

Final Report

New Jersey Task Force on Long-Term Care Quality and Safety Trenton, New Jersey

Issued April 2024

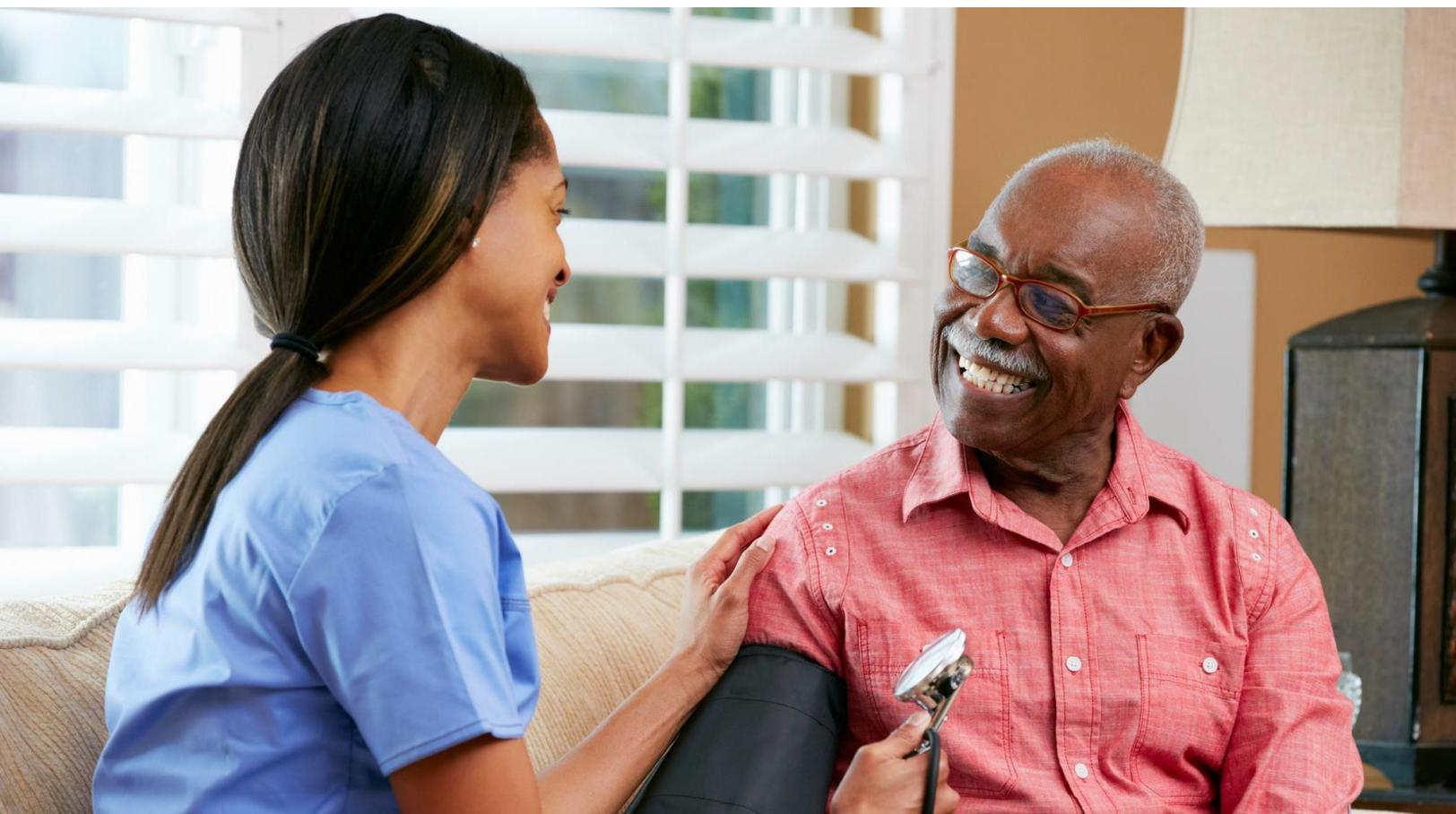


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- Health Dimensions Group® (HDG®) for their assistance in reviewing the recommendations, providing background research, and drafting report language.

Disclaimer

The views expressed herein represent the collective view of the Task Force and involved dialogue and compromise. They do not necessarily represent the views of Governor Murphy’s Administration, the State of New Jersey, its contractors, or individual Task Force members.

LETTER TO THE GOVERNOR AND STATE LEGISLATURE

Dear Governor Murphy and Members of the New Jersey Legislature:

The New Jersey Task Force on Long-Term Care Quality and Safety (Task Force) was established in 2020 in response to concerns related to the loss of life and quality and safety at long-term care (LTC) centers during the COVID-19 pandemic. Members were tasked to use our collective experiences, outcomes, and lessons learned from this unprecedented health crisis to formulate our recommendations. The appointed members represent a broad-based group of impacted stakeholders. The diversity of our membership afforded us the opportunity to hear many different voices and consider each one carefully. Every perspective was honored and appreciated.

Many other key stakeholders in the public and private sectors have been asking some of the same questions as this Task Force. We provided an early opportunity for the public to contribute their own recommendations for consideration. Many interested parties with strong opinions raised important questions that helped refine our work.

While the pandemic brought about innovation and creativity, it exposed some new and long-standing concerns and reinforced the need for improvement in certain areas. In addition, it reinforced the need for consumers to have a wider array of choices in the place they call home. While New Jersey has made significant progress toward the balance of resources offered for institutional communities versus home- and community-based services (HCBS), there is an historic opportunity to improve the allocation of those resources and increase the total resources for the LTC delivery system.

The pandemic also cast a spotlight on the heroic work of many LTC workers, who provided round-the-clock care and comfort to New Jersey's most vulnerable population. Their level of dedication and commitment is to be applauded, particularly in the early days when personal protective equipment (PPE), testing, vaccines, or other forms of infection prevention and control were unavailable or extremely limited.

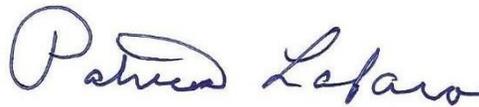
Throughout a 20-month-long comprehensive and collaborative process, Task Force members worked diligently to issue a series of recommendations, recognizing our commitment to New Jersey residents. The recommendations contained herein rely upon evidence-based data rather than anecdotal evidence or simply maintaining the status quo. The firsthand experiences of the consumers and family members among us were compelling and served to reinforce the seriousness of our responsibility. We dedicate our work to one of those consumer members of our Task Force—Ms. Sharon Gierie—who passed away during this past year after a passionate, lifelong journey to rise above many challenges.

Lastly, we appreciate the many areas of State government that allowed us access to data and other information requested. Looking back, we acknowledge that this novel virus affected every aspect of our healthcare system and placed significant strains on the LTC delivery system.

Looking forward, we hope that our efforts will contribute to improved quality and safety in New Jersey's delivery of LTC services.

Handwritten signature of Douglas A. Struyk in blue ink.

Douglas A. Struyk, CPA, LNHA

Handwritten signature of Pat Lafaro in blue ink.

Pat Lafaro, BS, RN, CIC

Task Force members are listed in Appendix A.

INTRODUCTION

The COVID-19 crisis laid bare the need to reimagine and fundamentally transform New Jersey's system of long-term services and supports (LTSS), which includes home- and community-based services (HCBS) and institutional care, primarily nursing homes.

As of this writing, more than 9,000 people residing in long-term care (LTC) facilities and more than 100 staff have died from COVID-19 in New Jersey. Together, these souls make up more than 25 percent of the State's total COVID-19 deaths, despite comprising a very small percentage of the total population. This tragedy was a call to action, spurring the formation of the New Jersey Task Force on Long-Term Care Quality and Safety¹ (Task Force), which has a statutory charge to:

"... [develop] recommendations to make changes to the long-term system of care to drive improvements in person-centered care, resident and staff safety, improvements in quality of care and services, workforce engagement and sustainability, and any other appropriate aspects of the long-term system of care in New Jersey as the task force elects to review."²

Like other states in our region, New Jersey was hit early and hard by the COVID-19 crisis, before the best information about controlling and preventing the virus was known. Since then, infection control practices have improved. New Jersey providers achieved some of the highest vaccination rates in the country. There are now ample supplies of personal protective equipment (PPE), and facility staff are better trained and engaged in proper infection control. In addition, there has been significant follow-up on the "Manatt Report" by State policymakers.³ The federal Public Health Emergency (PHE) was declared over on May 11, 2023, signaling that the pandemic has moved into an endemic phase.

Since 2020, New Jersey has invested millions of dollars into the LTSS system by increasing the rates paid to nursing homes and to HCBS providers, with a specific focus on increasing salaries for direct care workers. Moreover, the State has implemented several groundbreaking reforms, adopting legislation and policies that include:

- A requirement that nursing homes pay a rebate to the State if less than 90 percent of the revenue received from Medicaid is expended on the care of residents.
- One of the country's only minimum direct care staffing ratios for nursing homes.
- Stronger financial transparency requirements for nursing home operations and ownership.

¹ See Appendix A for a full list of members.

² See Appendix B for a full description of P.L. 2020, c. 88.

³ See Manatt, *Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19*, June 2020, https://www.manatt.com/Manatt/media/Documents/NJ-LTC-Report_2.pdf.

- The creation of a rapid-response Mission Critical Team program to intervene early when LTC facilities are struggling to meet quality standards.

Despite these positive reform steps, many of the underlying pre-pandemic dynamics still persist. New Jersey's policies continue to strongly favor institutional care over consumer preferred HCBS. Our nursing homes are often large, hospital-like spaces, but today's consumer prefers smaller, homelike settings that offer greater levels of person-centered care. New Jersey also lacks an adequate workforce to care for our aging population. These dynamics are historic, deep, systemic, and cultural; to change them requires a shift in thinking and planning that transcends year-to-year budget cycles and piecemeal policymaking.

The Task Force strongly believes that public policy should drive the transformation of LTSS in New Jersey. Although virtually all publicly funded LTSS services now flow through State Medicaid managed care organizations (MCOs), the responsibility for reinventing and rebalancing the LTSS system lies with the State, working closely with relevant stakeholders.

New Jersey's process of adjusting Medicaid rates for LTSS (both HCBS and nursing homes) is largely ad hoc and is set through the legislative budgetary process on a year-to-year basis. While New Jersey recently initiated a comprehensive stakeholder process to explore a new Medicaid payment methodology for nursing homes, no such process exists for HCBS, which has a much more diverse set of services affecting a larger number of New Jerseyans. We note that any recommendations in this report about provider funding must be tied to demonstrated quality and financial transparency.

It is the hope and expectation of the Task Force that this dialogue among stakeholders will continue as New Jersey works to create a future where quality LTSS are accessible to all who need them, when they need them, and where they choose to receive them

EXECUTIVE SUMMARY

In analyzing and reflecting on the history and current landscape of our long-term supports and services (LTSS) system, the New Jersey Task Force on Long-Term Care Quality and Safety (Task Force) identified three central themes:

1. New Jersey is historically over-reliant on nursing homes and has not sufficiently invested in home- and community-based services (HCBS).

New Jersey remains 23 percent above the national average in utilizing nursing homes on a per Medicare beneficiary basis. In 2019, New Jersey ranked 37th in spending on HCBS. These are not only issues of consumer choice (over 80 percent prefer HCBS when given a choice) but are more fundamentally about human rights. People are entitled to live in the least restrictive environment possible. The lack of sufficient supportive housing in our State remains one of the primary barriers to transitioning people out of nursing homes and preventing them from entering them in the first place.

2. New Jersey’s nursing homes, by nature of their large size, hospital feel, and lack of privacy, often do not meet the population’s desire for homelike, person-centered environments and contribute to infection control risks.

Our nursing homes are large, on average, compared to other states and contain mostly shared rooms. There are too many traditional nursing home beds for current and projected need. While other states are adopting policies and spurring investment in smaller, alternative nursing home models, New Jersey currently has very few “small home” nursing homes and few, if any, that use innovative staffing models that empower the direct care workforce.

3. New Jersey’s long-term services and supports (LTSS) workforce is shrinking, worsening the imbalance of supply relative to the growing elderly population.

New Jersey’s direct care workforce is shrinking and cannot meet the needs of the growing elderly population. Many LTSS staff are feeling overwhelmed and undervalued, while engaged in physically and emotionally difficult work. Challenges include inadequate pay, training costs, lack of upward mobility, language barriers, and ageism. This leaves both institutional and HCBS providers short-staffed, and our aging residents without high-quality, reliable care, which can have serious physical, psychological, social, and financial consequences.

The findings and recommendations in this report are informed by these central themes. The report is structured in four major sections, following the mandates of P.L. 2020, c. 88: Expanding Home- and Community-Based Services, Nursing Facility Reforms, Workforce Engagement and Sustainability, and Broad-Based Reforms. Where recommendations fall into multiple sections, they are placed into the most relevant section. This summary will describe the key findings and recommendations, while the body of the report provides additional context and details for the recommendations and contains supporting data & citations.

SECTION 1: EXPANDING HOME- AND COMMUNITY-BASED SERVICES

State policies should drive growth in home- and community-based services (HCBS)—not only for Medicaid-covered individuals but for all New Jersey citizens—and promote consumer and family choice about settings of care. This will be a paradigm shift for New Jersey and will require new and ongoing investment.

Studies consistently show that people strongly prefer to receive LTSS in their homes rather than institutional care. Unfortunately, current State policies continue to favor institutional care over HCBS in the New Jersey Medicaid program. The resulting disparities in eligibility, coverage, and payment are referred to as “institutional bias” throughout this report. Addressing institutional bias will help New Jersey move toward an “HCBS First” approach. This is in line with the guiding principle of the landmark U.S. Supreme Court decision in *Olmstead v. L.C.* finding that health care services for people with disabilities should be provided in the most integrated setting appropriate to their needs.

Enhancing HCBS and Reducing Institutional Bias in State Policy

- Within the next three years, New Jersey should set and achieve a goal of having 80 percent of the Medicaid “nursing facility level of care eligible” participants served in HCBS, and 60 percent of such funding devoted to HCBS, with the expenditure goal moving to 70 percent within five years. The State is currently at 63 percent for participants and 46 percent of expenditures devoted to HCBS for this population.
- The State should track and publicly report on a regular basis the achievement of the above goals across important subgroups, including those that are historically marginalized.
- New Jersey should adopt a three- to five-year strategic plan and front-load funding to rapidly expand HCBS, similar to the planning and “bridge funding” investments made to deinstitutionalize people from State developmental centers.
- Enact a series of changes designed to reduce institutional bias in State policy, including Medicaid eligibility changes, more timely authorizations for community-based services, and a series of coverage changes all designed to promote “HCBS First.” The report contains real-world examples of how these policies directly and indirectly contribute to institutional bias.
- The New Jersey Department of Human Services (DHS) should develop an equitable plan across provider types with stakeholder input prior to expiration of the “one-shot” enhanced federal funding contained in the American Rescue Plan Act (ARPA).

- Increase affordable supportive housing through a variety of policies, including better coordination of programs at the State level, and promote integration of acute, primary, and long-term care through expanding integrated care models such as the Program of All-Inclusive Care for the Elderly (PACE).
- Medicaid payment methods for HCBS need to ensure a living wage for caregivers, have strong and explicit quality incentives as part of a strategy to provide resources for activities that drive good outcomes, and offer acuity adjustments to help ensure that every care setting is appropriately incentivized to care for persons with the greatest needs. There should be periodic and systematic review of the adequacy of rates in a transparent, verifiable manner, with predictable adjustments going forward to account for inflation.
- New Jersey should consider establishing a state income tax credit for unpaid family caregivers. A tax credit will begin to offset some of the financial losses experienced by unpaid family caregivers and allow them to continue to provide this care.

SECTION 2: NURSING FACILITY REFORMS

The Task Force has placed the needs, preferences, dignity, and self-determination of people who require LTSS at the center of our thinking about how to reinvent long-term residential care in the State of New Jersey. The traditional large, hospital-style nursing home model that dominates in our State presents inherent barriers to person-centered care and is not in line with the more homelike environments that New Jersey residents prefer.

The Task Force recognizes that New Jersey is home to many good nursing home providers that score well on federal quality metrics, with staff who performed heroically and with very little public acknowledgement during the worst of the COVID-19 pandemic. However, the current framework for delivering nursing home care is outdated and generally does not support person-centered care.

There are alternative models of nursing home care, such as the Green House® model and other “small home” models that involve more than just structural changes to buildings; these models also embody a different operating culture and practices. Small home models are proliferating across the country, yet New Jersey has very little activity in this area.

The Task Force had extensive discussions about the nursing home survey and regulatory oversight processes. New Jersey is one of seven states with a surveyor vacancy rate greater than 50 percent. Required inspections of nursing homes are running as far as a year behind. Other concerns include the State’s failure to cite resident rights and abuse and neglect deficiencies and the speed and effectiveness of enforcement. There is also a need for better collaboration among State authorities and escalating penalties for the worst performing nursing homes.

The Task Force is concerned about the rise of corporate consolidation, private equity investment, and related party transactions across the industry. Concerns include the impact of

these trends on the quality of patient care and proper use of Medicaid funds, as well as the lack of financial transparency to better monitor and evaluate these dynamics.

The Task Force concurs with a recent U.S. Government Accountability Office (GAO) report concluding that limitations on visitation and group activities for a prolonged duration were detrimental to residents, potentially causing more harm than good. Among other things, the report noted that it would be helpful in the future to have guidance containing a limit on the duration of these restrictions during an outbreak or outlining how to ease restrictions.

Finally, the Task Force is greatly concerned about the quality of life of nursing home residents who may feel powerless to change conditions in the facility they consider to be home or impact LTSS policymaking. Although every resident can participate in their own care planning, often they accept a diminished quality of life as the inevitable consequence of living in a nursing home. While the State has a system for responding to individual complaints, it has no statewide mechanism to elevate the voices of the people living in nursing homes or their families.

Reimagining Nursing Homes to Be More Person-Centered and Homelike

- New Jersey should develop a demonstration project to incentivize the creation of Green House[®] models and other small home models of care including dementia care villages.
- New construction and major renovations of nursing homes should focus on private rooms and baths, clustering, or neighborhood unit configuration, and increasing outdoor recreation space and access to natural sunlight.
- Aim to eliminate higher occupancy (three and four persons) bedrooms.
- Develop regulations for licensure and Certificate of Need that would prevent new large, hospital-style nursing homes.
- To facilitate a planned and orderly downsizing of nursing homes, New Jersey should establish a grant program to fund certain downsizing expenses associated with voluntary bed reductions to promote single rooms or repurposing.
- At least one of the New Jersey State veterans' homes should incorporate the ability to care for veterans in need of ventilator care, and each should be assessed for access to mental health services.

Enhancing Effectiveness of Surveys and Regulation

- The New Jersey Department of Health (DOH) should develop an action plan and bring timeliness of standard surveys up to at least the national benchmark and eventually surpass it. The State must hire enough surveyors to improve the timeliness of inspections. Strategies to consider may include, seeking a waiver from or updating the civil service requirements, increasing starting salaries to quickly hire additional nurses, and diversifying the survey teams to include other disciplines. Other recommended reforms include refresher training, more timely resolution of plans of correction, and consistent surveyor assignments.

- The DOH should provide public, easily accessible data on the type and number of deficiencies being cited in nursing homes, including comparative data from other states.
- For clarity and accuracy, State nursing home regulations should be updated to meet or exceed federal rules. Emphasis is needed on updating State rules (e.g., resident rights) to reflect federal changes in rules enacted since 2016. This strategy simplifies the survey process for both providers and surveyors and ensures conformity to the latest standard, be it federal or State.
- The DOH, which licenses and regulates nursing homes, and the DHS, which pays for most nursing home care through Medicaid, should continue working together to ensure compliance with applicable laws and regulations governing the quality of care and services, including escalating consequences for poor performance. Based on the circumstances, this may include higher fines for noncompliance, curtailing admissions, or revoking a facility's license to operate in New Jersey. The State should use all tools available to intervene as early as possible and expand funding for Mission Critical Teams.

Addressing Staffing in Nursing Homes

- The State should curtail admissions in appropriate circumstances when nursing homes consistently do not meet minimum staffing ratios.
- New Jersey should review the results of the federal research on nursing home staffing standards and consider whether further refinement or modification of New Jersey's existing minimum staffing standards is necessary or desirable, including whether to: 1) acuity-adjust the direct care staffing ratios, 2) change the basis from ratios to hours per patient day, and 3) consider incorporation of other disciplines that vary by acuity of a facility's caseload, such as social work and therapeutic recreation.
- As part of the above process, or as a separate activity, New Jersey should review the nursing procedures and clinical characteristics used to adjust staffing minimums in New Jersey's long-standing acuity-based staffing standards (Subchapter 25, Section 8.39-25.2). Those acuity adjustments should be examined for continued relevance and accuracy, including for facilities that have differing mixes of short- and long-term care populations.

Addressing Medicaid Rates While Promoting Quality and Fiscal Transparency

- Include detailed and verifiable ownership information about any person or group that owns any part of a nursing home in the recently reinstated State cost reports required by the State Medicaid agency (DHS).
- Require annual independently audited financial statements for individual nursing homes that show how much facilities are spending on related party transactions, and where money flowing to those related parties is ultimately going.
- Medicaid payment rates should be adjusted for differences in acuity of residents—strongly considering the Patient-Driven Payment Model (PDPM)—to ensure that people with high care needs have access to services and to promote the development of clinical systems to serve high-needs residents. Undertake a careful re-examination of Medicaid capital payment

policies, including a methodology that supports and incentivizes small homes and single rooms.

- New Jersey's Quality Incentive Payment Program (QIPP) for nursing homes should be reformed to drive transformational change, including by incorporating meaningful and actionable performance metrics such as 24-hour registered nurse (RN) coverage, nursing turnover rate, weekend staffing, and presence of single rooms, among others. In addition, significant structural changes to this program should be considered as described in the report.

Continuing Progress on Infection Prevention and Control

- Nursing homes should continue to be required to maintain the capacity to provide single rooms for residents who require isolation, as well as for residents who are receiving outside dialysis or are immunocompromised.
- The State must establish standards for improving airflow systems in nursing homes.
- The State should adopt more rigorous certification standards for infection preventionists (IPs) working in nursing homes than what is required by the federal government.
- The DOH should work with the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) to streamline and align their policy guidance regarding infection control and prevention to the maximum extent appropriate. This is especially important during times of rapid policy evolution in order to provide strong protections to vulnerable populations in NJ while minimizing the potential for provider and consumer confusion.
- The State should start to develop a statewide Essential Caregiver policy that is consistent with and adaptable to any applicable federal and state laws, regulations, and guidance, that permits residents to designate essential caregivers who can visit with them during an outbreak, epidemic, or pandemic of an infectious disease, and requires these designated visitors to adhere to any infection control practices and vaccination schedules as may be required or recommended during the public health emergency or state of emergency.
- A series of other recommendations on infection prevention and control are made in the report, such as that the State should provide incentives for facilities that achieve 90 percent or higher compliance on vaccinations including COVID-19 vaccine, flu, pneumococcal, Tdap, and herpes zoster (shingles).

Empowering Nursing Home Residents to Improve Living Conditions

- New Jersey should regularly evaluate and improve its statewide mechanism and system to elevate the voices of LTC residents and their families.
 - The State should prioritize enforcement of the federal requirement that nursing homes have an active resident council, which provides a forum for residents to bring complaints to the facility administrator, and it should develop a plan to expand the number of family councils present in New Jersey nursing homes.

- The State should establish a Statewide Resident and Family Support Network to provide a feedback loop to State agencies, including the DOH, DHS, and the Office of the State Long-Term Care Ombudsman.

SECTION 3: WORKFORCE ENGAGEMENT AND SUSTAINABILITY

New Jersey, as with many other states, faces an acute and growing workforce challenge that raises the possibility of decreased access to services for seniors and those with disabilities and threatens the long-term viability of some LTSS providers. There is a well-documented shortage of professional and paraprofessional personnel to manage, supervise, and provide LTSS in facility-based and home care settings. This includes a shortage of nurses and direct care workers, as well as leadership personnel such as nursing instructors, licensed nursing home administrators, and qualified drivers, among other categories.

Looking to the future in New Jersey, the working age population is expected to decline by 1.3 percent over the next five years, while the age 65+ population is expected to grow by 14 percent, worsening the current imbalance between supply and demand. Moreover, because LTSS has increasingly shifted to HCBS, it is reasonable to expect that the total demand for LTSS workers will increase significantly as well, since HCBS can involve one-on-one care in many instances. Given these realities, it will be imperative that New Jersey embrace all strategies to increase the supply of workers available to LTSS. This should include an all-of-government approach, as well as public-private partnerships.

Wage and Benefit Parity

- Consistent with our recommendations in Section 1 regarding rate-setting of Medicaid HCBS, the State should conduct a periodic review of the impact of Medicaid payment policies on direct care workers' total compensation, including paid time off, to ensure a living wage. Future Medicaid rate increases should prioritize pay equity and cost-of-living increases for direct care staff.
- The State should consider utilizing unexpended federal COVID-19-related funds to provide bonuses to staff of all kinds (including housekeeping, kitchen, transportation, etc.) who worked in LTSS during the worst of the pandemic.

Career Enhancement/Advancement in HCBS and Facility-Based Settings

- Create a single curriculum and training for the direct care workforce in both institutional and community-based settings, with the goal of creating a workforce that can flow between both systems.
- Incentivize LTSS providers to develop and adopt advanced roles. New roles would elevate their title, function, and compensation. Examples of roles could be Senior Aide, Peer Mentor, Preceptor, and Certified Medication Aide (CMA).

- Allow Certified Medication Aides (CMAs) in nursing homes, as are permitted in over 35 states nationwide.

Simplifying Entry to the LTSS Workforce

- Provide free or reduced tuition, award scholarships, or loan forgiveness to individuals interested in working in LTSS.
- Permit an online, hybrid approach to credentialing/certification for direct care workers, certified nurse aides (CNAs), and certified home health aides (CHHAs), which would include a mix of online training, in-person instruction and skills testing, and written testing, and provide accommodations for those who have English as a second language.
- Develop additional testing sites for CNAs and CHHAs throughout the state and allow certification testing to be done at the facility level with a trained instructor.
- Streamline the process for out-of-state reciprocity; and consider the feasibility to establish a Direct Care Worker Compact similar to the Nursing Compact. This would facilitate workers from other states working in New Jersey.

Recruitment and Exposure to LTSS Work Opportunities

- Create a wide-ranging media campaign that highlights the positive and rewarding aspects of working in an LTSS setting.
- Establish credit programs for high school students for work/study in LTSS settings.
- Encourage state schools, universities, and colleges that provide medical education to have students complete clinical rotations through LTSS settings. Require that nurses have clinical rotation pathways that include LTSS settings.
- Medical and nursing school curricula should include geriatric and palliative medicine.
- Incentivize nurses to become nurse instructors, such as by providing grant funding to educational institutions to provide more competitive salaries, offering loan forgiveness, and/or offering tax credits for nurses who agree to become nurse instructors. Adjust the educational requirements to become a nurse instructor.

SECTION 4: BROAD-BASED REFORMS

The Task Force discussed a broad array of system-wide reform topics, including the role of Medicaid managed care organizations (MCOs) in quality and promoting HCBS, how to increase the use of technology in LTSS to promote the right care at the right time, reforming how behavioral health needs are better addressed for an LTSS population, and providing a platform for nursing home residents and their families to provide input on recommended system reforms.

Addressing the Role of Medicaid MCOs in LTSS

LTSS provided by the New Jersey Medicaid program are now almost exclusively administered by five managed care organizations (MCOs): Amerigroup, UnitedHealthcare, WellCare, Aetna, and Horizon. The Task Force finds that the MCOs serving a Managed Long-Term Services and Supports (MLTSS) population (hereafter “MLTSS plans”) should be more involved in driving quality by conducting a more holistic assessment of enrollee needs and focusing more on intervening early in situations where enrollees’ health or functional status is at risk of declining. This includes recommendations for the State to:

- Identify a more robust range of MLTSS quality oversight measures and implement them in a transparent, quality incentive payment framework aligned with statewide goals for quality and HCBS rebalancing.
- Require MLTSS plans to do more to ensure nursing home quality, including substantially reducing care management caseloads of nursing home residents (currently 240:1); requiring more frequent, face-to-face visits to nursing home members; and improved, more accountable efforts to transition residents back to the community.
- Investigate other MLTSS plan payment models that would have an even more positive impact on rebalancing the system to HCBS and assess impact of barriers to transitions of nursing home residents to the community (e.g., lack of affordable supportive housing).

Technology Enhancements

With the implementation of the Health Information Network (HIN) for residential LTSS providers, the State is developing an infrastructure for increased use of technology to improve care transitions and reduce avoidable adverse events in LTSS. It is time for New Jersey to take the next step on the path to development of widespread, interoperable, and user-friendly electronic medical records across the continuum of care. This includes recommendations to:

- Build upon the implementation of the electronic medical record requirement and HIN connection for nursing homes. The State should provide resources for hospitals and nursing homes to exchange user-friendly clinical information.
- Expand interoperability requirements to home health and other HCBS providers to improve transitions of care across the continuum.
- Require that all residents of LTC facilities have access to Wi-Fi, cable/dish/streaming, and telephones in their rooms.
- Encourage the adoption of remote pharmacy dispensing systems in New Jersey nursing homes via grants or low-interest financing programs.

Ensure People with Mental Health Disabilities Receive Quality LTSS and Behavioral Health Services in Appropriate Settings

The Task Force has deep concerns about individuals who have mental health disabilities who need LTSS, both in institutional and community settings. We are concerned that many are not being served in the most appropriate and integrated settings, are not receiving the specialized services they need, are not receiving care that addresses unmet needs (as opposed to controlling “behaviors”) and appear to be increasingly concentrated in nursing homes serving large numbers of residents with mental health disabilities. The crisis and closure of Woodland Behavioral and Nursing Center in 2022 highlighted these issues, but they continue to occur in less visible ways across our LTSS system every day.

The lack of affordable supportive housing (see discussion in Section 1 of this report) is a primary driver of these problems. Individuals with serious and persistent mental illness too often go from inpatient acute psychiatric hospitals to nursing homes, largely because there are no affordable, safe places for them to receive care. The same is true for unhoused people with mental illness in the community who pass through our acute care hospitals.

Additionally, it appears that New Jersey’s implementation of the Pre-Admission Screening and Resident Review (PASRR) process, which identifies people going into nursing homes who have serious mental illness or developmental or intellectual disabilities, is not functioning as intended and is contributing to these problems.

To address these concerns, the Task Force recommends that the State:

- Invest in supportive housing for the nursing home population, including for people with mental health disabilities (see affordable supportive housing recommendations in Section 1).
- Critically review and strengthen the State’s implementation of the PASRR process to ensure that people with mental health disabilities are living in the most appropriate setting, whether in a nursing home or the community, depending on their desires and needs.
- Look to other states to see how they deliver specialized services for this population in LTC and seek CMS guidance for implementation.
- Evaluate and publicly report on the pilot program established in two nursing homes after the closure of Woodland Behavioral and Nursing Center to assess whether the program:
 - Is achieving objectives of quality care.
 - Represents the least restrictive setting appropriate for care of its residents.
 - Is significantly differentiated from behavioral units in Special Care Nursing Facilities (SCNFs).
- Meaningfully address the requirement of the Nursing Home Reform Act that all residents should receive care to achieve or maintain their “highest practicable” mental and psychosocial well-being. Increase scrutiny and enforcement on nursing home policies and

practices that run counter to this (e.g., overmedicating residents, involuntarily discharging/transferring people for behavioral issues).

- Ensure all LTSS staff are trained to respond in person-centered ways to people who have mental health disabilities, as opposed to focusing on controlling or extinguishing “behaviors.”

Expand Statewide Clinical Outreach Program for the Elderly (S-COPE)

S-COPE has proved to be an invaluable service for many facilities reporting anecdotally that they have avoided hospitalizations and institutionalization through the program. It is a model program which few states have implemented and would be of value to citizens of all ages and capabilities.

- Build upon and expand funding for S-COPE to include citizens at every age, stage of development, and level of utilization of mental health and behavioral services to support nursing homes, assisted living, dementia treatment centers, and individuals living in more independent settings, including homes.

Reforming How LTSS Is Financed

The access problems experienced by people requiring LTC services could be eased if more people had LTC insurance. The current system requires people to become indigent after a time to access services through Medicaid. A public social insurance model could level the playing field.

- The State should explore the potential development of a public social insurance program for LTSS, using the Washington Cares model as an example. The plan should include mandatory and universal contribution by workers, provide access to needed funds when eligible, be portable to the maximum extent feasible, and address persons without Social Security.

SECTION 1: EXPANDING HOME- AND COMMUNITY-BASED SERVICES

Studies consistently show that people strongly prefer to receive long-term services and supports (LTSS) in their homes rather than institutional care. Unfortunately, current State Medicaid policies continue to favor institutional care over home- and community-based services (HCBS). The resulting disparities in eligibility, coverage, and payment are referred to as “institutional bias” throughout this report. Addressing institutional bias will help New Jersey move toward an “HCBS First” approach. This is in line with the guiding principle of the landmark U.S. Supreme Court decision in *Olmstead v. L.C.*, finding that health care services for people with disabilities should be provided in the most integrated setting appropriate to their needs.

Adopting an “HCBS First” Model

The Task Force finds that it is time for the State of New Jersey to take bold, transformative steps to end the institutional bias in State policy for older adults and people with disabilities. The institutional bias can result in premature and/or unnecessary placement in nursing homes. While the Task Force recognizes that congregate care will always be required for some individuals, the State’s current system of long-term services and supports tilts too heavily toward nursing home care.

- Over 80 percent of consumers prefer to receive their LTSS in home- and community-based settings when presented with various scenarios.⁴ HCBS includes care at home and in residential settings such as assisted living.
- Although New Jersey has made recent progress on shifting the focus of LTSS from institutions to home- and community-based settings (a process referred to as “rebalancing”), New Jersey remains 23 percent above the national average in use of nursing homes as measured on a per Medicare beneficiary basis (see Table 1 in Nursing Facility Reforms section for more complete discussion).
- As of 2019,⁵ New Jersey was ranked 37th in the country for the percentage of Medicaid spending on LTSS it directs toward HCBS, with 47 percent going towards HCBS (national average is 59 percent).⁶ States that have historically invested more heavily in HCBS alternatives (e.g., home care, adult medical day care, assisted living, supportive housing) have fared much better. For example, in 2019, Oregon spent 80 percent of Medicaid LTSS funds on HCBS, while Minnesota, New Mexico, and Arizona were in the high seventies.

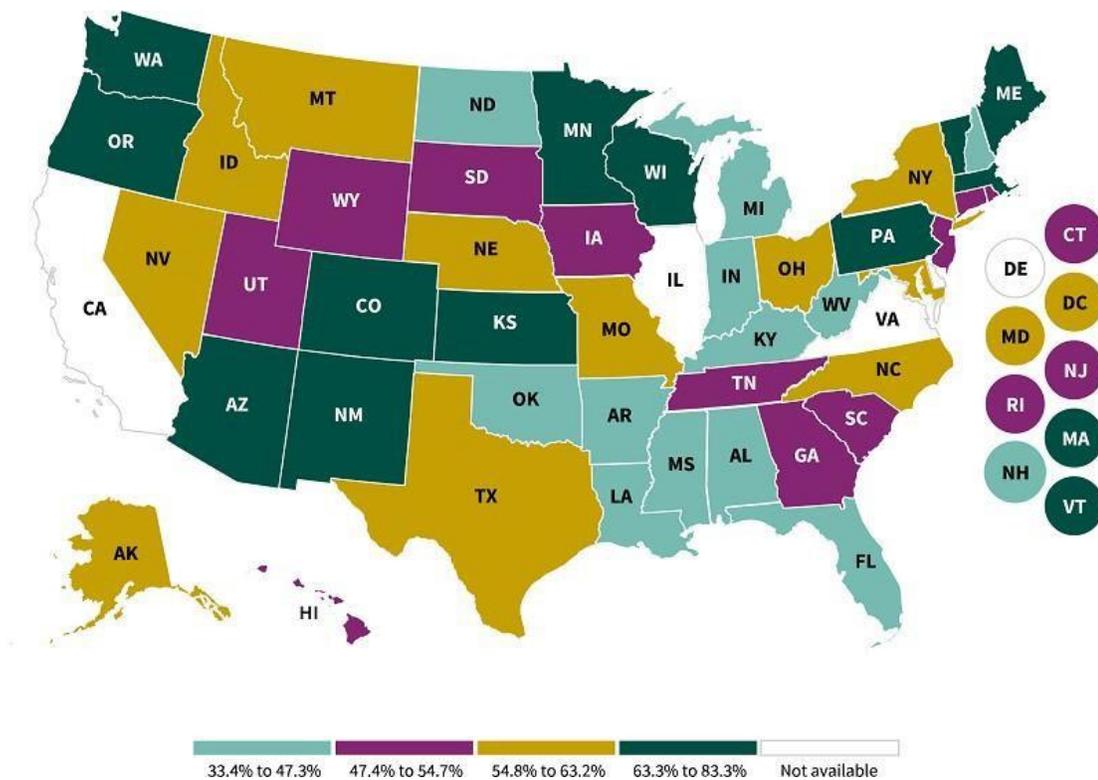
⁴ Source: The Gerontologist, *Care Arrangements of Older Adults: What They Prefer, What They Have, and Implications for Quality of Life*, November 2018, <https://doi.org/10.1093/geront/gny127>.

⁵ The most recent year with comparable data across states at the time of this report.

⁶ Source: Mathematica for CMS, *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019*, December 2021, <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>. Note: The data in this report includes developmentally disabled persons and as such has a slightly broader definition of LTSS than other analysis included in this report. It is, however, the most recently available data for cross-state comparisons.

With the implementation of enhanced federal funding as part of the American Rescue Plan Act (ARPA), many states across the country, including New Jersey, have increased their investments in HCBS. However, ARPA funds are non-recurring and sunset in March 2024. New Jersey must continue annually investing in HCBS (matched by federal dollars through the regular Medicaid matching process) in order to propel New Jersey toward a more consumer preferred and cost-effective LTSS system.

Figure 1: HCBS Percent of Total Medicaid LTSS Spending by State
New Jersey Was in Second Lowest Quartile in 2019



Source: <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>

Studies have shown that investing in HCBS is not only good for consumers and their families, but it also makes good fiscal sense. For instance, an early comprehensive study (2009) concluded: “Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings.”⁷ More recent studies affirm the same finding.⁸

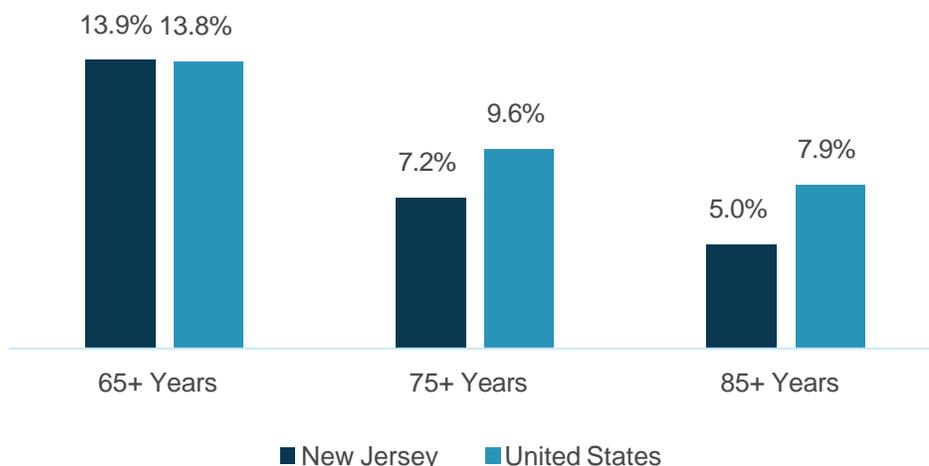
⁷ Source: Health Affairs, *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?*, January/February 2009, <https://doi.org/10.1377/hlthaff.28.1.262>.

⁸ See, for example: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3710567/> or <https://www.healthmanagement.com/wp-content/uploads/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf>.

As of January 2023, there were 67,300 persons receiving LTSS covered by Medicaid who met the clinical eligibility standard for “nursing facility level of care” (whether they resided in the community or in a facility). Given the projected population growth of LTSS users in New Jersey, there will be approximately 74,000 Medicaid LTSS users by 2028. Medicaid spends about 20 percent less per person on HCBS than the current overall average per person LTSS spending (which includes nursing home spending). This trend indicates that if all the added users were placed in HCBS and there was a more aggressive effort to transition current residents back into the community, the State could realize significant cost avoidance by further rebalancing the system.

Given the projected growth rate of the age 65+ population (14 percent) over the next five years in New Jersey (see Figure 2), the time to act to strengthen the HCBS system and reform and reduce the institutional long-term care (LTC) system is now.

Figure 2: Age 65+ Population in New Jersey Is Expected to Grow by 14 Percent from 2022 to 2028



Source: Claritas, Inc.

The Task Force is also concerned about equity of access to HCBS. For instance, a recent Justice in Aging report showed that the HCBS benefits package for older low-income adults provides fewer Medicaid HCBS services than for younger adults with physical disabilities. Further, assisted living is virtually out of reach for middle- and low-income New Jersey residents, and more difficult for Medicaid-eligible people to access in racially diverse counties versus less diverse ones. The report also highlights the dearth of robust publicly available data that would inform public policies about HCBS equity.⁹

⁹ Source: Justice in Aging, *Building an Equitable Medicaid HCBS Infrastructure in New Jersey for Older Adults*, June 2022, <https://justiceinaging.org/wp-content/uploads/2022/06/Building-an-Equitable-Medicaid-HCBS-Infrastructure-in-NJ-for-Older-Adults.pdf>.

The Task Force strongly believes that State policy should drive growth in HCBS not only for Medicaid-covered individuals but also for all New Jersey citizens and promote consumer and family choice about settings of care. This is a paradigm shift for New Jersey and will require new and ongoing investment.

New Jersey should do this not only because it is enshrined in the first mandate of P.L. 2020, c. 88, but because it is *the right thing to do* and overwhelmingly preferred by consumers. It is also consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, which found that unjustified segregation of people with disabilities in institutions is a form of unlawful discrimination under the Americans with Disabilities Act (ADA).

Recommendations to Accelerate HCBS Expansion:

- **1.1.1:** Within the next three years, New Jersey should set and achieve a goal of having 80 percent of the Medicaid “nursing facility level of care eligible” participants served in HCBS, and 60 percent of such funding devoted to HCBS, with the expenditure goal moving to 70 percent within five years. The State is currently at 63 percent for participants and 46 percent of expenditures devoted to HCBS for this population.
- **1.1.2:** The State should track and publicly report on a regular basis the achievement of the above goals across important subgroups, including those that are historically marginalized (e.g., age, disability, race, gender, ethnicity, LGBTQI status, language proficiency). The public reporting should be done in a way that is readily accessible and easy for the public to understand.
- **1.1.3:** New Jersey should adopt a three- to five-year strategic plan and front-load funding to rapidly expand HCBS, similar to the planning and “bridge funding” investments made to deinstitutionalize people from State developmental centers.
- **1.1.4:** The New Jersey Department of Human Services (DHS) should develop a plan to address the end of time-limited ARPA funds in an equitable manner across all HCBS provider types and seek public input.

Reducing Institutional Bias by Expanding Access to HCBS

The Task Force received feedback from stakeholders and members about how difficult it is to obtain Medicaid eligibility for HCBS services when those services are needed. This leads to potentially unnecessary and often permanent nursing home admissions. These challenges include timeliness and ease of Medicaid eligibility determinations, restrictive clinical and financial eligibility policies, and the inability of persons just above arbitrary thresholds to become and remain eligible for HCBS.

¹⁰ https://njfamilycare.dhs.state.nj.us/analytics/LTC_explorer.html

Recommendations to Expand HCBS Access:

- **1.2.1: Allow presumptive financial Medicaid eligibility** for HCBS so that clinically eligible people can receive needed services without waiting weeks or months for Medicaid to review the applicant's financial information.
- **1.2.2: Streamline the Medicaid eligibility application process and provide retroactive eligibility for HCBS.** DMAHS should post online, and update monthly, the average waiting time for applications to be approved.
- **1.2.3: Create more holistic criteria for HCBS clinical eligibility** by incorporating Instrumental Activities of Daily Living (I-ADLs), such as assistance with shopping, cleaning, managing money and/or medication, with a greater focus on cognitive impairment. Many people would benefit from earlier services to forestall avoidable decline. New Jersey should review other states' clinical criteria and existing federal authorities (e.g., Medicaid waiver) to establish more holistic clinical eligibility for LTSS coverage.
 - Example: Elders with mild or moderate cognitive impairment may be able to eat independently (an ADL measure), but may not be able to plan, shop, and prepare meals (I-ADL measures).

- **1.2.4: Increase resource limits for HCBS.** Applicants should not have to deplete nearly all their hard-earned resources in New Jersey to qualify for LTSS services they need. This sometimes results in people waiting to apply for Medicaid services until the situation is critical and/or unsustainable. This is also an equity issue, as it limits marginalized groups' ability to accrue and pass on intergenerational wealth.

Other states allow more generous resource standards. New Jersey should raise its current limits for all Managed Long-Term Services and Supports (MLTSS) applicants. One way to address this for married individuals enrolled in an MLTSS plan or the Division of Developmental Disabilities (DDD) Supports and Community Care programs is for New Jersey to adopt the more generous federal standard that determines what spouses remaining in the community can keep (New Jersey currently uses a more restrictive standard).

- **1.2.5: Phase out Qualified Income Trusts (QITs) and adopt a suitable replacement that meets federal requirements.** Qualified Income Trusts (so-called "Miller Trusts," created to allow people over the institutional income limit for MLTSS to qualify), do not provide retroactive eligibility, require a trustee (some people have no one to serve in this role), and are treated differently across the banking system. The result is that it is difficult for people with limited resources or support to qualify and maintain eligibility using this tool. To promote equity and accessibility, the State should consider the hypothetical medically needy spenddown model that was originally approved by the Centers for Medicare & Medicaid Services (CMS) in 2012. Louisiana is an example of this model. The State should work with CMS to resolve any problems with post-eligibility treatment of income that may result.
- **1.2.6: Increase income limits** for the Aged, Blind, and Disabled (ABD) Medicaid eligibility category. Aged, Blind, and Disabled are Medicaid State plan services that can provide hands-on assistance at home for people who do not qualify for enrollment into MLTSS

because their clinical needs are not quite high enough to meet the MLTSS standard (e.g., the person only needs help with two ADLs as opposed to three). However, the income limits to qualify for personal assistance through ABD are even lower than for MLTSS. The State should raise the income limits by increasing the amount of unearned income that it disregards (ignores) in its calculations, which is currently only \$35. Other states disregard much more income. This would have the potential benefit of preventing unnecessary institutionalization.

- **1.2.7: Allow people in nursing homes to keep their income for longer periods of time,** so they can maintain housing and/or resources in the community. This issue affects peoples' ability to move back into the community after a nursing home stay. Residents must turn over their income to the facility to supplement the cost of their care. However, people who wish to move out need income to pay rent and other expenses. When people covered by MLTSS go into a nursing home for short-term care but do not intend to stay, allow them to keep their income for up to one year as opposed to six months.

Ensuring Availability of HCBS to Promote Aging-in-Place

Even after people become Medicaid eligible, they sometimes struggle to get the timely, robust Medicaid services they need to age in place. Delayed service authorizations, limitations on personal care hours, inability to complete needed home modifications and/or to access needed transportation, and many other barriers can reduce the amount of time people are able to remain at home.

Recommendations to Strengthen HCBS Services:

- **1.3.1: Ensure timely authorization of home visits.** Managed care organizations (MCOs) may take up to 15 days to authorize home care visits for a Medicaid individual returning home from an acute event, potentially placing the patient at risk of returning to the hospital. The State should ensure that Medicaid MCO providers can make an assessment visit and up to three visits while the MCO is making its decision about the necessity for ongoing home health visitation.
- **1.3.2: Remove the 40-hour/week Personal Care Assistant (PCA) limitation.** Current Medicaid rules limit PCA services to 40 hours per calendar week, with case-by-case approval required for more hours.¹¹ This limitation can have the practical effect of limiting some working families from being able to care for their loved ones at home, forcing individuals into nursing homes prematurely when their needs could otherwise be met. Remove and replace this limitation with a needs-based model that may include authorization of 24-hour care PCA services.
- **1.3.3: Revise the State-required PCA prior authorization process¹²** to focus on

¹¹ N.J.A.C. 10:60-3.8.

¹² See: <https://casetext.com/regulation/new-jersey-administrative-code/title-10-human-services/chapter-60-home-care-services/subchapter-3-personal-care-assistant-pca-services/section-1060-39-prior-authorization-for-personal-care-assistant-pca-services>.

functional ability, not just medical needs. Revisit PCA prior authorization tool to ensure that it conforms with person-centered planning standards contained in the HCBS Final Rule.

- **1.3.4: Ensure people who hit the Annual Cost Threshold (ACT) have advocacy.** The ACT is a tool to flag high cost of care situations that also raises the prospect of institutional bias. For MLTSS enrollees who hit the ACT, an offer of assistance by an independent advocate should be provided and the independent advocate notified.
- **1.3.5: Expand Medicaid coverage to include palliative care.** Palliative care is specialized medical care for people living with a serious illness that is focused on providing symptom and stress relief. The goal is to improve quality of life for patients and caregivers. Palliative care is based on the needs of the patient, not on the patient's prognosis, is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.¹³ The State should add a community-based palliative care benefit to Medicaid. This benefit should provide palliative care services outside of hospice, without a six-month time requirement of a terminal illness or a requirement to end curative care, thus allowing reimbursement for interdisciplinary teams to support patients throughout the continuum of care. California and Hawaii have implemented this benefit for Medicaid. It can be accomplished through managed care plans, 1115 waiver, or reimbursement policy changes.¹⁴ As part of this expansion, increase public education on the value of early referral to hospice and palliative care and advance care planning more generally.
- **1.3.6: Increase annual and lifetime limits for home modifications.** Home modifications can be part of a Medicaid MLTSS plan member's care plan and may include ramps, grab bars, and wider doorways, for example. MLTSS plan members not living in a licensed facility are entitled to up to \$5,000 of home modifications per year, which may not exceed \$10,000 over their lifetime. One problem is that for an elder who requires home modifications exceeding \$5,000, but less than \$10,000, that person will be forced to defer a portion of the needed modifications, increasing the risk of injury and premature and/or unnecessary nursing home placement. Another issue is that construction and installation costs have risen sharply, but the limits have not increased. The State should increase the annual and lifetime limit for residential modifications and tie future increases to an appropriate cost index.
- **1.3.7: Conduct study to improve choice and access to Non-Emergency Medical Transportation (NEMT).** As the LTSS system serves more people in HCBS settings, there is an increased need for responsive and user-friendly transportation, which is not always available for HCBS recipients. When appointments are missed or delayed, adverse health consequences can occur. DHS should conduct a study of gaps in transportation services, including availability of drivers with a Commercial Driver License, to assess where those gaps are limiting Medicaid recipients' choice, potentially forcing premature and/or unnecessary institutionalization.

¹³ Source: Center to Advance Palliative Care, *About Palliative Care*, <https://www.capc.org/about/palliative-care/>.

¹⁴ Source: National Academy for State Health Policy, *Emerging State Innovations in Developing a Medicaid Community-Based Palliative Care Benefit*, August 2022, <https://nashp.org/emerging-state-innovations-in-developing-a-medicaid-community-based-palliative-care-benefit/>.

- **1.3.8: Expand funding and delivery of State-funded respite services.** Respite is crucial for informal caregivers, who can become overwhelmed and burned out from providing LTSS to loved ones. These breaks for caregivers can forestall the need to place their loved one in a nursing home. Expand State funding for respite care services and increase awareness of these services. The State should explore alternatives to temporary institutional placement to provide respite services. The State should also take a close look at funding through HCBS to maintain and expand options where family members or friends are delivering care rather than having to place their loved one in a nursing home for respite care.
- **1.3.9: Coverage flexibility for Adult Family Care (AFC).** Per New Jersey Medicaid manual (Chapter 7, pg. 109), up to three unrelated individuals can receive services in the home of another unrelated person under the AFC program. This limitation may cause families that could otherwise care for their own family members to provide care for unrelated individuals, potentially requiring their own family member to be institutionalized or face foregoing necessary income to sustain the household. Consider allowing up to three individuals receiving services to be either related or unrelated to the caregiver or other residents. This would increase the delivery of services to persons in a homelike setting and would potentially prevent or delay institutional placement.
- **1.3.10: Flexibility for Adult Day Health Services (ADHS).** ADHS are a cost-effective substitute for institutional care, but continue to face significant financial and workforce challenges, causing some programs to close and raising the risk of premature and/or unnecessary institutionalization. Regulations require that a registered nurse (RN) be always on-site when participants are present, which means that programs can close for the day when a nurse is not available. A review of 10 states found the most common nursing oversight model to be licensed practical nurses (LPNs), in some cases with periodic RN oversight. Among the 10 states reviewed, New Jersey is alone in always requiring RN presence.

DMAHS and the New Jersey Department of Health (DOH) should work with ADHS representatives to provide regulatory flexibility with respect to the RN coverage requirement. RN supervision of LPNs is safe and effective and can be coupled with an acuity assessment to ensure that all patient needs can be met by LPNs working under the supervision of an RN. RN supervision can be on-site or remote. For example, an RN can be immediately available via phone or video platform. Alternatively, depending on geography, ADHS programs could opt to have an RN available within a 10- or 20-mile radius, ensuring prompt assessment of emergent care needs.

- **1.3.11: Remove the five day per week limitation for ADHS.** Current Medicaid rules limit ADHS services to five days per week. This limitation can have the practical effect of limiting some working families from being able to care for their loved ones at home, forcing individuals into nursing homes when their needs could otherwise be met. Remove and replace this limitation with a needs-based model that may include the possibility of seven days a week of ADHS.
- **1.3.12: Promote Assisted Living Programs.** New Jersey's Assisted Living Program (ALP) is a long-standing, flexible model that allows lower-income seniors to age in place in public

housing and requires partnerships and a minimum number of participants to operate effectively. There are currently only 17 ALPs in New Jersey, and providers face numerous challenges in scaling their programs. The State should: 1) review how regulatory and payment changes can help expand the number of ALP providers and their ability to deliver the full range of services possible, 2) update State licensing requirements to better reflect the structure and operations of ALPs, and 3) educate all relevant housing providers about the benefits of ALPs.

- **1.3.13: Continue to expand access to the Jersey Assistance for Community Caregiving (JACC)**, which is a State-funded program that provides a broad array of in-home and community-based services to individuals aged 60 and older who meet clinical eligibility for nursing home level of care and who desire to remain in the community. Services include: adult day, chore services, respite care, durable medical equipment (DME), and transportation. A significant increase in funding was authorized in FY24. The Task Force recommends that the State continue to expand access to this program.
- **1.3.14: Expand Program of All-Inclusive Care for the Elderly (PACE)**. PACE programs provide comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. The Task Force finds that PACE is an effective model of integrating care for a dually eligible (i.e., eligible for both Medicare and Medicaid), community-based population with LTSS needs.¹⁵ Growth of this program has been hampered by several factors, including lack of consumer awareness and antiquated financial and clinical eligibility processes at the State level. The State should:
 - Ensure there is at least one PACE program covering every county in New Jersey.
 - Modernize PACE clinical and financial eligibility systems. Currently, these tasks are performed manually, slowing enrollment growth.
 - Ensure that Office of Community Choice Options counselors and MCO care managers are knowledgeable about PACE. Mandate training and use of a core script to make sure service options are uniformly and accurately described. Identify trigger points where Medicaid recipients are to be apprised of new service options such as PACE (e.g., when a member becomes nursing home eligible).
 - Allow PACE participants to receive services before the first of the month for enrollment. For instance, California permits expedited eligibility (with retroactive validation) and provides for prorated capitation.
 - Review PACE encounter data categories to be sure that they are inclusive of the nature, range, and intensity of services provided to participants, and adjust rates accordingly.

¹⁵ See <https://www.npaonline.org/start-pace-program/understanding-pace-model-care> for full explanation of PACE and <https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html>.

- Develop a PACE-like integrated care model for specialty care populations, such as those with developmental disabilities, alcohol or drug dependency, substance use disorders (SUDs), dementia, behavioral issues, and/or traumatic brain injury.

Increasing Access to Affordable Supportive Housing

Affordable supportive housing for seniors and people with disabilities is one of the primary barriers to rebalancing the LTSS system in New Jersey. People cannot age in place or transition from nursing homes back to the community if there is not enough affordable, accessible housing to meet the needs. According to the Corporation for Supportive Housing (CSH), approximately 17,000 older adults across a variety of settings need supportive housing, including over 5,000 people age 65+ in nursing homes.¹⁶ Additionally, New Jersey's responsibility to develop housing is diffused across several agencies; this has led, in part, to fragmented and inadequate housing infrastructure. Please refer to Section 4 for additional discussion about the challenges that the lack of housing creates for persons with mental disabilities.

Recommendations:

- **1.4.1: Establish a single cabinet-level individual to coordinate housing initiatives and services across all State departments.**
- **1.4.2: Develop a short-term action plan for affordable supportive housing.** The Task Force urges that the State develop a short-term action plan to address the needs for supportive, affordable, housing for those in New Jersey who are at risk for premature and/or unnecessary institutionalization. The plan should include strategies for repurposing currently built structures (such as schools) and identification of funding sources (e.g., grants and low-interest loans), as well as State statutory and fiscal appropriation needs.
- **1.4.3: Improve coordination between the tax-exempt bond cap (NJEDA) and the Low-Income Housing Tax Credit (NJHMFA) programs** regarding development of affordable senior supportive housing. Developers have cited the lack of coordination between the New Jersey Economic Development Authority (NJEDA) and New Jersey Housing and Mortgage Finance Agency (NJHMFA), which can lead to underdevelopment of affordable senior housing projects. NJEDA too infrequently uses its cap toward senior supportive living developments—such as Assisted Living Residences (ALRs)—and those developments do not score well in the competitive 9 percent Low-Income Housing Tax Credit annual allocation.
- **1.4.4: Increase funding opportunities for social and health care services in subsidized senior housing buildings** in the State through either direct funding or indirect methods such as co-locating and/or partnering with health care providers. Successful models such as Northgate II in Camden should be replicated throughout the State.

¹⁶ Source: Corporation for Supportive Housing, *Assessing New Jersey's Need for Supportive Housing for an Aging Population*, October 2020, <https://www.csh.org/wp-content/uploads/2020/10/CSH-Assessing-New-Jerseys-Need-for-Supportive-Housing-for-an-Aging-Population.pdf>.

- **1.4.5: Encourage New Jersey’s MCOs to invest in affordable housing** as they have done in other states. For example, UnitedHealth Group alone has invested over \$800 million in the creation of 19,000+ housing units in other states.¹⁷ The State should determine the best mechanisms to achieve MCO housing investment in New Jersey and pursue this.
- **1.4.6: Expedite the licensing process for affordable ALRs that house at least 50 percent of the Medicaid population.** Create stronger incentives and resident protections for ALRs to admit and retain low-income persons, including by establishing: Medicaid payment for bed holds, rules around improper/involuntary discharge, and landlord-tenant protections (see recommendation below).
- **1.4.7: HCBS Settings Rule and Protect from unlawful evictions** State policies need to be amended to ensure that residents of HCBS settings that receive Medicaid waiver dollars have the full protections of New Jersey’s Anti-Eviction Act. At the time a resident enters an applicable setting (e.g., assisted living), the resident should enter into an agreement that the facility expressly agrees to the provisions of New Jersey’s Anti-Eviction Act, which specifically disallows the self-help lockout or eviction without notice (which can occur in these settings when a resident is hospitalized or attempting to return after hospitalization). New Jersey should, in conjunction with legal counsel and interested stakeholders, develop a model contract for ALRs that comports with the federal HCBS rule.

Need for More Formal Medicaid Rate-Setting Process for HCBS

New Jersey’s process of adjusting Medicaid rates for LTSS (both HCBS and nursing homes) is largely ad hoc and is set through the legislative budgetary process on a year-to-year basis. Recently, however, New Jersey has initiated a two-year process to re-establish cost reports, receive stakeholder input, conduct analytics, and ultimately implement a new Medicaid payment methodology for nursing homes by January 1, 2025.¹⁸ No such process exists for HCBS, which contains a much more diverse set of services affecting a larger number of New Jerseyans and is of similar magnitude expenditure-wise. In addition, some HCBS service lines such as home health do not have protections from inadequate rates. In turn, this leads to wage scales that are not sufficient for a living wage for direct care workers.

As the Task Force makes recommendations in this report about sustaining or increasing funding to any type of provider, it is important that reimbursement only occur when a provider has demonstrated the delivery of quality care and service with adequate, verifiable, and credible transparency.

¹⁷ Source: UnitedHealth Group, *Additional \$100 Million Investment in Housing Bolsters UnitedHealth Group’s Efforts to Address Social Determinants and Achieve Better Health Outcomes*, April 2022, <https://www.unitedhealthgroup.com/newsroom/2022/additional-housing-investment-bolsters-uhg-efforts.html>.

¹⁸ Source: Mercer, Nursing Facility Rate Setting Rebase Town Hall Presentation, March 2023.

Recommendations:

- **1.5.1: Systematic review of HCBS rates.** The State should ensure that HCBS rates are periodically and systematically reviewed through an auditable and transparent comparison of rates to allowable cost and to direct that rate adjustments are effectuated consistent with well-established rate-setting principles as necessary to ensure viability of access to each HCBS service line and for living wages to be provided to direct care workers. Prevent payment erosion in the future by automatically adjusting rates through an index that measures changes in cost inputs and addresses unfunded mandates.
- **1.5.2: Implement quality metrics as appropriate for all HCBS service lines.** As part of adjusting rates as described above, quality metrics should be developed for all service lines in HCBS¹⁹ and incorporated into provider payment methodologies. The State should monitor implementation of the federal Home Health Value-Based Purchasing Model and align quality metrics and incentive structures for Medicaid home health providers where possible and view the federal demonstration as a model. Assess promising practices for quality measurement and improvement for HCBS from other states' Medicaid programs.
- **1.5.3: Evaluate and implement acuity adjustments as necessary across all HCBS service lines.** The necessity for acuity adjustments to payment rates should be evaluated for each HCBS service line. This should be part of a coordinated strategy to appropriately incentivize every setting (including nursing homes) to admit and care for persons with the highest needs and to develop robust clinical systems of care.
- **1.5.4: Implement service line–specific rate reforms to reduce institutional bias.** Including, but not limited to:
 - The State should re-examine how payment for room and board is set for ALRs using the Optional State Supplements to Supplemental Security Income (SSI). These rates are too low, which creates access problems to this care setting for low-income persons, forcing premature and/or unnecessary institutionalization in nursing homes. This re-examination should include consideration of using vouchers like the DDD Community Care Program (which are set to HUD rates). In conjunction with this effort, DOH should prioritize enforcement of the current law requiring 10 percent bed complement for Medicaid-eligible individuals, as well as distribution of Medicaid waiver eligibility information and disclosure of wait list to Medicaid-eligible persons needing ALR services.
 - Increase Medicaid payment rates for assisted living services and, prior to the sunset of the tiered Medicaid rate increase for ALRs in March 2025, DMAHS should formally evaluate whether the existing payment tiers have been adequate to encourage increased access to ALRs for Medicaid recipients and make recommendations going forward for continuation or refinement.

¹⁹ See July 21, 2022, State Medicaid Director Letter for comprehensive listing of HCBS quality measures suggested by CMS: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf>.

- Increase ALP provider rates, considering variation in operating costs across regions/municipalities (e.g., adjust for differences in wage scales across regions) to incentivize ALPs where they are most needed, provided that further rate changes become increasingly tied to quality metrics.
- As a starting point to moving back to a more cost-related payment structure, return ADHS rates to the payment structure used prior to 2008, wherein rates are set to 45 percent of nursing home rates, plus an add-on per diem to accommodate differential levels of acuity.²⁰
- Develop a “second tier” of higher Medicaid payment rates for visit-based services such as home health, personal care, and private duty nursing to address difficult-to-serve patients, considering factors such as geography and acuity of patients.
- To allow assisted living residents time to recover from temporary illnesses or disabilities, Medicaid should provide temporary coverage for additional assisted living services for people who need time to achieve their baseline functional level after an acute event. Too often, people who don’t qualify for Medicare rehabilitation services are prematurely and/or unnecessarily institutionalized and risk losing their ALR altogether.²¹
 - Example 1: An ALR resident who develops a stage 3 or 4 pressure ulcer will usually require daily treatment by a nurse. Medicare home health covers only “intermittent” skilled care. This gap in coverage can result in discharge to a nursing home if the resident is unable to pay for the additional nursing care needed.
 - Example 2: An ALR resident who suffers an injury may require multiple caregivers to assist with transfers. Even if the injury could improve or resolve with time, this resident may be discharged due to the level of care needed.
 - Example 3: Following an acute event, an ALR resident who is discharged from the hospital may be bedridden for several weeks. Even though the condition may improve or resolve over time, this resident may be discharged to a nursing home if they are unable to pay for the additional services required.

The above-listed changes are not meant to be an exhaustive list of HCBS service line rate reforms, but rather are intended to demonstrate priorities for change that have come to the Task Force’s attention. These changes are intended to be made in conjunction with the overall HCBS payment reforms described above, including integration of quality requirements into payment methods with adequate, verifiable, and credible transparency.

²⁰ The Medicaid payment rate for ADHS services is \$86.10 per diem, a \$0.22 increase since 2008, far below the increase in cost-of-living or what other providers have received.

²¹ The Task Force discussed situations where private pay individuals are able to pay for additional temporary service needs but Medicaid recipients cannot, which creates a risk of institutionalization.

Other: Increased HCBS Advocacy and State Tax Credits for Caregivers

Supporting Unpaid Caregivers: Family caregivers provide an essential service that ultimately saves the State money by helping to keep care recipients in their homes. Caregivers provide support in many ways, ranging from assistance with ADLs, grocery shopping, or paying bills to attending medical appointments and managing medications, and may perform complex medical tasks, such as giving injections or treating wounds. Most family caregivers pay for expenses out of their own pockets to care for a loved one, covering the cost of home modifications, transportation, care at home, and more. Family caregivers nationwide spend nearly 20 percent of their income, on average, providing care for an older parent, spouse, or other loved one. Unpaid and family caregivers in New Jersey provide care valued at \$17 billion annually.²²

- **Recommendation 1.6.1:** New Jersey should consider establishing a state income tax credit for unpaid family caregivers. A tax credit will begin to offset some of the financial losses experienced and allow the caregiver to continue to provide this care.

Establish a Statewide Managed Long-Term Services and Supports (MLTSS) & HCBS

Advocate: As Medicaid MLTSS and HCBS continue to expand, concerns about access, provision, and quality of such services will also increase. MLTSS and HCBS, like other entitlements, are constitutionally protected and have strict rules about how and when to contest denials, terminations, and other service changes. These legal processes can be difficult for vulnerable people to understand and navigate and can have serious consequences. Consumers in this program need and deserve the same protections and advocacy as those who receive their MLTSS services in institutions such as nursing homes. New Jersey organizations such as the Protection and Advocacy agency Disability Rights New Jersey (DRNJ), Legal Services of New Jersey (LSNJ), and Community Health Law Project (CHLP) already advise/represent MLTSS and HCBS recipients in these matters.

- **Recommendation 1.6.2:** Create a Medicaid MLTSS & HCBS Advocate function to advocate for the rights of recipients. The MLTSS & HCBS Advocate would present an annual report to the State summarizing its activities and flagging systemic issues.

²² Source: AARP New Jersey, *New Report Shows NJ Family Caregivers Have Earned a Tax Credit by Providing More Than \$17 Billion in Unpaid Care to Loved Ones*, March 2023, <https://states.aarp.org/new-jersey/new-report-shows-nj-family-caregivers-have-earned-a-tax-credit-by-providing-more-than-17-billion-in-unpaid-care-to-loved-ones>.

SECTION 2: NURSING FACILITY REFORMS

The Task Force has placed the needs, preferences, dignity, and self-determination of people who require LTC services at the center of our thinking about how to reinvent long-term residential care in the State of New Jersey. To that end, the Task Force recognizes that while investments in HCBS are necessary and transformative, the need for congregate care²³ for at least some percentage of people will remain. However, the Task Force finds that the traditional large, hospital-style nursing home model that dominates in our State presents inherent barriers to person-centered care and is not in line with the more homelike environments that New Jerseyans prefer.

For this reason, it is critical that the State utilizes all the tools at its disposal to encourage culture change and innovative models of care that are more prevalent elsewhere in the country. The Task Force envisions nursing homes in the future to be smaller and more homelike, with nearly exclusively single rooms, person-centered operating culture, adequately staffed with highly trained and well-compensated caregivers, continually improving, and technologically up to date.

As with HCBS, equity in nursing home quality, access, and experience also concerns the Task Force. High income New Jerseyans have access to higher quality facilities and continuing care retirement communities, where people can age in place on the same campus. Medicaid recipients, especially those in very high Medicaid population nursing homes, tend to have more limited nursing home options and receive lower quality care. Racial disparities in care also exist between facilities and even among residents in the same nursing home.²⁴

Nursing homes also need to be better situated within the “HCBS First” system laid out in Section 1 of this report and more integrated with acute and primary care. While there are many organizations that actively focus on some or all these objectives, current State policy and piecemeal provider innovation has not resulted in the transformational change that is required.

In addition, there is a group of chronically poor performing facilities that consistently fail to provide high-quality, safe care, in some cases for many years. The Office of the State Comptroller’s recent reports have highlighted this issue.²⁵ The Task Force finds this unacceptable and believes that more resources dedicated to oversight and intervention, along with more assertive and coordinated enforcement, are needed. This group of chronic poor performers also makes it hard to mobilize public support for increased resources to create the necessary systemwide change we are seeking.

New Jersey should prioritize appropriate enforcement actions against facilities that persistently fail to meet standards of care. New Jersey has taken a positive step forward to provide early intervention with struggling nursing homes with the creation of Mission Critical Teams (see

²³ By congregate care, we mean care provided in group settings of many kinds, including nursing homes, assisted living facilities, etc.

²⁴ See: <https://justiceinaging.org/wp-content/uploads/2022/09/Racial-Disparities-in-Nursing-Facilities.pdf>.

²⁵ See: <https://nj.gov/comptroller/reports/2021/approved/20230331.shtml>.

below), but Mission Critical Teams are explicitly not an enforcement entity. Additional enforcement is required. For a brief description of existing quality tools, see Appendix C: Quality Tools for Nursing Homes.

The Task Force notes that New Jersey uses nursing homes at a 23 percent higher rate than the national average when analyzing use on a per Medicare beneficiary basis. (New Jersey is at 22.8 nursing home users per 1,000 Medicare beneficiaries, compared to the national average of 18.5).

- New Jersey’s nursing home use rate has been higher than the national average, both before the onset of the pandemic as well as after, as can be seen from Table 1 below.
- It is important to note that there is considerable variation in nursing home use rates (per 1,000 Medicare beneficiaries) across the country, with some states in the single digits (e.g., Oregon and Arizona) and others over 20 percent higher than New Jersey (e.g., Connecticut and Rhode Island).

**Table 1: Comparison of Nursing Home Use Rates Pre-COVID to 3Q 2022
New Jersey vs. National**

Location	Beds	Average Daily Census (ADC)	Percent Occupancy	Medicare Eligibles	SNF ADC Per 1,000
Pre-COVID Baseline (4Q 2019)					
NJ	52,600	43,139	82%	1,624,613	26.6
National	1,639,713	1,319,179	80%	60,689,359	21.7
Most Recent Post-COVID Onset (3Q 2022)					
NJ	51,167	38,495	75%	1,686,919	22.8
National	1,608,132	1,181,252	73%	63,745,903	18.5

Source: HDG analysis of Nursing Home Compare and CMS Medicare County Enrollment file

Reimagining Nursing Homes to be More Person-Centered and Homelike

As noted, the Task Force is concerned about the large size, institutional feel, and lack of single rooms. Table 2 compares bed size of New Jersey nursing homes to neighboring states. As can be seen by the data, except for New York, New Jersey nursing homes are larger than neighboring states. Some of this, no doubt, reflects the fact that New Jersey is the most population-dense state in the U.S., and real estate is at a premium. Some of it is also due to the State’s Medicaid payment policies, Certificate of Need regulations, and licensure rules.

Table 2: Comparison of Size of Nursing Homes in New Jersey to Nearby States

State	# SNFs	Total Beds	Bed Size			
			25th Percentile	Median	Mean	75th Percentile
NJ	351	51,167	109	130	146	180
CT	207	24,911	86	120	120	148
PA	678	85,964	75	120	127	150
MA	357	42,429	89	123	119	142
DE	43	4,769	81	110	111	137
NY	609	112,790	112	160	185	240

Source: HDG analysis of Nursing Home Compare Provider File as of January 27, 2023

Encouraging New Models of Care: The Task Force had considerable discussion about new models of nursing home care that employ some or all of the following features: small in total size, all single rooms, neighborhood/clustering design, universal workers, and person-centered philosophy of care that maximizes resident choice and autonomy. These are sometimes referred to generically as “small homes,” though elements could be employed in larger, high-rise buildings.

The most successful and widely replicated model is Green House[®], which employs a set model with set principles. As such, it has the most data available. The key features of the Green House[®] model include all private rooms with private bathrooms, no more than 12 people per home, universal caregivers (CNAs trained to perform culinary and housekeeping tasks), outdoor space, and person-centered care principles. Nationally, 80 percent of Green Houses[®] are licensed as nursing homes; the remainder are assisted living or other lower-acuity licenses. Approximately half of residents are covered under Medicaid. More than 90 percent are operated by nonprofits. Barriers to growth include start-up capital, perception of Medicaid rate inadequacy, and need for regulatory education.²⁶

These facilities are designed to create a family home type environment with informal gathering areas, casual meal planning, resident-directed resting/sleep patterns, and a staff that is trained to perform multiple tasks for the individual resident. The same universal worker may provide activities, assist with meals, and help with ADLs. Workers tend to experience higher levels of job satisfaction and become more involved with residents. The use of such workers is an essential aspect of the Green House[®] model but is not necessarily incorporated into all “small homes.”

Early research found that Green House[®] operations streamline management and department structures through self-managed teams of universal workers and shift those hours to direct care, using no more total staff hours per resident than traditional nursing homes, but providing 23 to 31 minutes more direct care per resident per day. Green Houses[®] were found to shift time away from more expensive administrative and departmental staff, allowing higher direct care hours

²⁶ Source: Alex Spanko, Green House[®] Project, presentation to the Task Force, October 20, 2022.

and wages without raising costs. After adjusting costs to account for fewer high-need short-stay residents, operational costs are at the 60th percentile of nursing home costs nationally, with higher occupancy and private pay penetration. Capital costs are higher for Green House[®] homes due to more square feet per resident for private rooms and baths—approximately \$10/day/resident more in 2011 after accounting for occupancy differences.²⁷

Green House[®] models were much safer for residents than traditional nursing homes during the COVID-19 pandemic, with one study showing that infection rates were nine times lower in Green House[®] homes as compared to traditional nursing homes with more than 50 people.²⁸

New Jersey had two Green House[®] models in operation, both of which have closed. New Jersey also has a version of small homes run by a nonprofit organization. Across the country, there are 80 Green House[®] campuses operating close to 400 Green Houses[®] implemented in over 30 states. It will be important for New Jersey to figure out the specific reasons why this innovative model has been successful elsewhere yet is not widely available here.

Another innovative small home option is called Dementia Villages[®], which are gated centers that create an entire living community for individuals with dementia. With small homes, community centers, “stores” for groceries, beauty and barber shops, areas for music, crafts, religious expression, and friends, it is possible for residents, and often their caregivers, to enjoy outdoor spaces, pets, and socialization safely and autonomously.

Recommendations:

- **2.1.1:** New Jersey should develop a demonstration project to jump-start Green House[®] models and small homes. The demonstration project should include regulatory analysis, capital funding grants, innovative housing funds, incentives to convert existing capacity, Medicaid rate add-ons, and changes to Certificate of Need as necessary.
- **2.1.2:** The upcoming Medicaid nursing home payment review (see Medicaid rate discussion later in this section) should include a financial assessment of how to support the Green House[®] model.
- **2.1.3:** New Jersey should closely monitor proposed federal legislation (IMPROVE Nursing Homes Act – HR 8677, as introduced on August 5, 2002) that provides federal funding and rewards innovative processes for nursing homes that meet criteria for small homes.

²⁷ Source: Robert Jenkins presentation to NJ AARP, November 23, 2022.

²⁸ Source: Journal of the American Medical Directors Association, *Nontraditional Small House Nursing Homes Have Fewer COVID-19 Cases and Deaths*, January 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7835101/>.

Encouraging Single Rooms: While the ultimate preferred solution is holistic change in the model of care, the Task Force believes that increasing the number of single rooms is an important step in that direction for a host of reasons, including that “single-resident rooms are associated with decreased risk of facility-acquired infections, medication errors, resident anxiety, and incidence of aggressive behavior, while improving sleep patterns, sense of privacy, and satisfaction.”²⁹

Encouraging smaller facilities and single rooms has many benefits but also carries the potential to increase costs. This occurs because fixed costs would be spread over a smaller base. Roughly speaking, cost increases by approximately \$1 per patient day for every decrease of one bed. The converse is also true. That said, there are also cost offsets for smaller facilities, especially those that adhere to different operating models as described above.

Recommendations:

- **2.1.4:** The State should incentivize private rooms and bathrooms, while maintaining the choice to have up to two persons in a room to facilitate couples and roommate situations where desired.
- **2.1.5:** New construction and major renovations should focus on private rooms and baths as well as increasing access to natural sunlight and outdoor recreation space to the maximum extent possible by modifying State approval policies as necessary and providing financial incentives (also see downsizing and repurposing discussion below).
- **2.1.6:** Aim to eliminate higher occupancy (three and four persons) bedrooms.
- **2.1.7:** Clustering or neighborhood unit configuration should be encouraged to the maximum extent feasible.
- **2.1.8:** The State needs to update Medicaid operating and capital payment policies to be in sync with these policies by recognizing the higher operating costs of smaller nursing homes with more single rooms (depending on the extent to which those homes employ cost offsetting strategies such as universal workers) and through capital payment policies that encourage and properly reimburse increased capital investment necessary to achieve these aims.
- **2.1.9:** Maximum nursing home bed size should be limited (size limit to be specified at a future date), and/or this limitation should be combined with a strategy to incentivize moving to neighborhood clustering model noted above where feasible.
- **2.1.10:** Develop regulations for licensure and Certificate of Need that would prevent new large, hospital-style nursing homes.

²⁹ Source: Health Management Associates, *Fundamental Nursing Home Reform: Evidence on Single-Resident Rooms to Improve Personal Experience and Public Health*, March 2021, https://www.healthmanagement.com/wp-content/uploads/HMA.Single-Resident-Rooms-3.22.2021_final.pdf.

Downsizing and Repurposing Nursing Homes: The Task Force sought to project future use of nursing homes for the purpose of assessing future capacity needs considering changing use patterns and future population demographic change. Several use rate scenarios were considered, including pre-COVID New Jersey use rate (High), post-COVID New Jersey use rate (Medium), and post-COVID national use rate (Low).

The Task Force found that over the next five years, based on the most likely use rate scenario (somewhere between the Medium and Low use rate depicted in Table 3), there will likely continue to be excess nursing home capacity of at least 8,200 beds even after factoring in demographic growth. It is important to stress that this is a statewide analysis and may not address specific regional variations or specialty care needs.

Table 3: Future New Jersey Nursing Home Use Projections Based on Use Rate Scenarios

NH Bed Use Scenario		SNF Census Per 1,000 Medicare Beneficiaries	Current NJ Medicare Beneficiaries (in 1000's)	5 Year Projected Medicare Beneficiary Growth NJ	Estimated Nursing Home Census in 2028	3Q 2022 NJ Nursing Home Beds	Projected Unoccupied Beds 2028
High	Pre-COVID NJ	26.6	1,687	11.6%	49,999	51,167	1,168
Medium	Post-COVID NJ	22.8	1,687	11.6%	42,968	51,167	8,199
Low	Post-COVID US	18.5	1,687	11.6%	34,892	51,167	16,275
Medicare age growth projection blend 85% 65+ and 15% under 65 age growth projection							

Source: HDG analysis of Nursing Home Compare and CMS Medicare County Enrollment file

Recommendations:

- **2.1.11:** To facilitate a planned and orderly downsizing of nursing homes as part of a strategy to promote HCBS and help keep persons from being prematurely and/or unnecessarily institutionalized, New Jersey should fund certain voluntary downsizing expenses. As part of the design of the program, the prevalence of inappropriately placed persons and the reasons for their placement should be thoroughly reviewed. The program should be comprehensive and address related expenses for:
 - **Bed reductions**—Conversion of semi-private rooms to private rooms and associated costs of physical plant upgrades, remodeling, and installation of medical equipment such as high-flow oxygen.
 - **Repurposing**—Meeting unmet needs for housing and services consistent with the federal HCBS Settings Rule. For example, this could include repurposing closed nursing homes to become affordable supportive housing.
- **2.1.12:** Further study will be necessary to develop the specific parameters for the downsizing program and assess the impact of a potential reduction in bed supply resulting from increased single rooms, implications of increased operating costs of smaller nursing homes, necessity for compensation for the inherent value of beds, necessity to change Certificate of Need rules and Medicaid payment policies, among other things.

Improving Access to Specialty Care for New Jersey Veterans: The Task Force received feedback that none of the New Jersey State veterans' homes currently provide high-acuity respiratory services (e.g., ventilator care) and have limited mental health services. This can force veterans to receive care in non-veterans' facilities (contracted by the VA), reducing their ability to exercise preference about their setting of care.

- **Recommendation 2.1.13:** At least one of the New Jersey State veterans' homes should provide ventilator care. Each of the veterans' facilities should assess the need for specialized behavioral services.

Enhancing Effectiveness of Surveys and Regulation

The Task Force had extensive discussions about the nursing home survey and regulatory oversight processes. Concerns expressed included the lack of adequate numbers of State survey staff, the speed and effectiveness of enforcement, and a lack of use of the full array of tools available.

Timeliness and Effectiveness of Surveys: CMS contracts with each state to establish a State Survey Agency (SSA) for the purpose of oversight of nursing homes and other providers. For nursing homes, this includes the enforcement of the CMS Requirements of Participation (ROP), a complex set of regulations and guidance that are designed to be implemented and maintained to ensure quality of care.

New Jersey is behind in completing surveys of nursing homes. The federal expectation is that all nursing homes should receive a recertification (standard) survey between 9 and 15.9 months from the previous survey exit date. In New Jersey, 42 percent of nursing homes have not had a standard health survey in over 15 months. Nationally, this number is 35 percent, indicating that while nationally all states are behind relative to federal standards, New Jersey is even further behind.

A major driver of the delays in completing required surveys of nursing homes is the shortage of surveyors. According to a report from the U.S. Senate Special Committee on Aging, New Jersey was one of only seven states with a greater than 50 percent vacancy rate of surveyors.³⁰ At present, the DOH reports that there are 53 surveyors and estimates a need for an additional 30 to 40 full-time equivalents (FTEs).

In 2020, the Office of Inspector General, U.S. Department of Health and Human Services, published a study that indicated that New Jersey's SSA failed to adequately respond to incidents of potential abuse or neglect of Medicaid beneficiaries who resided in nursing

³⁰ Source: U.S. Senate Special Committee on Aging, *Uninspected and Neglected: Nursing Home Inspection Agencies are Severely Understaffed, Putting Residents at Risk*, May 2023, <https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20%20NEGLECTED%20-%20FINAL%20REPORT.pdf>.

homes.³¹ This study relied on data from 2016 and made specific recommendations to New Jersey to reinforce teaching, inspection, and enforcement to better ensure that all allegations of such instances are thoroughly investigated, with action taken to protect residents, educate staff, and stiffen standards.

The Task Force reviewed 2022 survey data findings that suggest the pattern might still exist. For instance:

- The survey category “A resident will be free from Abuse, Neglect, Exploitation and Misappropriation” (F 600) is a cited deficiency in 10.4 percent of facilities nationally, while New Jersey cites this deficiency 2.0 percent of the time, a five-fold difference.
- Another area of concern is “Resident Rights,” a set of federal regulations that guarantee residents strong and specific rights to ensure their dignity and freedom within the nursing home. A review of states with similar populations and numbers of nursing homes indicated an average number of Resident Rights citations per survey of 2.9, while New Jersey averages 1.7, a 70 percent difference on a per survey basis.

These results bear further examination as to the root cause of these findings.

Recommendations:

- **2.2.1:** The DOH should develop an action plan and allocate sufficient resources to bring the timeliness of standard surveys up to at least the national benchmark and eventually surpass it. The action plan should include:
 - Hiring more State staff.
 - A triage process to place emphasis on most urgent complaints and facilities with a poor performance history.
 - Appropriate use of outside contracted surveyors, except for Special Care Nursing Facilities (SCNFs) licensed under unique New Jersey rules.
 - Updating civil service rules that create barriers to hiring surveyors, including the potential need to increase starting wages and the allocated number of positions available for hiring.
 - Diversifying survey teams to include social workers and Certified Therapeutic Recreation Specialists, among others, to create a larger pool of candidates and sharpen the survey team’s focus on resident rights.
 - Identifying technologies that would assist in timely and effective surveys.
- **2.2.2:** All New Jersey surveyors continue to receive refresher training on existing and new regulations to identify chronic and emerging patterns of deficient practices and the urgency

³¹ Source: Office of Inspector General, U.S. Department of Health and Human Services, *New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported*, August 2020, <https://oig.hhs.gov/oas/reports/region2/21801006.pdf>.

of remediation. This especially includes issue identification and enforcement of regulations regarding patient abuse and neglect, as well as resident rights.

- **2.2.3:** Long delays in getting surveys closed should be reduced through more timely resolution of plans of correction.
- **2.2.4:** The DOH should monitor and publicly report on statistical citation standards of New Jersey compared to similar states in a user-friendly format.
- **2.2.5:** For clarity and accuracy, State nursing home regulations should be updated to meet or exceed federal rules. Emphasis is needed on updating State rules (e.g., resident rights) to reflect federal regulations enacted since 2016 (commonly referred to as the “Mega Rule”). This strategy simplifies the survey process for both providers and surveyors and ensures conformity to the latest standard, be it federal or State.
- **2.2.6:** The DOH should consider consistent but time-limited (two to three years) surveyor assignments to specific nursing homes. There may be an advantage in consistent surveyor assignment to build performance improvement relationships with assigned facilities. The Task Force understands that this policy is in the process of being re-implemented after a hiatus due to COVID-19.

Improving or Closing Perennial Low Quality Nursing Homes: Considering the Office of the State Comptroller’s recent reports, the Task Force had extensive discussions about the chronic poor performance of a small group of facilities that persistently provide low quality care, how this impacts residents, and how the State should stop this from happening.

The DOH, which licenses and regulates nursing homes, and the DHS, which pays for the majority of nursing home care through the Medicaid program, have been collaborating more closely to focus on nursing home quality. The Task Force recognizes and values a formal collaborative process to identify poor performing nursing homes and work to improve (or in some instances, take enforcement actions against) them in a coordinated manner.

In addition, the Task Force believes that both DOH and DHS have more State authority to take stronger action against perennial poor performing providers than they have historically used.

The federal Special Focus Facility (SFF) program is designed to identify and focus increased oversight efforts on chronic poor performers, with the goal of either forcing increased compliance or removing facilities from Medicare and Medicaid participation. Pursuant to federal rules, a state the size of New Jersey can designate two SFFs and between five and 10 SFF candidates based on a point system derived from health inspection data. The Task Force is concerned that the SFF candidate process does not sufficiently identify the entire cohort of poor performing facilities and that the chronic poor performers can stay on the list for extended periods of time without making intended progress.

³² See: <https://www.nj.gov/health/ltc/>.

Also available to the State and the public to assess and ensure nursing home quality is the Five-Star Quality Rating System, which was originally developed by CMS to assist consumers in comparing nursing homes across several dimensions. The Five-Star Quality Rating System assigns facilities an “Overall” star rating (on a 1 to 5 scale) based on three sub-categories: Health Inspections, Staffing, and Quality Measures (QMs). (See Appendix D for more information about these sub-categories and data on New Jersey’s performance.)

Mission Critical Teams: The DOH has developed an innovative approach through the Office of Long-Term Care Resiliency, which deploys Mission Critical Teams that assist struggling facilities with training, operational guidance, and resources to identify root causes and focus efforts on rapidly improving care delivery. The Task Force finds that the intended policy of separating Mission Critical Team activities from the DOH regulatory enforcement process is appropriate and should be a central component of the program, but that this collaborative and optional program will not be sufficient to reign in all poor performers.

Recommendations:

- **2.2.7:** The DOH should use all tools available, whether through Mission Critical Teams, SFF process, and/or survey and certification, to intervene early with poor performing facilities, whether chronically poor performing or recently identified as problematic. The tools used should include a wide array of carrots and sticks, with the goal of reducing the possibility of being a chronic poor performer. Chronically poor performing facilities should be defined to include SFFs, SFF candidates, and facilities that are identified through criteria established in advance, including but not limited to persistently low star ratings, that recognize long-standing patterns of non-compliance.
- **2.2.8:** The State should apply escalating enforcement tools to chronic poor performers. These enforcement tools should include requiring these providers to:
 - Seek technical assistance from an outside resource, which could include the Office of Long-Term Care Resiliency, a Quality Improvement Organization, and/or reputable consultants,
 - Hire an experienced administrator, promptly denying payment for new admissions for a sufficient period and imposing fines, and
 - Pay civil money penalties in amounts that are large enough to make the need for compliance clear and immediate. Where additional authorities are required, such should be sought.
- **2.2.9:** The DHS and DOH should continue to work together to use existing State authority to take more powerful and coordinated action against consistently low-quality nursing homes, including punitive actions against a facility’s license and Medicaid participation. Currently, these tools are rarely used.
- **2.2.10:** The State should expand funding for Mission Critical Teams that provide technical support and training to poor performing nursing homes that are a) identified through a

systematic, targeted process or b) may be self-identified by facilities that recognize their need for quality improvement (though Mission Critical Teams will be establishing priorities by which they will intervene with or without the request of the facility). The Task Force hopes that, over time, providers will see the value of this program and increasingly self-identify, and that Mission Critical Team funding is increased to support these efforts.

Addressing Staffing in Nursing Homes

The Task Force recognizes that staffing is fundamental to the quality of care and quality of life in a nursing home. A series of studies have shown that various quality outcomes are related to staffing characteristics of nursing homes, particularly the presence of RNs.³³ P.L. 2020, c. 88 specifically requests identifying appropriate nursing home staffing levels for certain resident acuity and special population needs.

Staffing Measures Already in Place: New Jersey is one of the few states that has adopted a direct care staffing ratio that sets a floor for the minimum number of direct care staff per shift. (New Jersey Statute 30:13-18). One of the fundamental aspects of staffing ratios is that they are relatively easy to administer by regulators, facility administrators, rank and file staff, and consumers, helping to ensure their effectiveness.

New Jersey also has regulations that focus on minimum nursing levels, which do include acuity adjustments (see Subchapter 25, Section 8.39-25.2). The acuity adjustments contained in these staffing minimums were established many years ago and are based on a model that establishes a base level of nursing hours per day (2.5) and then adds on various increments of minimum nursing staff time based on facility-wide presence of up to seven resident clinical characteristics or procedures (e.g., number of persons receiving wound care, oxygen therapy). The rules also specify that at least 20 percent of the nurse coverage is provided by RNs and that facilities with greater than 150 beds have 24/7 RN coverage. The rules do not make a distinction between short-term vs. long-term residents except to the extent that the seven resident or service characteristics indirectly reflect differences in staffing required for these two populations.

There are also separate staffing requirements for SCNFs that reflect the mix of disciplines and the amount of staff required to care for select specialty populations (e.g., behavioral, ventilator). As such, these standards are implicitly acuity-adjusted in that they are customized to certain specialty populations.

Despite these minimum staffing standards, nursing home residents continually complain about understaffing, and the types of problems and conditions that are attendant to understaffing (pressure ulcers, lack of response to call bells, medical mistakes, failure to follow care plans) proliferate to this day.

³³ See, for example: <https://academic.oup.com/psychsocgerontology/article/55/5/S278/536413>.

Of note, the federal government is actively engaged in the issue of analyzing staffing minimums in nursing homes and is expected to have a staffing study completed soon. Among other things, the federal study is expected to analyze the relationship of staffing levels to quality outcomes.

Recommendations:

- **2.3.1:** As stated in the previous section, the DOH should curtail admissions in appropriate circumstances when nursing homes consistently do not meet the minimum staffing ratios. The minimum staffing law is a state requirement that affords regulators the ability to stop understaffed facilities from accepting more residents.
- **2.3.2:** New Jersey should review the results of the federal research on nursing home staffing standards when released. After review, New Jersey should consider whether further refinement or modification of existing staffing standards is necessary or desirable, including whether to: 1) acuity-adjust the direct care staffing ratios, 2) change the basis from ratios to hours per patient day, and 3) consider incorporation of other disciplines that vary by acuity of the caseload, such as social work and therapeutic recreation.
- **2.3.3:** As part of the above process, or as a separate activity, New Jersey should review the nursing procedures and clinical characteristics used to adjust staffing minimums in the long-standing acuity-based staffing standards (Subchapter 25, Section 8.39-25.2). Those acuity adjustments should be examined for continued relevance and accuracy, including for facilities that have differing mixes of short- and long-term care populations and for ease and consistency of application.
- **2.3.4:** The Task Force emphasizes the need for specific staff to be in place for people with special needs and urges continued consideration of this in future refinements. For example, in a facility that serves individuals with behavioral issues or SUDs, more social workers may be needed. DOH should study and potentially lower the required ratio of social workers to beds (currently 1:120), taking into account the different needs of long-stay residents and those with specialized needs.

Addressing Medicaid Rates While Promoting Quality and Transparency

The Task Force is concerned about the rise of corporate consolidation, private equity investment, and related party transactions across the industry. Related company transactions are those in which a facility pays a company for services that is owned or controlled by the same person/entity that owns the nursing home.³⁵ These issues have also been a topic of concern to the federal government through the Biden-Harris Plan: *Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes*, announced in February

³⁴ CMS, *Centers for Medicare & Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes*, August 2022, <https://www.cms.gov/blog/centers-medicare-medicare-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes>.

³⁵ Although some related party transactions allow provider groups to spread administrative costs among multiple entities, thus lowering overall costs, these transactions nonetheless also have the potential to artificially inflate costs and facilitate diversion of funds from patient care.

2022. As part of that plan, CMS issued a proposed rule on February 13, 2023, to increase ownership reporting as part of Medicare and Medicaid certification of nursing homes.³⁶

Concerns include the impact of these trends on the quality of patient care and proper use of Medicaid funds, which pay for the majority of nursing home patient days in New Jersey and across the country, as well as the lack of financial transparency to better monitor and evaluate these dynamics. The lack of transparency, especially around related party transactions and shared ownership, makes it more difficult for all parties concerned to precisely evaluate the cost of care, overall fiscal health of nursing homes (including larger systems with multiple nursing homes), and/or the amount of needed Medicaid rate adjustments.

New Jersey currently lacks a Medicaid cost report for rate-setting purposes and consequently also lacks information on related company transactions. The Medicare program has a cost report requirement, which contains a related party schedule. However, this data is not routinely audited or analyzed by the Medicare program or the State of New Jersey, is difficult for consumers to access or interpret, and the related party schedule does not contain information to show where funds to related parties are ultimately flowing. In a review of 359 Medicare cost reports, 290 New Jersey facilities reported related party transactions, the most prevalent of which seemed to be a related therapy organization.

Full accounting of ownership shares as part of changes in ownership is required to be reported to the State in the licensure process. However, there are concerns that this information is not detailed enough and not required in all instances (e.g., minor changes in ownership shares) and reporting requirements do not have teeth to ensure full compliance.

New Jersey Medicaid Rate Process: The base year for Medicaid payments has not been updated since 2010.³⁷ Instead, Medicaid rates have been increased on an ad hoc basis through the legislative budget process by increasing the prior year's rate as of June 30th by a set amount or percentage.

New Jersey has initiated a two-year process for nursing homes to re-establish cost reports, receive stakeholder input, conduct analytics, and ultimately implement a new Medicaid payment methodology by January 1, 2025. That process envisions re-institution of Medicaid cost reports, which have not been required since the transition to MLTSS in 2014.

The degree to which the ultimately revised Medicaid payment system for nursing homes will be cost-based, price-based, or some hybrid of the two is not yet known. The Task Force is concerned that detailed and verifiable related party financial data is not yet required or available to inform the rate-setting process.

³⁶ Source: CMS, *Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities — Proposed Rule*, February 2023, <https://www.cms.gov/newsroom/fact-sheets/disclosures-ownership-and-additional-disclosable-parties-information-skilled-nursing-facilities-and>.

³⁷ Source: Mercer, Nursing Facility Rate Setting Rebase Town Hall Presentation, March 2023.

Recommendations:

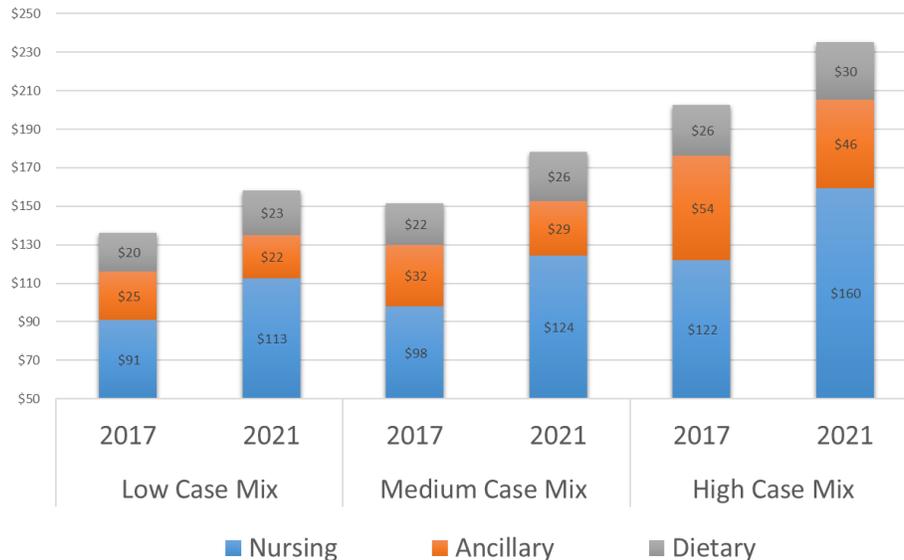
- **2.4.1: Rate-setting considerations.** In addition to implementing an acuity adjustment (noted below), the Task Force recommends that the rate setting process undertake a careful re-examination of Medicaid capital payment policies, including a methodology that supports and incentivizes smaller homes, the Green House[®] model, and single rooms. The Task Force also recommends that the process pay careful attention to the prospect of related party transactions and their potential effects on cost, and that detailed related party reporting information is included in the rate setting process as soon as such information is available. Finally, Medicaid rate setting should not be done in a siloed manner; the State should center the goal of incentivizing HCBS, along with better nursing homes, in this process.
- **2.4.2: Reinstating cost reports.** The Task Force agrees that it is essential to reinstate the requirement for annual Medicaid cost reports, which should include detailed and verifiable ownership information about any person or group which owns any part of a nursing home, as well as the members of any such group. New Jersey should carefully review the federal proposed changes to ownership disclosure requirements (February 13, 2023) and, where possible, seek to align and leverage changes ultimately adopted by the federal government to minimize duplication in ownership information requested and to increase compliance.
- **2.4.3: Creating visibility in related party finances.** The Task Force agrees it is essential to require annual financial statements that are independently audited and contain detailed information that allows the State to scrutinize how much individual facilities are spending on related party transactions, where money flowing to those related parties is ultimately going, and the overall fiscal health of nursing home health systems—not just the fiscal health of individual facilities. Analysis of this information should reside in State agency or agencies with sufficient background and expertise to understand detailed financial information, Medicaid rate-setting policies, and Medicaid program integrity issues.
- **2.4.4: Public reporting.** Detailed information should be publicly reported in a way that informs public policy about taxpayer-funded expenditures and assists consumers in selecting facilities, including through reporting user-friendly nursing home information.

Acuity-Adjusting Medicaid Rates: New Jersey does not currently adjust Medicaid nursing home payments by acuity and has not done so for eight years. This means that the Medicaid payment system does not dynamically adjust Medicaid payments as acuity of the caseload changes. The lack of acuity adjustment reduces the incentives for providers to admit residents with heavier care needs and creates disincentives for providers to invest in systems and processes of care for clinically complex patients. The Task Force finds that acuity adjustment of Medicaid rates is an essential component of a broader strategy to reduce premature and/or unnecessary institutionalization and ensure that persons who require nursing home placement receive the care they need.

It is well understood that direct operating costs across facilities vary according to the acuity of the resident population. The Task Force reviewed data from Medicare cost reports from 236 facilities in New Jersey that had filed 2021 cost reports at the time of the analysis.

Unsurprisingly, selected cost centers increased proportionately in relation to acuity, as can be seen from Figure 3 below.

Figure 3: Sum of Nursing, Ancillary, and Dietary Costs, 2017 Compared to 2021 by Case Mix Group



Source: HDG analysis of Medicare cost reports and Nursing Home Compare data

- Recommendation 2.4.5:** New Jersey should acuity-adjust Medicaid payment rates for nursing homes as soon as possible and strongly consider using the Patient-Driven Payment Model (PDPM), as has been done in Wisconsin and Illinois and which is under active consideration by several other states.³⁸ Selecting PDPM as the case mix system will help to align Medicare and Medicaid payment systems, promoting efficient and accurate documentation, as well as maximizing response to payment system incentives to admit and retain heavier care residents.

Reforming the Quality Incentive Payment Program (QIPP): New Jersey’s nursing home QIPP is a program that has been put in place to provide financial incentives for quality improvement in nursing homes. These programs are increasingly common across the country, with approximately 30 states using some form of quality scoring system to adjust Medicaid payment rates. Up until this year, in the New Jersey QIPP, there were six measures utilized to determine funding. Five come from the Minimum Data Set: physical restraints, antipsychotic medications, falls with major injury, pressure ulcers, and influenza vaccination. The sixth measure is a resident satisfaction measure derived from the experience of care survey (CoreQ). In the most recent State budget, a seventh measure was added regarding hospitalization rates.

³⁸ In September 2022, CMS issued guidance to states about the impending phase-out of federal support for the Resource Utilization Groups (RUGs) system. PDPM is a payment model originally developed by Medicare for a short-term rehabilitation population and would have to be calibrated for use by Medicaid for a long-term care population.

Funding received is generally determined by meeting or exceeding an average for each measure.

In the FY 2023 State budget, funding for QIPP was increased from \$0.60/patient day for each metric achieved to \$1.80/patient day. The new funding included a reallocation of COVID-19 funding for infection prevention. QIPP funding was eliminated for nursing homes that were included on the SFF list (current or recent graduates), ranked as a one-star facility by the CMS Five-Star Quality Rating System, or cited by DOH for two or more Level G licensing violations. Total Medicaid funding for QIPP is approximately \$47 million annually, which equates to about \$7.68 per day on average, or about 3 percent of the average rate.

Table 4: Estimated Distribution of FY 2023 QIPP Funds

FY 2023 QIPP Add-On	# SNFs	Annualized Est. Payout (2021 Medicaid Days)	Average QIPP Payment Per Facility
\$1.80	4	\$245,574	\$61,394
\$3.60	23	\$1,526,368	\$66,364
\$5.40	37	\$5,283,824	\$142,806
\$7.20	55	\$9,105,055	\$165,546
\$9.00	71	\$18,019,548	\$253,796
\$10.80	38	\$12,089,704	\$318,150
\$12.60	3	\$1,006,853	\$335,618
No Payment	94	–	
	325	\$47,276,926	

Source: HDG analysis of FY 2023 Medicaid rate file – DMAHS, 2021 Medicaid days from Medicare cost reports

There is an internal State review of the QIPP underway among State subject matter experts and stakeholders.

The Task Force reviewed QIPP programs from multiple states (Kansas and Texas), as well as best practices for quality incentive programs as identified in *A Review of Nursing Home Medicaid Value-Based Payment Programs* (Center for Health Policy Evaluation in Long-Term Care, 2022). In that report, New Jersey’s QIPP for nursing homes is one of five states (out of 30 reviewed) rated as “not aligned” with best practices for quality incentives (predictable and consistent, stable benchmark, tiered payment, simple incentives). Also, other states’ QIPP programs have important features, including voluntary participation, targeted eligibility for funding, and having an outside entity conduct evaluations of effectiveness.

Recommendations:

As the nursing home QIPP is re-evaluated, the following should be carefully considered:

- **2.4.6:** Specifically identify and prioritize meaningful and measurable performance improvement goals that are actionable by providers, including but not limited to: reducing ADL decline against projected baseline, providing 24-hour RN coverage, meeting enhanced staffing levels (including social workers), employing a full-time infection preventionist (IP), reducing staff turnover, reducing multi-occupancy rooms, achieving key performance indicators relative to antibiotic stewardship, utilizing medical directors who are certified under AMDA – The Society for Post-Acute and Long-Term Care Medicine standards, and selecting physicians and physician extenders with a specialty in geriatrics.
- **2.4.7:** Assess need for tiered funding tied to increased levels of performance to induce meaningful change.
- **2.4.8:** Carefully consider program eligibility requirements and whether participation should be voluntary and/or scaled to various levels of commitment.
- **2.4.9:** Review how and whether to incorporate compliance with the totality of the Advisory Standards program into QIPP.
- **2.4.10:** Ensure that the quality measures are appropriately risk-adjusted to mitigate disincentives for facilities to admit heavier-care residents.
- **2.4.11:** Conduct evaluation of QIPP effectiveness on an ongoing basis. Assess any proposed changes to QIPP in relation to best practices as identified in *A Review of Nursing Home Medicaid Value-Based Payment Programs* (2022).
- **2.4.12:** Monitor pending federal changes to Medicare SNF Value-Based Purchasing (VBP) Program and consider aligning New Jersey QIPP measures with expanded Medicare SNF VBP measures.

Continuing Progress on Infection Prevention and Control

As noted in the introduction to this report, the nature and specific challenges of the COVID-19 pandemic have evolved significantly since the novel virus was declared a Public Health Emergency (PHE) in March 2020. There have been many lessons learned during that time and considerable follow-up on the recommendations outlined in the Manatt Report issued in May 2020.³⁹ From an infection control standpoint, many things have changed for the better, including the availability of personal protective equipment (PPE), testing, vaccines and boosters. Along with those changes, there have been changes to state, local, and federal policies on infection control practices, visitation, and much more. That said, concerns have been raised about the

³⁹ Source: Manatt, *Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19*, June 2020, https://www.manatt.com/Manatt/media/Documents/NJ-LTC-Report_2.pdf.

consistent emergence of variants to COVID-19, resurgence of viruses such as influenza and RSV, as well as novel viruses such as mpox.

These concerns mean that there will need to be a continued focus on infection control for the foreseeable future. A recent U.S. Government Accountability Office (GAO) report on an expert roundtable came to many of the same conclusions, citing a need for ongoing mandatory training on infection control and prevention, as well as for increased technical assistance to nursing homes, among other things.

Importantly, the GAO report also concluded that extended limitations on visitation and group activities were detrimental to residents. Centers for Disease Control and Prevention (CDC) officials were quoted as agreeing that the use of limitations on visitation and group activities for a prolonged duration can potentially cause more harm than good to residents and noted that it would be helpful to have guidance containing a limit on the duration of these restrictions during an outbreak or outlining how to ease the restrictions.⁴⁰

Enhancing Infection Prevention and Control Activities

The need for continued enhancement of infection control measures as research points to new strategies is expected to continue. It is essential that as scientific knowledge evolves, LTSS providers continually update, train, and implement the latest standards.

Capacity for Isolation: Due to occupancy declines since the onset of the pandemic, the capacity for isolation of infectious nursing home residents in single rooms has increased. In 4Q 2019, there were approximately 9,400 unoccupied beds in Medicare-certified nursing homes in New Jersey (82 percent occupancy). As of 3Q 2022, there were approximately 12,600 unoccupied nursing home beds (75 percent occupancy), so the availability of beds has increased by nearly 34 percent since onset of the pandemic.⁴¹ It is unlikely that the increased availability of beds translates to a 34 percent increase in available rooms for isolating infectious residents, as some facilities may have completely closed units while others may have spread residents out (creating more single rooms in the process).⁴² Nonetheless, it appears at present that there is sufficient excess capacity at a statewide level for increased isolation of infectious residents in the event of a sudden surge in need, although there is an ongoing concern about how these extra rooms would be staffed.

- **Recommendation 2.5.1:** The State should: a) establish recommendations for prioritization of existing single rooms for residents who require isolation, outside dialysis, or are immunocompromised and b) continuously track regional trends in occupancy and available single rooms for isolation purposes in the context of planning for surges that could occur as

⁴⁰ Source: U.S. Government Accountability Office, *COVID-19 in Nursing Homes: Experts Identified Actions Aimed at Improving Infection Prevention and Control*, March 2023, <https://www.gao.gov/assets/gao-23-105613.pdf>.

⁴¹ Source: HDG analysis of Nursing Home Compare provider information files.

⁴² The DOH Nursing Home Infection Control Infrastructure Assessment Survey (October 2022) indicated that approximately 14 percent of rooms are single rooms; however, it is unclear whether this is a representative sample due to a smaller than expected response rate (46 percent).

a result of a novel pathogen or resurgence of an existing pathogen (e.g., flu, RSV, COVID-19 variant). The tracking may include the need to develop new reporting by facilities and/or data gathering during the routine survey and certification process. In the event of a surge in need, pre-existing emergency plans by the State and providers would need to be triggered.

Aligning Infection Control Standards: During the pandemic, providers and consumers were often faced with rapidly changing infection prevention and control standards issued by DOH, CMS, the CDC, and local public health departments. Sometimes these standards were similar, however at other times they were different (e.g., there was a period of time when the federal government allowed compassionate care visits and New Jersey did not). Many times, due to the exigencies of the situation, the standards were not developed pursuant to prior notice and public comment process. It became confusing and challenging for providers and consumers to assess constant changes from multiple different government sources and to know which source was the most authoritative. The GAO expert roundtable also identified this issue.

- **Recommendation 2.5.2:** The Task Force recommends that DOH work with CMS and the CDC to streamline and align their policy guidance regarding infection control and prevention to the maximum extent appropriate. This is especially important during times of rapid policy evolution, to provide strong protections to vulnerable populations in NJ while minimizing the potential for provider and consumer confusion.

Strengthening Infection Preventionist Credentials: In 2017, CMS issued a rule that provides that a facility must have an infection preventionist (IP) at least part-time, and the IP must be able to meet the needs of the resident population. In June of 2022, CMS provided guidance (QSO-22-19) for nursing homes and surveyors regarding that rule which recommended, among other things, the types of experience, specialized training, and certifications for the IP and the factors that should be considered in determining the hours of work of the IP.

- **Recommendation 2.5.3:** The Task Force recommends that the CMS recommendations contained in QSO-22-19 be strengthened by a state rule that requires Certification in Infection Control (CIC) or LTC CIC within a five-year period of assuming the role of IP through the Certification Board of Infection Control and Epidemiology (CBIC) and maintaining certification thereafter (every five years). This level of required certification will help to ensure a degree of uniformity in credentials and a level of competence to help prepare New Jersey for ongoing and future infection control challenges.

Air Handling and Purification: Based on experience and knowledge gained during the pandemic, increased attention has been placed on facility air handling and purification systems, as well as basic airflow in the facility. The DOH issued a “Nursing Home Infection Control Infrastructure Assessment Survey” in fall 2022. Based on the survey, between 45 to 50 percent of the respondents rated the facility’s refrigeration, heating, air conditioning, and ventilation systems as high quality, with consistent results across all four subcategories listed above. Two-thirds of facilities had no plans to replace their Heating, Ventilation, and Air Conditioning (HVAC) system in next two years; another 20 percent were planning to change within one to two years. Of respondents, 8 percent had negative pressure rooms. Approximately half of respondents

indicated that they had made changes to infection control and prevention infrastructure at their facilities, with a wide range of changes indicated and varying degrees of permanency.

Recommendations:

- **2.5.4:** The State should engage ventilation and air purification experts to establish standards for improving airflow systems that may impact the health of residents and workers. The Task Force recommends an initial pilot project to assess a range of facilities to provide the State with the information needed to determine the scope and cost of meeting updated standards and a timeline with potential for funding sources to ultimately meet those standards in all facilities.
- **2.5.5:** If not done already, the State should seek available funding from sources such as the Nursing Home & Long-term Care Facility Strike Team and Infrastructure Project (funded through ARPA) and make available funds allocated for HVAC assessment and improvements.⁴³ The Task Force's understanding is that up to \$150,000 per facility is available through this source.

Other Infection Prevention and Control Recommendations

- **2.5.6:** The State should start to develop a statewide Essential Caregiver policy that permits residents to designate caregivers who can visit with them during an outbreak, epidemic, or pandemic of an infectious disease, consistent with, and adaptable to, any applicable laws, and requires these designated visitors to adhere to any infection control practices.
- **2.5.7:** Achieving very high vaccination rates for a range of pathogens for staff and residents continues to be an ongoing challenge. The State should consider further incentives to maintain or achieve 90 percent or higher vaccination up-to-date coverage on a group of vaccines including: flu, pneumococcal, Tdap, and COVID-19 for staff and residents as applicable, and herpes zoster (shingles) for nursing homes residents. Continuously update the list of incentivized vaccines based on Advisory Committee on Immunization Practices (ACIP) recommendations and accommodate valid exemptions while maintaining infection prevention.
- **2.5.8:** Provide support to all LTSS providers (broadly defined to include HCBS providers) to educate all staff, families, and residents on hand hygiene on an annual basis, complete with competency evaluations of staff and reporting requirements as deemed necessary.
- **2.5.9:** The DOH should provide guidance to nursing facilities regarding proper placement of hand sanitizer dispensers inside and outside all rooms and in common areas, considering facility layout and other pertinent issues.

⁴³ Source: CDC, *Nursing Home & Long-term Care Facility Strike Team and Infrastructure Project Guidance*, October 2021, <https://www.cdc.gov/ncezid/dpei/pdf/guidance-nursing-home-ltc-facility-strike-team-and-infastructure-508.pdf>. ⁴⁴ See, for example: Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1157 of the Affordable Care Act.

- **2.5.10:** Further guidance should be developed by DOH regarding establishing policies, training, and timelines for cleaning and disinfecting of equipment, proper selection and use of disinfectants, terminal cleaning of rooms (i.e., upon discharge or transfer), and requirements around reporting as part of quality assurance processes.

Empowering Nursing Home Residents to Improve Living Conditions

Finally, the Task Force is greatly concerned about the quality of life of nursing home residents who often feel powerless to change conditions in the facility that is their home or to impact LTSS policymaking. Although every nursing home resident can participate in their own care planning, nursing home residents very often feel disempowered and come to accept poor care and diminished quality of life. While the State has a system for responding to individual complaints, it has no statewide mechanism to elevate the voices of the people living in LTC or their families or to focus on fundamental but less visible aspects of quality of life that may not be addressed through the regulatory process.

For example, residents have the right to expect comfortable and safe surroundings, including mattresses that are comfortable and clean, water that is warm enough for bathing, and equipment that is in good condition and does not place a resident at risk. Residents also need and deserve good quality food, friendly and respectful staff, access to natural light and fresh air, and furniture for visitors. Residents should be free to express their needs and their dissatisfaction when those needs are not met. Residents must be encouraged to express these reasonable needs with the expectation of a satisfactory resolution within a reasonable period.

Recommendations:

- **2.6.1:** The State should prioritize enforcement of the federal requirement that nursing homes have a resident council, which provides a forum for residents to discuss issues amongst themselves and bring complaints to facility administration, in every facility, and should develop a plan to expand the number of family councils present in New Jersey nursing homes.
- **2.6.2:** The State should establish a Statewide Resident and Family Support Network to provide a feedback loop to State agencies, including the DOH, DHS, and the Office of the State Long-Term Care Ombudsman.

Water Temperatures: Improper water temperatures in nursing homes have the potential to create discomfort and compromise resident safety. For example, if the water is too hot, it can create burns and be extremely uncomfortable for resident bathing. If it is too cold, it can improperly disinfect. There are federal standards on water temperature (see federal Tag 689 in federal Medicare ROP), but states have discretion to set frequency of water temperature checks in nursing homes. The standard of practice for routine water temperature checks is weekly.

- **Recommendation 2.6.3:** As a State standard, New Jersey should require water temperatures to be checked and documented weekly in multiple sites on a rotating basis to improve both safety and comfort. This data should be kept available for surveyor review and should include any corrective action taken to bring temperatures into compliance.

SECTION 3: WORKFORCE ENGAGEMENT AND SUSTAINABILITY

New Jersey, as with many other states, faces an acute and growing workforce challenge that raises the possibility of decreased access to services for seniors and those with disabilities and threatens the long-term viability of some LTSS providers. There is a well-documented shortage of professional and paraprofessional personnel to manage, supervise, and provide LTSS in facility-based and home care settings. This includes a shortage of nurses, social workers, direct care workers, qualified drivers, as well as leadership positions such as nursing instructors and licensed nursing home administrators (LNHAs).

We did not get here overnight. For many years, LTSS providers have struggled to attract and retain workers because of high turnover, competition from other better-funded provider types and other market-driven sectors of the economy, ageism by younger workers, and/or poor operating culture in which employees do not feel valued or have career ladders. Unnecessary logistical and financial barriers to training and entry into the LTSS workforce further reduce the number of available direct care workers.

In addition to industry-related reasons, this sector was also disproportionately impacted by larger societal trends—declining birth rates, younger workers entering the workforce later, decreased immigration, and earlier retirements, all leading to a contraction of available workers.⁴⁵ Women, the main workforce for LTSS, are participating in the labor force at the lowest rates since the 1970s. In 2020, their entry into the workforce went from 70 to 55 percent and is only slowly rebounding.

Compensation in LTSS is largely predicated on third-party reimbursement. To have the ability to recruit and retain workers, third-party payment rates must provide adequate resources to allow providers to be competitive with other health care entities, as well as with other sectors of the economy that employ persons with similar skill sets.

Looking to the future in New Jersey, the imbalance between the working age population and seniors needing care will only worsen (see below). Moreover, as LTSS is increasingly shifted to HCBS, it is reasonable to expect that the total demand for LTSS workers will increase significantly as well, since HCBS care can be one-on-one in many instances.

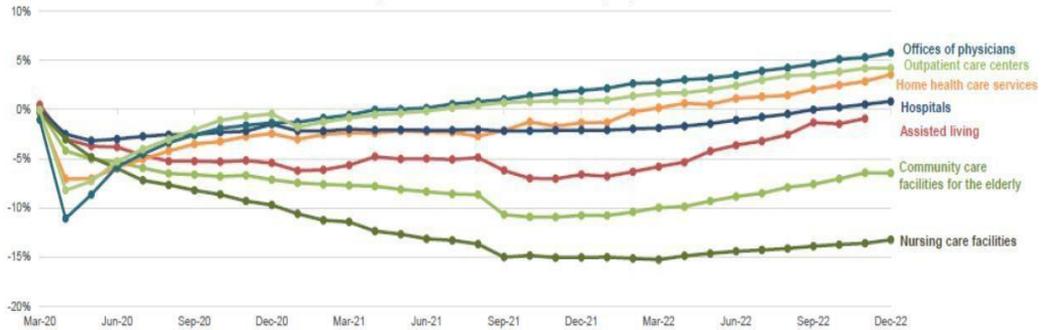
It will be imperative that New Jersey embrace all strategies to increase the supply of workers available to LTSS. This should include an all-of-government approach, as well as public-private partnerships.

⁴⁵ Source: Emsi Burning Glass, *The Demographic Drought: Bridging the Gap in Our Labor Force*, 2022, <https://www.economicmodeling.com/wp-content/uploads/2022/02/Demographic-Drought-Bridging-the-Gap.pdf>.

Increasing the Supply of Available Workers

In some sectors, employees lost during the pandemic were regained—but that has not been the case with LTSS providers, especially nursing homes (see Figure 4).

Figure 4: Cumulative Percent Change in Health Care Sector Employment Since February 2020



Source: American Health Care Association LTC Jobs Report, U.S. Bureau of Labor Statistics, February 2020–December 2022 *Assisted Living BLS data through November 2022

In New Jersey, the working age population is expected to decline by 1.3 percent over the next five years, while the age 65+ population is expected to grow by 14 percent, worsening the imbalance between supply and demand.

Table 5: Over Next 5 Years, New Jersey Working Age Population Is Declining by 1.3 Percent, Worsening the Imbalance Between Demand and Supply

Age Cohort	2023 Estimate	2028 Projection	Percent Change 2023-2028
18-20 Years	352,186	360,903	2.5%
21-24 Years	450,424	473,083	5.0%
25-34 Years	1,176,931	1,137,125	-3.4%
35-44 Years	1,184,393	1,172,452	-1.0%
45-54 Years	1,193,544	1,162,201	-2.6%
55-64 Years	1,278,330	1,258,216	-1.6%
18-64 Years	5,635,808	5,563,980	-1.3%

Source: Claritas, Inc.

Strengthening the Direct Care Workforce

The Task Force finds that there is a need for empowering direct care workers and for culture change in LTSS providers. As previously noted, new models of care such as Green Houses[®] have successfully employed these principles, which has resulted in less turnover and higher staff satisfaction. (Note: the terms direct care workers or direct care partners are used to connote paraprofessionals such as home health and nurse aides who provide direct hands-on care.)

According to a recent survey of certified nursing assistants (CNAs, also known as “nurse aides”), nearly 84 percent of respondents said it would take better wages and benefits to be hired back by their nursing homes, while just under half said that better training/opportunities for career advancement would lure them back. Poor wages and benefits were cited as the primary reasons why CNAs have left or are considering leaving their jobs. According to more than half of the respondents, the staffing shortage is the most pressing challenge for currently working CNAs. Burnout/exhaustion and lack of respect from leadership are the second and third biggest challenges, respectively.⁴⁶

Wage and Benefit Parity

Improvements in wages and benefits in LTSS are impacted by third-party reimbursement and Medicaid in particular. Rates must provide adequate resources to allow providers to be competitive with other health care entities and other sectors of the economy employing persons with similar skill sets. As noted previously, New Jersey’s process of adjusting Medicaid rates for a broad range of LTSS providers (HCBS and nursing homes) is largely ad hoc and needs to be placed into a more formal, data-driven process with ongoing updates that prevent future rate erosion and ensure that all workers receive competitive, living-wage compensation. Additionally, because of the percentage of direct care workers that depend on public assistance, low-wage workers could see their total compensation remain the same or even drop when their wages increase, because of a corresponding decrease in public benefits.

Recommendations:

- **3.1.1:** Consistent with our recommendations in Section 1 regarding rate-setting Medicaid HCBS, the State should conduct a periodic review of the impact of Medicaid payment policies on direct care workers’ total compensation, including paid time off, to ensure a living wage and to address any unintended negative effects such as an effect of changes on availability of public benefits. Future Medicaid rate increases should prioritize pay equity and cost-of-living increases for direct care staff.
- **3.1.2:** The State should consider utilizing unexpended federal COVID-19-related funds to provide bonuses to staff of all kinds (including housekeeping, kitchen, transportation, etc.)

⁴⁶ Source: National Association of Health Care Assistants (NAHCA), *CNAs Cite Low Wages, Burnout, Lack of Respect as Key Contributors to Staffing Crisis*, March 2022, <https://www.nahcacna.org/cnas-cite-low-wages-burnout-lack-of-respect-as-key-contributors-to-staffing-crisis/>.

who worked in LTSS during the worst of the pandemic.

Dual Certification of Home Health Aides and Nursing Assistants

In the 1990s, the New Jersey Board of Nursing's Unlicensed Assistive Personnel (UAP) Task Force was charged with developing a curriculum to be used to educate UAPs to function in a variety of health care settings. The purpose was to offer a uniform and standardized curriculum including specific clinical skills required to prepare one to competently provide select delegated nursing services (e.g., direct care assistance with ADLs, I-ADLs). Although this program is still available, it is seldom utilized. Routine practice of utilizing the UAP would provide trainees with more career choices, opportunity mobility, and better marketability, as well as flexibility to meet their employment needs.

Both the certified home health aide (CHHA) and certified nursing assistant (CNA) curriculums are in need of updating. In their current form, they are a prime example of outdated skills tied to a single specific occupation. To maintain our workforce, we must keep their skills relevant and provide not only didactic but real-time, on-the-job training.

Recommendations:

- **3.1.3:** Update and modernize the CNA and CHHA curricula to reflect today's residents/clients/patients, anticipate their needs, and enhance the care provided. Incorporate learning strategies, teaching methods, and materials that are culturally inclusive, as well as additional topics on self-care, relationship building, leadership, and mentorship.
- **3.1.4:** Update and integrate the dual-certification UAP curriculum, testing, and certification requirements with the goal of a single curriculum and training for the direct care workforce, specifically a combined CHHA and CNA dual certification. Provide a more comprehensive, high-quality training program that provides the full set of skills needed, enhances the status and significance of direct care workers, and provides career mobility to both CHHAs and CNAs.
- **3.1.5:** Concurrent with the goal of a single curriculum, expedite the implementation of DOH's proposal to amend the minimum qualifications of an LTC nurse aide training program instructor/evaluator in N.J.A.C. 8:39-43.10. The proposal revises New Jersey's requirement to align with the comparable federal regulation issued by CMS. Anticipate the combining of qualifications for both LTC and home health trainers as soon as feasible to fully operationalize the dual certification program.
- **3.1.6:** Transfer CNA licensure to the Board of Nursing and ensure sufficient staffing to perform this function. Compare, standardize, and streamline roles and regulatory requirements for direct care workers.
- **3.1.7:** Enhance and develop a unified registry for CNAs and CHHAs identified as barred from providing care (e.g., due to substantiated cases of patient abuse).

Career Enhancement/Advancement in HCBS and Facility-Based Settings

Today's direct care workforce has few options for advancement. They often leave their employer in search of better pay, better working environments, and the hope of finding a means of career advancement.

Recommendations:

- **3.1.8:** Expand the CNA/CHHA Scope of Practice to specifically include tasks that can safely be provided by an aide who is fully trained, and competency evaluated.
- **3.1.9:** Incentivize LTSS providers to develop and adopt advanced roles. New roles would elevate their title, function, and compensation. Roles could include:
 - Senior Aide, Peer Mentors, and Preceptors
 - Certified Medication Aides (CMAs)
- **3.1.10:** Enact rules expanding the use of Certified Medication Aides (CMAs). CMAs (called Certified Medication Technicians in some work environments) are direct caregivers with advanced training in preparing medications for self-administration by residents. In New Jersey, CMAs are currently permitted in the ALR setting, but not in nursing homes. CMAs are not permitted to administer injections, medications by percutaneous tube, medications with variable dose orders, or medications for which administration is dependent on assessment of vital signs. Use of CMAs in nursing homes is currently authorized by 38 states⁴⁷ with positive outcomes and improved survey statistics. CMAs report value in the career path and advancement available to them.⁴⁸ The settings in which CMAs could practice should be expanded to include nursing homes and the rules should address:
 - Required prerequisite experience, prior training, and certification
 - Direction of CMAs by licensed nurses
 - Specific criteria and exclusions applicable to the practice of CMAs

The State should review other care settings to determine the appropriateness of permitting CMAs to provide medication under the same or different guidelines. Also, see Section 4 for discussion of remote pharmacy dispensing systems, which can further enhance the safety and efficiency of medication dispensing.

- **3.1.11:** Develop/update apprenticeship programs related to direct care workforce and incentivize nursing homes and HCBS to implement programs as a component or way of increasing their quality scores. (Apprenticeship programs offer direct care professionals the opportunity to receive didactic, on-the job training and career advancement opportunities.)

⁴⁷ Source: Skilled Nursing News, 'Creative Staffing': Nursing Homes Push to Allow CNAs to Administer Medication Citing Labor Benefits, Savings, April 2023, <https://skillednursingnews.com/2023/04/creative-staffing-nursing-homes-push-to-allow-cn-as-to-administer-medication-citing-labor-benefits-savings/>.

⁴⁸ Source: The Gerontologist, *Impact of Medication Aide Use on Skilled Nursing Facility Quality*, December 2014, <http://doi.org/10.1093/geront/gnt085>.

Simplifying Entry to the LTC Workforce

Reducing Barriers to Paraprofessional Training: The Task Force is concerned that unnecessary logistical and financial barriers to training and entry into the workforce further reduce the number of available direct care paraprofessionals. Direct care aide training can run from \$600 to \$3,000, depending on the location and type of training. In addition, there are book fees and testing fees, long commutes to testing and fingerprinting sites, and no promise of a paid position upon completion.

Recommendations:

- **3.2.1:** Create scholarships or incentives such as free or reduced tuition to enroll in a CNA or CHHA training program through a workplace sponsor.
- **3.2.2:** Create new statewide financial incentives, such as free or reduced tuition and/or loan forgiveness programs, for high school, trade school, and college students to enter, or advance in, a caregiving career path. Targeted areas would include programs for caregivers seeking to advance their skills (e.g., CNA-to-LPN, CNA-to-PCT, or CNA-to-CMA). Implement financial assistance for LPNs to enroll in RN programs and RNs to enroll in programs to become licensed nurse practitioners (NPs) with specialized training in geriatrics and other applicable fields. Except for providers subject to NJAC 8:39-43.18, employers should be permitted to condition reimbursement to a minimum tenure of one year.
- **3.2.3:** Develop additional testing sites for CNAs/CHHAs throughout the state or allow testing to be done at the facility level with a trained instructor. The State should provide flexibility for persons for whom English is a second language and would have difficulty passing the written test but who can provide culturally competent care. DOH should seek opportunities to have the discretion on a case-by-case basis, whether through a waiver or other policy, to permit facility-based nurse aide training for providers who otherwise would not be permitted due to recent survey deficiencies.
- **3.2.4:** Permit qualified organizations to offer the “train the trainer” course for CNA instructors using models from other states where LTSS trade associations provide the course.
- **3.2.5:** Permit an online, hybrid approach to credentialing/certification for CNAs and CHHAs, which would include a mix of online training, in-person instruction, and written testing (examples: NICE, Relias), followed by in-person, State-developed physical skills testing at regional sites or delegate in-person testing to qualified providers.

The process for out-of-state direct care workers to obtain a certificate to be able to work in New Jersey is unnecessarily bureaucratic and burdensome.

- **3.2.6:** Streamline the process for out-of-state reciprocity by considering the feasibility of implementing a Direct Care Worker Compact similar to the Nursing Compact (which is currently in effect in approximately 40 states, including New Jersey).
- **3.2.7:** Allow paraprofessionals certified in other states to begin employment immediately with skills competency and testing to occur within four to six weeks of continuous employment.

To maintain their certification, direct care workers must meet annual in-service requirements and, in some cases, as for CNAs, specific time worked.

- **3.2.8:** Permit documented in-services from any qualifying employer to meet the annual in-service requirements (e.g., home health, LTC, assisted living).
- **3.2.9:** Permit CNAs to count time worked in a PACE organization, home health, or assisted living setting toward their experience/hour requirement for recertification.

Recruitment and Exposure to LTSS Settings

Maximizing Early Exposure to LTSS Settings: When students are exposed to a broad range of settings during high school and post-secondary education, this can improve the likelihood that some workers will enter and remain in LTSS during their career. The Task Force is concerned that access and exposure to LTSS may be haphazard at present and not consistent across regions of the State.

Recommendations:

- **3.3.1:** Implement strategies aimed at attracting people to LTSS by highlighting positive and rewarding aspects of an LTSS career through a public-private partnership that includes a wide-ranging media campaign (example: WisCaregiver Careers program⁴⁹). Consider use of Civil Monetary Penalties (CMPs) to fund such programs, which could be led by a consortium of interested stakeholders.
- **3.3.2:** Build upon New Jersey Pathways to Career Opportunities and other initiatives to forge a sustainable, long-term plan to specifically attract and retain LTSS and HCBS workers.
- **3.3.3:** Elevate the importance/value of direct care workers in advertising, written brochures, etc.
- **3.3.4:** Participate in the National Nursing Career Pathways Campaign referenced in the Biden-Harris plan (February 2022) as it evolves and takes shape.
- **3.3.5:** Establish credit programs for high school students for work/study in LTSS settings.
- **3.3.6:** Encourage schools, universities, and colleges that provide physician, nurse, CNA, CHHA, radiology and laboratory technician, physical therapy/occupational therapy/speech-language pathology (PT/OT/SLP), and social work training and education to complete clinical rotations through LTSS settings and include appropriate pathways to geriatric and palliative medicine specialties.

Temporary Foreign Workers: H-2B visas are issued to nonimmigrant individuals who are in the U.S. on a temporary basis (visitors for business and pleasure, aliens in transit, academic and vocational students, exchange visitors, etc.).

⁴⁹ See: <https://wiscaregivercna.com/about/#>.

Recommendations:

- **3.3.7:** Establish policies for engaging qualified foreign-born workers, including temporary guest worker program and/or expanded visa programs, to increase health care team member base.
- **3.3.8:** Provide financial assistance such as to the provider for fees and transitional housing reimbursement, subject to parameters defined by the State.

Innovative Models of Staffing

Innovative models of staffing need to be actively encouraged as part of reimagining care delivery. This will involve regulatory reform to support, for example, universal workers in Green House[®] models and small homes (see Section 2). Reimagining care delivery will also need to be supported by payment reforms, including Medicare Alternative Payment Models (APMs) and changes to Medicaid QIPPs. Finally, these will also need to be supported by increasing the supply and availability of specialized practitioners and care providers that are exposed to LTSS early in their careers.

Recommendations:

- **3.4.1:** Incentivize use of board-certified geriatricians and medical directors certified by AMDA – The Society for Post-Acute and Long-Term Care Medicine in nursing homes (see recommendation in Section 2 regarding nursing home Quality Incentive Payment Program).
- **3.4.2:** Encourage Nurse Practitioner models of care in LTSS through APMs (such as bundling, Accountable Care Organizations, quality incentives, Medicare Advantage Special Needs Plans) to enhance and support integrated primary care and behavioral health and improve consistency of clinical presence in facilities.
- **3.4.3:** Encourage the establishment of a reimbursable Direct Care Department within nursing homes with a designated manager to lead, manage, support, and develop CNA teams, ideally led by a former CNA (example: The Enclave Principle⁵⁰).
- **3.4.4:** Develop innovative staffing models for care in nursing homes, including universal caregiver models that mimic family-based care. See Green House[®] models and small homes discussion in Section 2.

Promoting Leadership Stability and Effectiveness

Shortage of Nursing Instructors: The Task Force finds that the nursing shortage will reach its pinnacle in New Jersey in 2030. In response to current shortages and the anticipated shortages of the future, it is essential to graduate a greater number of nurses into the field. The industry reports that a shortage of nursing school instructors and a lack of classroom space and clinical

⁵⁰ See: <https://www.nahcacna.org/enclave/>.

training opportunities in hospitals are clear barriers to this goal, as they reduce the number of students who can be enrolled and effectively trained in nursing programs.⁵¹

Recommendations:

- **3.5.1:** Provide grant funding to incentivize high schools, technical colleges, and universities to create programs, space, and resources to increase the number of students enrolled in nursing programs. Ensure that incentives for new programs include the utilization of LTSS providers for clinical skills training.
- **3.5.2:** Allow nurses with master's degrees in nursing or related areas to teach in nursing programs, except for doctorate in nursing programs.
- **3.5.3:** Compensate nurses who choose to enter the teaching field by reducing or forgiving student loans in a program like the national program administered by Health Resources and Services Administration and providing tax credits.

Shortage of Licensed Nursing Home Administrators (LNHAs): The Task Force is concerned that there is an increasing shortage of LNHAs relative to available positions, and that existing requirements fail to consider background and prior training that may be valuable and allow for reduced training period. There are long delays in obtaining approvals.

Recommendations:

- **3.5.4:** The Nursing Home Administrators Licensing Board should initiate meaningful changes to the LNHA 100-hour course curriculum to better reflect today's LTC environment, improve readiness of newly licensed administrators, and update program requirements to better account for relevant life experiences, graduate schooling, and work done in another state.
- **3.5.5:** The Board should make program changes so that more administrators are eligible to be preceptors (for example, see: Ohio, Virginia, New York, Texas).
- **3.5.6:** Streamline Administrator in Training (AIT) and preceptor approval process, including required timeframes and clear criteria for approval/denial, as well as early notification of likely denial so that alternate plans can be made.

⁵¹ Source: The Hechinger Report, *When Nurses Are Needed Most, Nursing Programs Aren't Keeping Up with Demand*, December 2020, <https://hechingerreport.org/when-nurses-are-needed-most-nursing-programs-arent-keeping-up-with-demand/>.

SECTION 4: BROAD-BASED REFORMS

Addressing the Role of Managed Long-Term Services and Supports

Role of Managed Long-Term Services and Supports (MLTSS) in Quality: Services provided by the New Jersey Medicaid program are now delivered almost exclusively by five Medicaid managed care organizations (MCOs): Amerigroup, UnitedHealthcare, WellCare, Aetna, and Horizon. These MCOs have a contract with the DMAHS, the State’s Medicaid agency, and receive a per-member per-month capitated rate and use those funds to pay providers directly for nursing home care and HCBS. These MCOs are referred to as “MLTSS plans.”

A periodic review of MLTSS plan performance is conducted by an External Quality Review Organization. This includes a review of MLTSS plan performance improvement projects, performance measure validation (generally quarterly), service delivery projects, and care management audits.⁵² The Task Force finds this to be a task-oriented list and feels that more could be done to drive systemic change.

The Task Force finds that MLTSS plans could be more involved in driving quality by conducting a more holistic assessment of enrollee needs and focusing more on intervening early in situations where enrollees’ health or functional status is at risk of declining.

Recommendations:

- **4.1.1:** DMAHS should identify a more robust range of MLTSS quality oversight measures and implement them in a transparent quality incentive payment framework aligned with statewide goals for quality and rebalancing. In addition, DMAHS should make all MLTSS reports public and develop a user-friendly report card that displays plan 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.
- **4.1.2:** DMAHS should require MLTSS plans to do more to ensure nursing home quality, including:
 - Substantially reducing care management caseloads for nursing home residents (currently 240:1).
 - Requiring more frequent, face-to-face visits to nursing home members and more in-depth questions and data gathering about resident quality and satisfaction.

⁵² Sources: New Jersey Department of Human Services, Division of Medical Assistance and Health Services, *Core Medicaid and MLTSS: External Quality Review Annual Technical Report*, https://www.state.nj.us/humanservices/dmahs/news/2021_Core_Medicaid-MLTSS_Annual_Technical_Report.pdf; *FIDE SNP and MLTSS: External Quality Review Annual Technical Report*, https://www.nj.gov/humanservices/dmahs/news/2022_FIDE_SNP-MLTSS_Annual_Technical_Report.pdf.

- Enacting requirements to ensure that no person resides in an institutional level of care who prefers and has the capacity to reside in a lower level, and there should be an active process that includes reporting requirements and dedicated transition teams for complex transitions from institutional care to home.

MLTSS Incentives for HCBS: New Jersey pays MLTSS plans blended capitation rates, i.e., per-person rates determined by a weighted average of HCBS and nursing home utilization. New Jersey pays the MLTSS plans a single monthly amount per member requiring LTSS, regardless of whether the member receives HCBS or nursing home care. Capitation rates for MLTSS plans also contain a modest HCBS shift goal (0.3 percent), and there are two incentive programs available to MLTSS plans: an HCBS care management pay-for-performance program and a nursing home transitions bonus payment. Data from the External Quality Review Organization is used to rank MLTSS plans for HCBS care management. The MLTSS plan with the highest score is paid an additional \$4 million, and the plan with the second highest score is paid \$2 million. All MLTSS plans receive an additional \$20,000 for each individual that is transitioned from a nursing home to HCBS care. During the first half of SFY 2023, the State has paid about \$2.4 million in transition bonuses, implying about 240 nursing home transitions on an annualized basis.

- **Recommendation 4.1.3:** Investigate other MLTSS payment models that may have an even more positive impact on rebalancing, including increasing the HCBS shift goal. Assess barriers to increasing transitions from nursing homes to HCBS, including lack of affordable, supportive housing as described in Section 1 of this report.

Technology Enhancements

Technology Improvements More Generally

From March 2021 to the end of 2022, the State has implemented an electronic medical record requirement and Health Information Network (HIN) connection for residential LTSS providers. This was an important first step in developing the infrastructure for increased use of technology to improve care transitions and reduce avoidable adverse events in LTSS. It is time for New Jersey to take the next step on the path to development of widespread, interoperable, and user-friendly electronic medical records across the continuum of care.

Reducing Gaps in Care: The Task Force finds that gaps in care can arise during transitions between care settings, particularly after an acute event. This can lead to ineffective long-term placement, rehospitalization of patients, and reduced consumer satisfaction.

Recommendations:

- **4.2.1:** Building upon the implementation of the electronic medical record requirement and HIN connection for residential LTSS providers, the State should provide the funds (e.g., systems integration costs, licensing fees) and resources (e.g., training, equipment) to support hospitals and nursing homes to exchange user-friendly clinical information (in such cases

where it is not already happening) that allows practitioners to make timely and well-informed clinical decisions across settings and that this becomes the standard of practice.

- **4.2.2:** Interoperability requirements should be expanded to home health and other HCBS providers for improved transitions of care across the continuum.
- **4.2.3:** The Office of Long-Term Care Resiliency, in concert with internal State and external stakeholders, should specifically examine best practices and the state-of-the-art of how artificial intelligence and smart systems can reduce paperwork documentation time, lower the risk of falls, improve patient monitoring, facilitate early intervention in changes in condition for chronically ill patients, and maximize independence in LTSS settings.
- **4.2.4:** Establish requirement to ensure access to internet, cable/dish/streaming television, and telephone in LTC rooms for resident use. Consider providing funding to support.

Technology Requirements for Telemedicine and Telehealth

The Task Force finds that expanding technology can improve care at the bedside and enhance the effectiveness and productivity of staff, including: telehealth meetings and assessments with physicians/specialists; ability to monitor patients' vital signs and movement in real-time; close examination and thorough documentation of changes in skin integrity; and use of artificial intelligence to reduce falls.

Recommendations:

- **4.2.5:** New Jersey should survey all facilities for Wi-Fi capabilities to assess the extent of functionality to ensure adequacy into each resident bedroom, as well as common areas and corridors. Consider providing funds through CMP grants or low interest loans to facilities that are unable to meet this requirement. Consider implementing incentives for facilities to contract for after-hours and weekend support through telemedicine and technology-based solutions to improve early identification of condition change and to reduce the need for hospitalization.
- **4.2.6:** The DOH should include LTSS (broadly defined) in its upcoming assessment of pay parity for telehealth. State agencies should work with stakeholders to identify options to further bring technology to the bedside (whether in facilities or at home).

Remote Pharmacy Dispensing Systems

Use of remote pharmacy dispensing systems, which automate the dispensing of medications and include a live audio-video link with a licensed pharmacist, is gaining popularity in the nursing home setting and would further increase the safety of medication administration, reduce overall medication errors, and reduce waste.

- **Recommendation 4.2.7:** Encourage the adoption of remote pharmacy dispensing systems in New Jersey nursing homes, such as via grants or low-interest financing programs.

Ensure People with Mental Health Disabilities Receive Quality LTSS and Behavioral Health Services in Appropriate Settings

The Task Force has deep concerns about individuals who have mental health disabilities who need LTSS, both in institutional and community settings. We are concerned that many such persons are not being served in the most appropriate and integrated settings, are not receiving the specialized services they need, are not receiving care that addresses unmet needs and appear to be increasingly concentrated in nursing homes serving large numbers of residents with mental health disabilities. The crisis and closure of Woodland Behavioral and Nursing Center in 2022 highlighted these issues, but they continue to occur in less visible ways across our LTSS system every day.

The lack of supportive housing (see discussion in Section 1 of this report) is a primary driver of these problems. Individuals with serious and persistent mental illness often go from inpatient acute psychiatric hospitals to nursing homes, largely because there are no affordable, safe places for them to receive care. The same is true for unhoused people with mental illness in the community who pass through our acute care hospitals.

Additionally, it appears that New Jersey's implementation of the Pre-Admission Screening and Resident Review (PASRR) process, which identifies people going into nursing homes who have serious mental illness or developmental or intellectual disabilities to ensure they receive appropriate services and placement, is not functioning as fully intended and may contribute to these problems.

Recommendations:

- **4.3.1:** Invest in supportive housing for the nursing home population, including for people with mental health disabilities (see affordable supportive housing recommendations in Section 1).
- **4.3.2:** Revisit the State's implementation of the PASRR process to ensure that people with mental health disabilities are living in the most appropriate setting, whether in the nursing home or in the community, depending on their desires and needs.
- **4.3.3:** Look to other states to see how they deliver specialized services for this population in LTC and seek CMS guidance for implementation.
- **4.3.4:** Evaluate and publicly report on the pilot program established in two nursing homes after the closure of Woodland Behavioral and Nursing Center to assess whether the program is achieving objectives of quality care, whether further refinement is necessary, and how the pilot is differentiated from behavioral units in SCNFs.
- **4.3.5:** Meaningfully address the requirement of the Nursing Home Reform Act that all residents should receive care to achieve or maintain their "highest practicable" mental and psychosocial well-being. Increase scrutiny and enforcement on nursing home policies and practices that run counter to this (e.g., overmedicating residents, involuntarily discharging/transferring people for behavioral issues).

- **4.3.6:** Ensure all LTSS staff are trained to respond in person-centered ways to people who have mental health disabilities, as opposed to focusing on controlling or extinguishing “behaviors.”

Statewide Clinical Outreach Program for the Elderly (S-COPE) has proved to be an invaluable service for many facilities who report anecdotally that they have avoided hospitalizations and institutionalization through the program. It is a model program that few states have implemented and would be of value to citizens of all ages and capabilities.

- **Recommendation 4.3.7:** Build upon S-COPE to include citizens at every age, stage of development, and level of utilization of mental health and behavioral services to support nursing homes, assisted living, dementia treatment centers, and individuals living in more independent settings, including homes. The goal should be to intervene during a crisis to support the individual’s continued independence or facilitate an effective care transition to another setting, either temporarily or on a longer term, as well as preventing or delaying the placement in a nursing home.

Reforming How LTSS is Financed

LTSS Financing Reform: Individuals, government, and employers can all play a role in providing a more secure system to finance LTSS. Financing LTSS should include a public social insurance program, supplemented by private expenditures and Medicaid for those with the greatest needs. LTSS financing should be equitable and broad-based to ensure that LTSS is affordable for all.

Due to the high cost of LTSS, many older adults fear impoverishment and becoming a burden to their families. There is limited third-party coverage to ease this fear. As the baby boom generation ages, the need for services will increase at a time when there will be fewer family caregivers to provide such care. The uncertainty of needing LTSS, and the potentially catastrophic costs associated with it, lend itself to social insurance solutions where risk and costs are shared. Spreading risk widely is the best way to expand coverage and lower per-person costs. If everyone contributes, then everyone is protected.

Until a comprehensive national LTSS program is implemented, states can take interim steps to ensure that LTSS are affordable and fiscally sustainable both to individuals and governments. These efforts can also enhance the financial security of individuals and their families from the potential risk of impoverishment.

- **Recommendation 4.4.1:** New Jersey should explore the potential development of a public social insurance program for LTSS, using the Washington Cares model as an example. The public social insurance model should include mandatory and universal contribution by workers, provide access to needed funds when eligible, be portable to the maximum extent feasible, and address persons without Social Security.

APPENDIX A: TASK FORCE MEMBER LIST

New Jersey Task Force on Long-Term Care Quality and Safety

Amina Ahmed, MD / LTC Population Health
Alyce Brophy / President and CEO, Community VNA
Toya M. Casper-Cornelius / Nurse with Significant LTC Experience
Jim Donnelly / President of the NJ Adult Day Services Association
Sharon Gierie / Nursing Home Resident and Advocate (deceased)
Margaret Hopton / AARP Volunteer
Stephanie Hunsinger / State Director, AARP NJ
Jane Koza / Nursing Home Resident, Home and Community Service Recipient
Pat Lafaro, BS, RN, CIC / Director of Infection Prevention, Robert Wood Johnson University Hospital (retired)
Linda Martin, JD / Chief Compliance Officer (retired)
Catherine Martino / Not-for-Profit Assisted Living Administrator
James McGregor / LTC Policy Expert / 1199SEIU United Healthcare Workers East
Leilani Montes / V.P. 1199 Union
Kartikey Nanavati, MD / Physician
Gwen Orłowski / Executive Director, Disability Rights New Jersey
Glenn Osborne / Veteran, Nursing Home Resident and Advocate
Mike Pollock / Family Member and Advocate
Douglas A. Struyk, CPA, LNHA / Not-for-Profit Senior Living Provider
Gary White / Resident Rights Advocate

Ex-Officio

Eric Kaufmann / Commissioner of Human Services designee
Laurie Brewer, New Jersey Long-Term Care Ombudsman, Amy Brown, designee
Chris Sweeney, Vincent Solomeno, and Connor Frascati / Department of Military and Veterans Affairs Commissioner designee
Deborah Hartel / Commissioner of Health designee

Department of Health Staff

Casi Golaszewski, RN, Executive Director, Office of LTC Resiliency, Department of Health

APPENDIX B: P.L. 2020, C. 88 AUTHORIZING LEGISLATION

P.L. 2020, C. 88 - AN ACT establishing the New Jersey Task Force on Long-Term Care Quality and Safety.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. a. There is established the New Jersey Task Force on Long-Term Care Quality and Safety, which shall be tasked with developing recommendations to make changes to the long-term system of care to drive improvements in person-centered care, resident and staff safety, improvements in quality of care and services, workforce engagement and sustainability, and any other appropriate aspects of the long-term system of care in New Jersey as the task force elects to review. The task force shall specifically focus on:

(1) expanding home and community-based services and recommending strategies to improve the balance between facility-based services and home and community-based services and supports;

(2) nursing home reforms, including implementing new care models, optimizing nursing home size and configurations to foster resident wellness and infection control, increasing clinical presence in nursing homes, and identifying appropriate nursing home staffing levels for certain resident acuity and special population needs;

(3) maintaining the objectivity of the nursing home survey inspections and the cited deficiency appeals process;

(4) identifying the capital investments needed to support physical plant, technology, and workforce development initiatives in nursing homes; and

(5) broader reforms to the long-term system of care, including developing technology requirements to enable enhanced use of telemedicine and telehealth, instituting workforce engagement and advancement models including career laddering options and structures, increasing the use of Medicaid managed care to drive improvements in quality and oversight of nursing homes, and establishing acuity adjustments for Medicaid managed care payments to nursing homes.

b. The task force shall comprise 27 members as follows:

(1) the Commissioner of Health, the Commissioner of Human Services, the Commissioner of Military and Veterans' Affairs, and the New Jersey Long-Term Care Ombudsman, or their designees, who shall serve ex officio;

(2) seven public members to be appointed by the Governor, which public members shall include at least one member representing each of the following, with at least two members being from urban communities: a non-profit nursing home; a for-profit nursing home; a not-for-profit assisted living facility; a nurse with significant experience in long-term care; a consumer

rights advocate with experience or background related to long-term care; a Medicaid managed care organization; and a recipient of home and community-based services;

(3) eight public members to be appointed by the Senate President, which public members shall include at least one member representing each of the following, with at least two members being from urban communities: a medical director of a for-profit nursing home; a medical director for a non-profit nursing home; a certified nurse assistant; an advocate for worker safety in long-term care facilities; Disability Rights New Jersey; a resident of a veterans' home operated by the State; a family member of a resident of a nursing home; and a resident of a nursing home or a long-term care facility; and

(4) eight public members to be appointed by the Speaker of the General Assembly, which public members shall include at least one member representing each of the following: an adult day care center; a home health agency; a home health aide; a resident rights advocate; an expert on long-term care policy; an expert on infection control and prevention; a family member or caregiver of an individual receiving home and community-based services; and a family member of a resident of a veterans' home.

c. The members of the task force shall be appointed, and the task force shall organize, no later than 45 days after the effective date of this act. The members shall select a chairperson and a vice-chairperson from among the public members. The chairperson may appoint a secretary to the task force, who need not be a member of the task force. The task force shall meet at the call of the chairperson.

d. Members of the task force shall serve without compensation but shall be reimbursed for necessary expenditures incurred in the performance of their duties as members of the task force, within the limits of funds appropriated or otherwise made available to the task force for its purposes.

e. The Department of Health shall provide administrative and staff support to the task force. The task force shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available for its purposes.

f. No later than one year after its organization, the task force shall prepare and submit a report to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, concerning its recommendations developed pursuant to this section. The task force shall dissolve 30 days following the date on which it submits its report under this subsection.

2. This act shall take effect immediately and shall expire 30 days after the date the task force submits its report pursuant to subsection f. of section 1 of this act.

Approved September 16, 2020.

APPENDIX C: QUALITY TOOLS FOR NURSING HOMES

Table C-1: Summary of Available Quality Tools for Nursing Homes

Quality Tool	Description
CMS Five-Star Quality Rating System and New Jersey Long-Term Care Resources Website	Comparative data posted on the web designed for use by consumers in selecting facilities
Special Focus Facilities (SFFs) and Candidates	Federally designed process to identify chronic poor performing facilities for targeted oversight
Quality Incentive Payment Program (QIPP)	Provides financial incentives through Medicaid payment rate add-ons to meet specific quality metrics (currently seven metrics)
Advisory Standards	A set of higher standards that can be voluntarily agreed to (in totality) by facilities in return for increased recognition ⁵³
Specialty Care Nursing Facility (SCNF)	Provides financial resources and standards customized to specific populations
Mission Critical Teams	Resources for sustained quality improvement for at-risk facilities without regulatory involvement
Quality Improvement Organization (QIO)	Medicare contractor that assists providers in quality improvement activities

⁵³ The Task Force notes that one of the forms of recognition of meeting the higher Advisory Standards is being noted as such on the State’s Long-Term Care Resources website (<https://www.nj.gov/health/ltc/>). However, at present, that link is not functioning, thus limiting the value of increased recognition. Facilities are able, however, to use such designation in their own marketing materials and websites.

APPENDIX D: UNDERSTANDING STAR RATINGS

The Five-Star Quality Rating System was originally developed by CMS to assist consumers in comparing nursing homes across several dimensions. The system assigns facilities an “Overall” star rating (on a 1 to 5 scale) based on three sub-categories:

- **Health Inspections**—Based on the number of points accumulated over three survey cycles (approximately three years) from deficiencies not in compliance with the federal ROP. Points are awarded based on the number of residents affected and the potential for harmful effects of a deficient practice. A percentage of points drops off the oldest survey cycle as a new cycle begins.
- **Staffing**—Data derived from Payroll Based Journal (PBJ) quarterly reporting to CMS of actual staffing levels in each nursing facility.
- **Quality Measures (QMs)**—A combination of Medicare utilization data and Minimum Data Set assessment data submitted to Medicare for each nursing home resident in the facility at periodic intervals. This is a combination of facility self-reported data and claims data.

Of note, New Jersey nursing homes’ average Overall star rating is 14 percent higher than the national average, with a 12-percentage point higher proportion of 4- and 5-star rated facilities. This is primarily due to New Jersey’s consistently superior scores in the Quality Measures and Staffing sub-categories relative to national averages (22 and 15 percent higher, respectively).

Table D-1: Percent of Nursing Homes by Star Rating and Average Star Rating, New Jersey and U.S.

Rating	Overall		Health Inspection		Quality Measures		Staffing	
	NJ	US	NJ	US	NJ	US	NJ	US
1 to 2	32%	43%	44%	44%	6%	21%	37%	50%
3	19%	20%	25%	23%	10%	21%	28%	20%
4 to 5	49%	37%	31%	34%	85%	58%	35%	29%
	100%	100%	100%	100%	100%	100%	100%	100%
Average	3.3	2.9	2.8	2.8	4.4	3.6	3.0	2.6

Source: Nursing Home Compare February 2023 file

APPENDIX E: BIDEN-HARRIS PLAN FOR NURSING HOMES

Biden-Harris Plan: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes

On February 28, 2022, the White House released a plan for reform of nursing homes, entitled *Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes*, sometimes referred to as the "Biden-Harris Plan for Nursing Homes." Among other things, the plan calls for increased enforcement actions, single rooms, ownership transparency, and a study of minimum staffing standards. In addition, over the course of 2022 and into 2023, the White House and CMS made a series of announcements and policy changes consistent with the plan, including regarding the SFF program, updated guidance on ROP, and a proposed rule on ownership transparency.

The Task Force reviewed the original Biden-Harris plan in September 2022, as well as the updates during our deliberations, and carefully considered those items in reference to the Task Force's findings and recommendations. Our overall conclusions about the Biden-Harris Plan for Nursing Homes are as follows:

- New Jersey is well on its way to accomplishing the goals and expectations set forth in the Biden-Harris Plan for Nursing Homes for those issues under its span of control.
- New Jersey should continue to align State rules and program design with evolving federal rules and programs to streamline regulatory oversight and provider operations where possible.
- Like other states, New Jersey will continue to need to focus resources on workforce development.

As the Task Force has continued to deliberate, we have considered elements of the federal plan in our recommendations. The Task Force looks forward to the results of the nursing home staffing study expected in 2023 and has made recommendations herein regarding New Jersey's potential response in this report.

APPENDIX F: ABBREVIATIONS AND ACRONYMS

Acronym/ Abbreviation	Meaning
ACO	Accountable Care Organization
ADA	Americans with Disabilities Act
ADHS	Adult Day Health Services
ADL	Activity of Daily Living
ALP	Assisted Living Program
ALR	Assisted Living Residence
ARPA	American Rescue Plan Act
CDC	Centers for Disease Control and Prevention
CHHA	Certified Home Health Aide
CMA	Certified Medication Aid
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
DDD	Division of Developmental Disabilities
DHS	Department of Human Services
DMAHS	Division of Medical Assistance and Health Services
DME	Durable Medical Equipment
DOH	Department of Health
GAO	Government Accountability Office
HCBS	Home- and Community-Based Services
HIPAA	Health Insurance Portability and Accountability Act
IP	Infection Preventionist
LNHA	Licensed Nursing Home Administrator
LPN	Licensed Practical Nurse
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MLTSS	Managed Long-Term Services and Supports
NP	Nurse Practitioner
PACE	Program of All-Inclusive Care for the Elderly
PASRR	Pre-Admission Screening and Resident Review
PCA	Personal Care Assistant
PHE	Public Health Emergency
PPE	Personal Protective Equipment
QIPP	Quality Incentive Payment Program
RN	Registered Nurse
SCNF	Special Care Nursing Facility
SFF	Special Focus Facility
SNF	Skilled Nursing Facility