April 5, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC  20201

Re: New Jersey FamilyCare Comprehensive Demonstration 1115 Waiver Renewal Application

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members – including our 1.2 million members in New Jersey – and all older Americans nationwide, appreciates the opportunity to provide comments on the New Jersey FamilyCare Comprehensive Demonstration 1115 Waiver Renewal Application.

AARP New Jersey has been engaged with the state’s Demonstration since its earliest proposal, has provided input and formal comments during each of the prior Demonstration periods and was a member of the Department of Human Services (DHS) Medicaid Managed Long-Term Services and Supports (MLTSS) Multi-Stakeholder Work Group. Unfortunately, we note that the New Jersey Department of Human Services (DHS) has not supported the MLTSS Work Group for a number of years. We believe the opportunity for regular updates and input into MLTSS through this Work Group, separate from the broader meetings convened by the Medical Assistance Advisory Council (MAAC), is an important component of the Demonstration’s success and believe that it should be re-instated as part of the new program period. Given CMS interest in stakeholder feedback and engagement, we hope CMS will encourage the state to re-instate this important stakeholder engagement and input opportunity.

AARP is encouraged by New Jersey’s reported success in rebalancing the state’s spending from predominantly institutional-based care to care provided in home and community settings, and we have urged the state to continue its efforts rebalancing New Jersey’s long term-services and supports system. However, and as described more fully below, AARP recommends that the state establish rebalancing benchmarks to measure continued improvement during the demonstration period and incentivize such progress.

AARP supports many of the waiver renewal’s goals and applauds a number of the proposed innovative programs. We are pleased to see programs expanding housing supports, including coverage of home modifications, the development of a Medicaid housing unit, and increased responsibility and accountability for managed care organization (MCO) housing specialists. We also support the proposed nursing home diversion and transition efforts. AARP has also long advocated for expanding supports for unpaid family caregivers and strongly supports the proposal to expand respite services from 30 to 90 days, caregiver counseling and hotlines, and nutritional supports.

As outlined below, we urge the Centers for Medicare & Medicaid Services to consider and work with New Jersey to implement additional opportunities that can further the goals of this Demonstration and improve the quality of care for all beneficiaries.
Nursing Home Quality and Safety

Tragically, more than 9,400 COVID-19 related resident and staff deaths have occurred in New Jersey’s long-term care facilities. Today, over two years into the pandemic and as the state considers ending the public health emergency, there are still active outbreaks in 146 facilities. This tragic loss of life has exposed long-standing deficiencies in the state’s system and the need to intensify efforts to serve people at home or in the community, where the vast majority of New Jerseyans want to be. The 1115 Demonstration importantly focuses on the significant opportunities to transform New Jersey’s long-term care system to better enable older residents to receive care they may need in their homes and communities. Yet, improvements in safety and quality of care in nursing homes are required. New Jersey’s 1115 draft proposal fails to adequately address the need for improvements, despite actionable recommendations provided to the state by Manatt Health,1 and the opportunities for incentivizing improvements through the Demonstration program.

Given the importance of reforming nursing homes and the Administration’s efforts in this regard, we ask you to provide technical assistance, as needed, and encourage the state to establish a pay-for-performance demonstration program (under the waiver or not) to improve nursing facility quality and safety that incentivizes:

- A registered nurse on every shift
- Maintaining or exceeding minimum direct care staffing levels
- A full-time infection control specialist on staff
- Lowering staff turnover rates (see Workforce Development section)
- The elimination of multi-occupancy rooms
- Implementing a program to reduce pressure sores among nursing home residents. New Jersey ranks 37th among states in percentage of high-risk nursing home residents with pressure sores.2

Indeed, several of these criteria are consistent with the Administration’s recently announced nursing home reforms. AARP urges that the state closely monitor the impact of the demonstration program on quality of care and quality of life in nursing homes for both short-stay and long-stay residents. If it is observed that the nursing home pay for performance (value-based purchasing) program has adverse impacts on quality, New Jersey should take appropriate action to help ensure quality. We have also encouraged the state to suggest any legislative or regulatory changes that might be needed to address program issues as they arise.

Rebalancing Toward Home and Community-Based Services

Rebalancing Goals and Benchmarks

A balanced Medicaid system is one where access to home and community-based services (HCBS) is on par with access to institutional services. Goals around rebalancing can be measured in dollars spent and/or number of beneficiaries receiving HCBS vs. institutional services. We urge CMS to require that the state establish goals and benchmarks for both measures with the involvement and input of stakeholders, the MLTSS Multi-Stakeholder Work Group, and others, as appropriate. Further, these goals and benchmarks should distinguish among discrete groups of beneficiaries to ensure that no one is falling behind. Groups may include beneficiaries by age, race, ethnicity, gender identity, etc.

AARP recommends the following goals and benchmarks be included in the final version of New Jersey’s Demonstration Waiver renewal:

2 https://www.longtermscorecard.org/databydimension/table?ind=749&ch=4&tf=1089&bst=36&wst=10&sortch=4&sorttf=1089
Rebalancing Long-Term Services and Supports - Beneficiaries:
- By end of demonstration period (June 30, 2027): New Jersey has already made progress in rebalancing beneficiaries. To improve upon that progress, a potential goal is that all beneficiary subgroups, including older adults, demonstrate at least a 60/40 ratio of HCBS vs. institutional care.
- Long-term goal: Care settings for each beneficiary group are comparable to research findings regarding care setting preference. In other words, if the research indicates that 90% of a beneficiary group prefers HCBS over institutional care, the system should match and support these preferences.

Rebalancing Long-Term Services and Supports - Medicaid dollars:
- With only 21 percent of Medicaid and state funded LTSS spending going to HCBS for older people and adults with physical disabilities, New Jersey is 46th in the nation. In comparison, the national average is 45.1%, with New Mexico rating the highest with 73.5%.
- By end of demonstration period (June 30, 2027): Majority (>50%) of Medicaid dollars, across all beneficiary groups, go toward HCBS.
- Long-term goal: New Jersey leads the nation with the highest percentage of Medicaid dollars going to HCBS.

Monitoring Progress Toward Rebalancing Long-Term Services and Supports:
- Progress should be monitored annually.
- Findings should be shared publicly with enough granularity to assess potential differences among beneficiary groups.
- To the extent possible, measures used should be:
  - Scientifically validated
  - Nationally standardized
  - Risk adjusted
- Measures should assess rebalancing progress along with quality of services.

The Ability to Live in the Community - Housing Supports

Medicaid Housing Unit

As previously noted, AARP supports the establishment of a Medicaid Housing Unit. We appreciate that the Demonstration renewal application provides more detail on the unit’s functions and urge CMS to work with the state to provide more information on staff qualifications.

Enhanced Engagement between Medicaid and Housing Stakeholders

We are pleased to see the proposed collaboration set forth between Medicaid and other housing stakeholders. For this collaboration to have a significant impact, the state of New Jersey should consider expanding affordable housing production to fill the gap between supply and demand. To accomplish these goals, it is vital that there be dedicated Medicaid staff with backgrounds in the low-income housing tax credit (LIHTC) and housing voucher programs. We appreciate that as part of the state’s HCBS spending plan submitted to CMS under the American Rescue Plan Act (ARPA), they proposed funding for the development of deed-restricted, subsidized, and accessible rental units for Medicaid beneficiaries. We encourage continued efforts to address affordable housing and Medicaid staff with appropriate expertise.

Additionally, the goal of communication among the New Jersey Division of Medical Assistance and Health Services (DMAHS), MCOs, and housing resources should include more definition and accountability in the

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final version of the waiver renewal. One approach could be to establish a task force to set benchmarks and targets.

**Medicaid Covered Housing-Related Services**

AARP supports the expansion of Medicaid coverage to include more housing-related services. We appreciate the addition of language by the state to note that the initial assessment to identify potential need for housing-related services may also include information or support from family members or caregivers. We understand the state will consider our suggestion that family caregivers’ homes should also be eligible for a home modification program, similar to the program in Arizona, as the program is implemented.\(^5\) Home repairs should be included in addition to accessibility modifications, and the amount of funding available should be appropriate to address needed repairs and modifications.

In addition to the transition supports listed in the renewal application, we recommend assistance with organizing and supervising home modifications and repairs as needed for safety and accessibility be made available to beneficiaries. Transparency and accountability around the transition program should be ensured through a task force, including several case manager members, that provides input regarding what transition services are needed and how best to deliver them. We urge CMS to consider these recommendations at they review the state’s renewal application.

**Use Payment Models That Drive Rebalancing and Quality Care**

New Jersey pays MCOs blended capitation rates, i.e., per-person rates determined by a weighted average of the institutional and HCBS rates. New Jersey pays the MCOs a single monthly amount per member requiring long-term services and supports (LTSS), regardless of whether the member receives HCBS or nursing home care. Additionally, capitation rates are determined based on data from two years prior. As New Jersey makes progress rebalancing LTSS, thus increasing the percentage of people receiving lower cost HCBS, and the medical loss ratio caps MCOs’ profits as a percentage of gross revenues, there may be a financial disincentive for MCOs to prioritize HCBS. It is possible that over time MCOs will perceive rebalancing to be against their long-term interests, because as per-member rates drop due to rebalancing, so do gross revenues, and, as a result, total allowable profits.\(^6\)

We encourage CMS to help make New Jersey aware of this potential unintended consequence of the current payment structure and encourage the state during the upcoming Demonstration period to investigate other payment models that may have a more positive impact on rebalancing. As stated earlier, AARP supports the reinstatement of the MLTSS Work Group and recommends the creation of a subgroup that investigates and makes recommendations concerning the payment model. This subgroup should also evaluate the success of the program’s current HCBS performance incentive.

**Nutritional Supports**

The nutritional supports proposed in the application are positive ways to help individuals remain in their homes and communities. With respect to implementation, we urge the final Demonstration renewal to address the following:

- Will the State define or list the types of instances that qualify as a food disruption or mental health episode, or would there be self-attestation/case by case consideration?

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\(^5\) [https://www.azleg.gov/legtext/55leg/1R/laws/0180.pdf](https://www.azleg.gov/legtext/55leg/1R/laws/0180.pdf)
\(^6\) [https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/MLTSS%20Capitation%20to%20Promote%20HCBS%2011-17.pdf](https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/MLTSS%20Capitation%20to%20Promote%20HCBS%2011-17.pdf)
• What food items/nutritional content will be provided? Will the food items reflect cultural and religious preference? Will the food items be in a form that can be easily prepared/consumed given the beneficiary’s status and resources?

• The benefit is proposed to be limited to 30 days in duration. Is there a limit to the number of times a beneficiary would qualify for this type of support? We urge flexibility or extensions so that there is not a gap between temporary support and a permanent solution to the disruption. Will there be an appeals process if a beneficiary is denied the benefit?

• Navigation/training for SNAP and other nutrition supports (where to apply, where to find more information, etc.) is essential. Who would develop and deliver these trainings? DMAHS or MCOs? If the latter, how will DMAHS insure consistency across payers?

We look forward to working with the state to implement this benefit effectively for those who are eligible, if it is approved.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is another model of home- and community-based care supporting people age 55 and older who need nursing-home level of care but can live safely in the community with support. It provides primary care, adult day programs, rehabilitation, meals, and other resources, as well as home health services, transportation, nursing home care and hospitalizations.

According to a recent report by the Commonwealth Fund, PACE is one of the oldest and most successful models of integrating services for high-need people with acute and LTSS needs. Studies and evaluations have demonstrated the positive effects of enrolling in PACE. Such benefits include reductions in hospitalization, rehospitalization, and emergency department use; reductions in long-term nursing facility placements; reductions in mortality; and lower rates of functional decline and better reported health status and quality of life.7

Despite these promising findings, New Jersey PACE enrollment growth since 2014 (38%) has been outpaced by the growth of the entire Medicaid long-term care population (53%), and PACE participants represent less than 2% of the Medicaid LTC population.8 We encourage CMS to work with New Jersey to include in its 1115 Demonstration programs that can be implemented to:

• Increase the number of people served by current PACE organizations in their current communities
• Increase the number of PACE organizations and number of communities served by the current PACE model.

Community Health Worker Pilot Program

This pilot program is a promising opportunity. AARP recommends at least two target populations focus on complex conditions experienced by older populations.

Support for Family Caregivers

AARP strongly supports the proposed Demonstration’s programs to support family caregivers, the bedrock of our LTSS system. In New Jersey, over one million family caregivers annually provide over 900 million hours of care valued at approximately $13 billion.9 Adults with a chronic, disabling, or serious health condition rely mainly on family members, partners, or friends to provide needed day-to-day supports and services, and manage complex care tasks. Research finds that nearly half of older adults (65 and older) living in the community have

8 http://www.njfamilycare.org/analytics/LTC_explorer.html
difficulty carrying out daily living activities (such as help with bathing, getting in and out of a chair, or using the bathroom) without assistance.

Nearly one in five family caregivers report high physical strain due to caregiving and nearly four in ten caregivers consider their caregiving situation to be highly stressful.\(^\text{10}\) Family caregivers who try to balance their duties with paying jobs run into schedule conflicts that over time can undermine their careers and financial security. Medical and other care responsibilities are increasing, and more individuals are receiving serious health care treatments at home, including dialysis and chemotherapy. Additionally, family caregivers spend, on average, $7,242 in out-of-pocket costs annually, or more than one quarter of their income on average.\(^\text{11}\)

AARP recommends the final version of the 1115 Waiver include the following additional supports for family caregivers so that they are better able to support the care their loved ones need:

- A separate caregiver assessment as part of the member’s plan of care wherein questions are asked of the caregiver about their own health and well-being, and any services or supports they may need to be better prepared for their caregiving role.\(^\text{12}\) Family caregivers should be provided with the supports they need as identified in the assessment and/or be referred to where they can access such supports. We understand the state will continue to assess the need for a broader caregiver assessment. We ask CMS to urge the state to move forward with such an assessment and that it be culturally relevant and linguistically appropriate.

- Defining family caregivers: Avoid using the term “informal caregivers” and instead use “unpaid caregivers” or “unpaid family caregivers” to better reflect the role these individuals play. We do appreciate the state’s increased use of the term “unpaid caregiver.” As you may know, the recent RAISE Family Caregivers Act Initial Report to Congress provides additional guidance around caregiving language, including a broad definition of the term “family.”\(^\text{13}\)

- For the caregiver counseling and hotlines, the services should be offered to multiple caregivers of the same Medicaid beneficiary, as appropriate, as oftentimes caregiving responsibilities are split among multiple individuals. Additionally, these services should not be tied to a specific situation or life event.

- Support unpaid caregivers financially by:
  - Establishing a caregiver grant program to offset the thousands of dollars family caregivers spend every year to support their loved ones and which is a financial strain for many. This program should be available to all family caregivers, not just family caregivers of Medicaid beneficiaries, as caregiver support could prevent or delay eventual Medicaid utilization, though we understand it may need to be more targeted in the context of an 1115 Waiver.\(^\text{14}\) We understand that Arizona’s Family Caregiver Reimbursement Program allows family caregivers to be reimbursed 50% for home modifications and assistive care technology up to $1,000 per qualifying family member.\(^\text{15}\)
  - Better facilitating enrollment in self-directed services for MLTSS members so that more unpaid caregivers can be compensated for the care they provide.

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\(^\text{10}\) [https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf](https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf)


\(^\text{12}\) [https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-ib-AARP-ppi-ltc.pdf](https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-ib-AARP-ppi-ltc.pdf)


\(^\text{15}\) [https://des.az.gov/services/older-adults/family-caregiver-support](https://des.az.gov/services/older-adults/family-caregiver-support)
Workforce Development

A sufficient workforce, both in quality and quantity, is necessary for high-quality long-term services and supports, whether delivered in the home or an institution. Research shows that direct care workforce shortages have been persistent over the last 20+ years, are currently at a critical level, and will get worse over the next 10-20 years without significant policy interventions.\(^\text{16}\) No one workforce initiative or legislative strategy has emerged as a solution. While there is not a proven model, there is a research-based consensus emerging among academic and policy experts about the need to address three interconnected issues\(^\text{17,18}\) together to solve the direct care workforce crisis. These interconnected areas are:

1. Compensation (e.g., higher hourly wages, more consistent hours, and benefits).
2. Training (e.g., training focused on competencies and job advancement).
3. Better job design (e.g., better supervision, more respect, more meaningful work, consistent care assignments, specialized direct care roles, career advancement, etc.).

While workforce development has been included in New Jersey’s American Rescue Plan Act funding proposal, it is absent in the 1115 renewal proposal. Complementary initiatives should also be included in the final 1115 Waiver renewal in an effort to improve the three general job satisfaction areas simultaneously. We request that CMS work with the state to explore opportunities to address workforce development in this Waiver renewal. Higher wages are a necessary foundation for improvement in recruitment and retention, but they are not sufficient to mitigate other negative job factors that have repeatedly been found to contribute to low job satisfaction and high turnover in the sector. It is not enough to address one or two of these three general areas and expect to improve direct care jobs sufficiently to attract and retain the number of workers that are needed; knitting together an effective multifaceted legislative program is the next step. We have urged the state to leverage existing research and recommendations to the extent possible, such as those included in PHI’s *Caring for the Future* report.\(^\text{19}\)

Given the magnitude of the escalating crisis, time is of the essence. Expanding self-directed service programs is one way to quickly ease the pressure on paid service programs. Because a holistic solution has not been found, New Jersey can select interventions that best fit the state’s culture and capacity and modify as needed. While there is a small risk that state funding will not be used as optimally as possible when implementing a new program in the state, there is a great deal of risk to direct care consumers, their families, and direct care workers if not doing enough as quickly as possible.

Improving Access

*Presumptive Eligibility*

Individuals who cannot afford to pay for in-home services out-of-pocket must wait until a final Medicaid eligibility determination before Medicaid will start HCBS. On the other hand, nursing homes are generally willing to admit someone after hospital discharge or from the community and start services, even while the person’s ability to pay for services and/or eligibility for Medicaid is determined. If someone a nursing home admits is ultimately found to be ineligible and is unable to pay, the home assumes the cost for the services the resident received.

The time period between application and final approval of Medicaid HCBS eligibility can be particularly perilous for individuals with limited resources who want to stay at home. While federal rules require states to

\(^{16}\) [https://leadingage.org/making-care-work-pay](https://leadingage.org/making-care-work-pay)


\(^{19}\) [https://phinational.org/caringforthefuture/](https://phinational.org/caringforthefuture/)
make timely financial determinations—within 45 days from the date of application and within 90 days of when a disability determination is made—administrative complexities can delay the process. Those delays have serious consequences for an individual’s choice to remain in the community. Since nursing homes are generally more willing than home care agencies to admit individuals while their Medicaid application is under review and bear the risk that a client will be found ineligible, nursing home care may be the only viable option for individuals with immediate care needs.\footnote{20}

Presumptive eligibility allows applicants for Medicaid HCBS to temporarily access HCBS at the point when a need arises, while the formal administrative process to determine Medicaid eligibility is pending. Presumptive eligibility practices during the COVID-19 pandemic should be continued to improve access to HCBS. Older adults overwhelmingly prefer to remain at home and receive care in the community for as long as possible.\footnote{21} Unfortunately, Medicaid’s complex eligibility process does not necessarily reflect this preference, nor does the process account for the practical realities most individuals and family caregivers face when they wish to avoid a nursing home admission under stressful circumstances—an unexpected hospitalization or a rapid deterioration of health at home. In those situations, timely access to services can mean the difference between someone returning to the community or entering a nursing home.

One of the biggest barriers to implementation of presumptive eligibility is the perceived financial risk to the state. While it is true that the state could be responsible for the cost of HCBS when an individual is ineligible for Medicaid, that risk is relatively low and can be contained, as there are steps states can take and factors they can consider to reduce the financial impact.\footnote{22} HCBS are also generally more cost-effective than nursing home care. On average, Medicaid can serve about three people in their homes and communities for the cost of one person in a nursing home.

To address these issues, AARP recommends that CMS work with the state to expand the Financial Eligibility Determination Pilot Program to a permanent program for all MLTSS applicants with a defined timeline for implementation.

\textit{Continuous Eligibility for Adults}

The 1115 waiver proposal includes implementation of 12-month continuous eligibility for adults whose Medicaid eligibility is based on their Modified Adjusted Gross Income. Similar continuous eligibility requirements in New York have been shown to increase the duration of Medicaid coverage for adults.\footnote{23} AARP supports continuous Medicaid coverage for people of all ages, including people with disabilities and the working poor. Implementing 12-month continuous eligibility for adults as proposed in this waiver would help achieve this aim.

\textit{Transparency and Accountability}

Improved rebalancing must come with commensurate oversight and transparency. In a managed care context, robust MCO contract oversight and monitoring is critical to ensure that capitated payments do not create incentives for MCOs to skimp on needed care and services for this very vulnerable population. Robust oversight is also imperative to ensure that all reporting requirements and performance standards are being complied with and that they are leading to improved quality and access. AARP recommends that the state demonstrate how it uses data to improve performance for managed care programs that include MLTSS. AARP has urged the state

\footnotesize{\textsuperscript{20} https://www.aarp.org/content/dam/aarp/ppi/2021/04/presumptive-eligibility-for-medicaid-home-community-based-services.doi.10.26419-2Fppi.00138.001.pdf}
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\footnotesize{\textsuperscript{23} https://www.rand.org/blog/2021/12/twelve-month-continuous-eligibility-for-medicaid-adults.html}
to afford all opportunities to make this data collection transparent and make all MCO reports public. The state should adopt strong reporting requirements and hold the MCOs accountable for meeting those requirements. The state may want to consider developing a report card that displays quality rating information, including disenrollment data that can be made publicly available to consumers and their family caregivers on a centralized website maintained by the state. The data should be granular enough to be able to understand if different populations are not receiving equitable access and services. We encourage CMS to work with and urge the state to show how it uses data to improve performance for managed care programs that include MLTSS and increase public transparency of these data and hold MCOs accountable.

We appreciate the opportunity to offer comments on this important proposed waiver renewal application. AARP New Jersey looks forward to working with the state as they implement the waiver renewal and to improve the state’s long-term care system. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs