibility allows applicants who appear likely to be eligible for Medicaid to start receiving services immediately.<sup>48</sup> Many HCBS providers do not have the financial ability to render services unpaid until a Medicaid application is ultimately approved. As a result, many older adults and people with disabilities cannot access HCBS services immediately and are either forced to receive needed care in nursing facilities or experience a gap in care. This is particularly detrimental for older adults residing in subsidized housing or who are on Supplemental Security Income (SSI), who will not be able to maintain their housing while institutionalized. Alternatively, the health of individuals who choose to remain at home while waiting for Medicaid approval is at risk and requires families and friends to fill the gaps and provide care unpaid.<sup>49</sup>

### **14. Implement continuous eligibility for MLTSS.**

DMAHS has proposed to extend continuous eligibility to adults enrolled in Medicaid based on Modified Adjusted Gross Income (MAGI) eligibility that guarantees continuous coverage for twelve months despite any change in financial eligibility within the year. Continuous eligibility should be expanded to apply to adults of all ages, including those enrolled in MLTSS who typically live on fixed incomes. Terminations of coverage for MLTSS enrollees can cause significant disruption in access to essential HCBS and also can result in disenrollment from integrated plans like FIDE-SNPs. 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.

## **FINANCIAL ELIGIBILITY FOR HCBS**

New Jersey employs the Medicaid special income rule for MLTSS including both institutional long-term care and HCBS. Under this rule, individuals with gross income up to 300% of the Supplemental Security Income (SSI) rate are financially eligible for HCBS as long as their resources remain under \$2,000 for an individual.<sup>50</sup> For individuals whose income exceeds the 300% special income limit, New Jersey allows them to establish a qualified income trust (QIT) also commonly called a Miller Trust, to obtain income eligibility for Medicaid. Additionally, if an individual who qualifies for HCBS is married, Medicaid's spousal impoverishment protection allows their spouse to retain a modest amount of income and resources beyond the individual income and resource limits to pay for rent, food, and medication. Meanwhile, individuals who do not meet an institutional level of care and only require the PCA benefit, for example, must meet stricter income criteria (100% FPL) but can maintain more resources (\$4,000). The stricter income limit acts as a barrier for low-income older adults who do not have as high of care needs to be eligible for MLTSS, but who still require assistance.

Furthermore, while these financial eligibility processes and determinations are seemingly applied uniformly for all applicants, under scrutiny they result in inequities in who is ultimately deemed financially eligible. For example, stakeholders have reported concerns that individuals face barriers in both establishing and maintaining a QIT.<sup>51</sup> Stakeholder concerns are consistent with national data that show that individuals residing in states that use the QIT lose Medicaid eligibility at higher rates than individuals in states that do not employ the QIT: 35% of individuals in states using the QIT lose Medicaid eligibility over a 12-month period compared to 25% of individuals in states that do not use the QIT.<sup>52</sup> These administratively complex rules and processes disproportionately impact populations who are less likely to have the resources to navigate such complicated processes, particularly communities of color and individuals who are limited English proficient.

“While these financial eligibility processes and determinations are seemingly applied uniformly for all applicants, **under scrutiny they result in inequities in who is ultimately deemed financially eligible.**”

Likewise, New Jersey’s asset limits for an individual penalizes single individuals, women, renters, and communities of color. While married couples are able to maintain much higher resources and be eligible for HCBS, the \$2,000 asset limit for MLTSS enrollment, means single individuals cannot maintain enough in savings to weather an emergency. This especially impacts women and women of color who are more likely to be single as they age and require assistance. In New Jersey, women account for 55% of the population 60 and older and 66% of those 85 and older.<sup>53</sup> The low asset limit also puts renters at particularly high risk of further instability or homelessness when financial crises happen and disproportionately harms older adults of color as they are more likely to have cash savings instead of an exempt home due to well-documented discrimination in housing.<sup>54</sup>

These examples are illustrative of how inequities arise in financial eligibility rules and processes and present the state with the opportunity to reevaluate program rules and how they are implemented to advance equitable access to HCBS.

## Recommendations: Financial Eligibility

### 15. *Evaluate the QIT process and alternative eligibility pathways.*

That state should 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, and SOGI. It is well-documented that administrative burdens disproportionately impede health access for marginalized populations.<sup>55</sup> In addition to evaluating the QIT process, New Jersey should evaluate whether alternative pathways to eligibility would expand access to HCBS more equitably and reduce barriers for marginalized populations.

### 16. *Increase the income limit for NJ Care.*

Today, the current income limit through the NJ Care eligibility pathway is 100% of FPL. This income limit is lower than the income limit for the Medicaid expansion population for single adults under age 65, which is set at 138% of FPL. It is also significantly lower than the MLTSS income limit of 300% of the SSI limit and the NJ Workability program of 250% of FPL. At a minimum, New Jersey should increase NJ Care’s income limit to 138% of FPL. This would ensure that when individuals reach 65 or become Medicare eligible and are no longer eligible for Medicaid expansion, they do not have to meet the stricter NJ Care income criteria and lose Medicaid eligibility at a point in their lives when they likely have the highest need for Medicaid coverage.

### **17. Eliminate the asset limit for Medicaid only, NJ Care, and MLTSS.**

New Jersey should eliminate the exceedingly low \$2,000 asset limit for Medicaid only and MLTSS programs and the \$4,000 asset limit for NJ Care. DMAHS recently made this change to the NJ Workability Medicaid program recognizing the exceedingly low asset limit forces individuals to live in deep poverty and perpetuates poverty.<sup>56</sup> Eliminating the asset limit would address the inequities that arise by how assets are counted, increase the economic security of enrollees in order to save for an emergency or accumulate enough to pay a rent deposit, reduce administrative burden for both enrollees and the state, and make the eligibility criteria consistent with Medicaid expansion MAGI rules and the NJ Workability program.<sup>57</sup>

### **18. Increase income and asset limits for Medicare Savings Programs.**

Medicare Savings Programs (MSPs) help pay for Medicare costs, including premiums and out-of-pocket cost sharing (i.e., co-insurance, co-pays, and deductibles). Being eligible for MSPs allows an individual to retain more income to pay for basic needs, most importantly including housing. Today, New Jersey has set the income and asset limits for MSPs at the federal minimums, thus limiting enrollment in these programs.<sup>58</sup> As many other states have done, New Jersey should increase the income limits and eliminate the asset limit for these programs. For example, this year New York increased income limits from 100% of the federal poverty level to 138% of the federal poverty level for the most generous MSP, the Qualified Medicare Beneficiary program.<sup>59</sup>

### **19. Limit Medicaid estate recovery.**

Under federal law, the state of New Jersey is required to seek recovery for the costs of Medicaid-covered nursing home services, HCBS, and certain related services, if the recipient was 55 years or older when services were provided.<sup>60</sup> New Jersey, however, goes beyond the federal requirements and seeks recovery on all payments provided through the Medicaid program. New Jersey also has very limited hardship exceptions for families of deceased beneficiaries to maintain the estate and does not limit the amount of the recovery regardless of the size of the estate. These estate recovery rules both act to deter very low-income older adults from applying for Medicaid covered services and strips wealth from very low-income families perpetuating intergenerational poverty and the racial wealth gap.<sup>61</sup> New Jersey should limit its estate recovery to the federal minimums, expand its hardship exceptions to limit recovery of estates that are of modest value.<sup>62</sup>

### **20. Expand coverage regardless of immigration status.**

The Governor recently announced plans to expand health coverage to all children who otherwise meet eligibility for Medicaid but-for immigration status.<sup>63</sup> New Jersey should build on this expansion to include adults. Both California and New York have expanded their Medicaid programs to include coverage for aging adults regardless of immigration status, including coverage for long-term services and supports using state dollars.<sup>64</sup> Providing such coverage ensures immigrants are able to seek care earlier, reducing future costlier care and hospitalizations, and ensures all individuals can receive the supports they need to remain living at home. Without the availability of LTSS, individuals will either have to forgo care and risk hospital readmission or alternatively rely on family to fill in gaps forcing them out of the workforce and putting their health and economic security at risk.



# CLINICAL ELIGIBILITY FOR HCBS AND AUTHORIZATION FOR SERVICES

In addition to meeting financial criteria, individuals must also be found functionally eligible or what New Jersey calls “clinically eligible” for HCBS. To be found clinically eligible, an individual must undergo an assessment conducted by the Division of Aging Services, Office of Community Choice Options (OCCO) if the individual is not already enrolled in Medicaid or by the enrollee’s Medicaid health plan if the individual is already enrolled in Medicaid. The individual must meet an institutional level of care defined as requiring assistance with three or more activities of daily living. The OCCO and Medicaid plan both employ the “New Jersey Choice Assessment System” to conduct the initial clinical eligibility assessment. OCCO also created and implemented an online “Enhanced At-Risk Criteria (EARC)” screening tool to be utilized by hospitals and other facilities to identify individuals who may be eligible for MLTSS (either HCBS or institutional care) and expedite MLTSS eligibility.

Medicaid plans also utilize the New Jersey Choice Assessment System to assess the type and level of HCBS services an individual is eligible to receive from the plan. The Medicaid plan employs an additional tool when an individual is determined eligible for personal care services, the personal care assistant (PCA) nursing assessment tool, to determine the number of personal care hours an individual can receive. These assessment processes are ripe for inequities. There is an inherent conflict with Medicaid plans conducting needs assessments since they have a financial interest in approving and denying services. This conflict introduces both conscious and unconscious bias into the assessment process. Evidence of this bias was illustrated in an audit of New Jersey’s MLTSS program in 2020, where the United States Office of the Inspector General found that Medicaid plans failed to adequately assess and cover enrollees’ LTSS needs in 68 of the 100 cases the agency reviewed in its random sample.<sup>65</sup>

New Jersey’s Medicaid plans are required to provide members with person-centered service planning and intensive care management. Bias can also arise in these processes. For example, research has found that Black HCBS enrollees with Multiple Sclerosis (MS) were less likely to receive case management, equipment, technology and modification services, and nursing services compared to white individuals with MS. Black men had the lowest HCBS use.<sup>66</sup>

## Recommendations: Clinical Eligibility for HCBS and Authorization for Services

### ***21. Strengthen care management standards and bias training.***

The state should strengthen care management requirements in its contracts with MLTSS plans to improve person-centeredness. 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. Stakeholders have also reported that very similarly situated individuals receiving very different levels of services due to who is conducting the assessment within an MLTSS plan and across MLTSS plans.<sup>67</sup> Bias training is necessary to ensure all plan staff from those staffing hotlines to care coordinators and those completing assessments for services to ensure assessment tools are being consistently applied and understand health beliefs, practices, and behaviors of enrolled members.

### ***22. Increase oversight of MLTSS plans.***

New Jersey should increase oversight of MLTSS plans, including, at a minimum, tracking and publicly reporting the number of MLTSS enrollees whose services are decreased (including by age, disability, race, ethnicity, primary language, 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 training and designated care coordination staff in dementia care management.

## CONCLUSION

New Jersey has made significant progress in increasing access to HCBS and in reducing the number of individuals residing in institutional settings to receive care over the last decade. The state now has the opportunity to establish itself as a leader in advancing equity in HCBS by implementing policies, strategies, and interventions that ensure those most at risk for institutionalization have access to HCBS. By capitalizing on the state's strategic plan on aging and federal funding opportunities, New Jersey is primed to develop an equitable long-term care system that can serve as a national model.

# APPENDIX A

## NJ FamilyCare MLTSS Benefits, 2022

<b>Adult Family Care</b>	Allows up to three unrelated individuals to live in the community in the primary home of a trained caregiver who provides support and health services for the member.
<b>Assisted Living Program (ALP)</b>	Assisted living services to those living in certain public housing.
<b>Assisted Living Residence (ALR)</b>	Assisted living services provided in an assisted living residence/facility.
<b>Caregiver/participant training</b>	Teaching provided to a member and/or caregiver either one-to-one or in a group to teach a variety of skills needed for independent living.
<b>Chore services</b>	Services needed to keep the home clean, sanitary, and safe.
<b>Cognitive Therapy (group and individual)</b>	Therapeutic interventions to keep skills and prevent deterioration, including direct retraining, use of compensatory strategies, use of cognitive orthotics, and prostheses for individuals with a traumatic brain injury.
<b>Community Residential Services (CRS)</b>	A package of services given to a member living in the community, residence-owned, rented or run by a CRS provider for individuals with a traumatic brain injury.
<b>Community Transition Services</b>	Benefits and services given to a member who is moving from an institution to their own home. This benefit is only available once.
<b>Comprehensive Personal Care Homes (CPCH)</b>	Assisted living services provided in a licensed CPCH including supportive personal and health care services, drug administration, and occasional skilled nursing services.
<b>Home-based Supportive Care</b>	Designed to help MLTSS members with their instrumental activities of daily living (IADL) needs. HCBS is available to members whose activities of daily living (ADL) needs are given by nonpaid caregivers such as family members or as a wrap-around service to non-Medicaid programs since the personal care attendant (PCA) is also available to MLTSS members.
<b>Home-Delivered Meals</b>	Delivery of no-cost healthy meals delivered to the member's home.
<b>Home Modifications</b>	Physical changes to a member's private home to help them live independently.
<b>Medication-Dispensing Device</b>	Allows for a set amount of drugs to be dispensed based on dosing instructions.
<b>Nursing Facility Services</b>	Custodial services given in a licensed facility that provide health care under medical supervision and constant nursing care for 24 or more hours.

<b>Personal Care Assistant (PCA) Services</b>	Non-emergent, on-going health related tasks performed by qualified staff in a member's home including help with activities of daily living, household duties, and instrumental activities of daily living. PCA is a state plan benefit available to both MLTSS enrollees and non MLTSS enrollees in NJ FamilyCare.
<b>Personal emergency response system (PERS)</b>	An electronic monthly monitoring device that allows members at high risk of institutionalization to get help in an emergency.
<b>Private Duty Nursing</b>	One-on-one nursing care up to 16 hours per day.
<b>Respite</b>	Services given to members who can't care for themselves provided on a short-term basis because an unpaid, informal caregiver is unavailable or requires assistance.
<b>Social Adult Day Care</b>	A community-based group program to meet the nonmedical needs of adults with functional needs through a structured full program that provides various health, social, and related support services in a protective setting during any part of a day, but less than 24 hours.
<b>Structured Day Program</b>	Services and supports to maintain and improve independent and community living skills for individuals with traumatic brain injury.
<b>Supported Day Services</b>	Activities to help individuals with traumatic brain injury to remain engaged in the community including shopping, recreational activities, and volunteering.
<b>Therapy</b>	Occupational, physical, speech, hearing, cognitive, and language therapies available to members to improve and/or prevent loss of function.
<b>Vehicle Modification</b>	Changes to a vehicle that would help individuals be more independent at home and in your community.



## APPENDIX B

**TABLE 1**  
**NJ FamilyCare Enrollment by Age and LTSS Program, March 2022**

LTSS Program	Enrollees Age 65 and Over	Enrollees Age 64 and Under
MLTSS Nursing Facility	15,896	4,409
Fee-for-Service Nursing Facility	2,391	790
MLTSS HCBS	25,984	10,324
MLTSS Assisted Living Residence	2,870	239
Total	47,141	15,762

Source: NJ FamilyCare, "Long-Term Care at a Glance," (Mar. 2022) accessed May 16, 2022, available at [http://www.njfamilycare.org/analytics/LTC\\_explorer.html](http://www.njfamilycare.org/analytics/LTC_explorer.html).

**TABLE 2**  
**PACE Enrollment, by Age, March 2022**

Age 55-64	Age 65-79	Age 80 and Over	Total
252	594	302	1,148

Source: NJ FamilyCare, "Long-Term Care at a Glance," (Mar. 2022) accessed May 16, 2022, available at [http://www.njfamilycare.org/analytics/LTC\\_explorer.html](http://www.njfamilycare.org/analytics/LTC_explorer.html).

**TABLE 3**  
**FIDE-SNP Enrollment, April 2022**

Health Plan	Enrollment Total
Aetna Assure Premiere	1,772
Amerivantage Dual Coordination	13,983
Amerivantage Due Secure	779
Horizon NJ Total Care	17,491
United Health Care	30,141
Wellcare Dual Liberty	7,136
Total	71,302

Source: Centers for Medicare & Medicaid Services, "Special Needs Plan Data," (April 2022), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data>.

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