



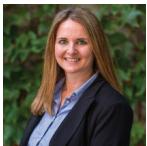
# Balancing Care and Costs: Sustainable Medicaid Reform for New Jersey



**A REPORT FOR THE GARDEN STATE INITIATIVE  
BY DANIELLE ZANZALARI**

**SEPTEMBER 2025**

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Her research focuses on the impact of regulations in the banking sector, cryptocurrency markets, and public finance. She also conducts applied policy work on New Jersey’s economy, including Medicaid reform, energy policy, NJ Transit performance, and the Teachers’ Pension and Annuity Fund (TPAF).

In addition to her academic research, Dr. Zanzalari is a frequent public commentator and writer. She has authored dozens of op-eds in outlets such as *USA Today*, *The Hill*, *NorthJersey.com*, and *HousingWire*, and is regularly featured in national media including NPR’s *Marketplace* and *Morningstar*. She also develops personal financial literacy resources for teachers across the country, helping bring economic and finance concepts into the classroom.

She has taught courses ranging from introductory economics to graduate courses in asset pricing and risk management. She was named Faculty Teacher of the Year for Seton Hall’s Stillman School of Business in 2024, Faculty Teacher of the Year at UNT Dallas in 2019, and was Clemson University’s departmental nominee for Graduate Teacher of the Year in 2013.

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## Introduction

Following Medicaid's expansion under the Affordable Care Act, New Jersey's Medicaid program, known as [NJ FamilyCare](#), extended eligibility to many low-income adults, including able-bodied adults without children who were not traditionally eligible. It now serves a diverse population: low-income children, adults, seniors, and individuals with disabilities. FamilyCare plays a large role in the state's health care system, providing coverage to nearly 2 million residents—about 1 in 5 people, far beyond what the program was initially designed to support. The program finances roughly [30% of all births](#) and about [60% of nursing home care](#) statewide.

This expanded scope comes at a significant cost. State expenditures [exceed \\$6 billion annually](#), one of the largest components of New Jersey's budget. Additionally the program leverages a large federal Medicaid contribution of about [\\$13 billion](#). In total, combined state and federal aid for NJ FamilyCare is expected to reach [\\$22.8 billion in FY 2026](#). While these investments expand access to care for millions of New Jersey's people, they also pose a growing fiscal challenge.

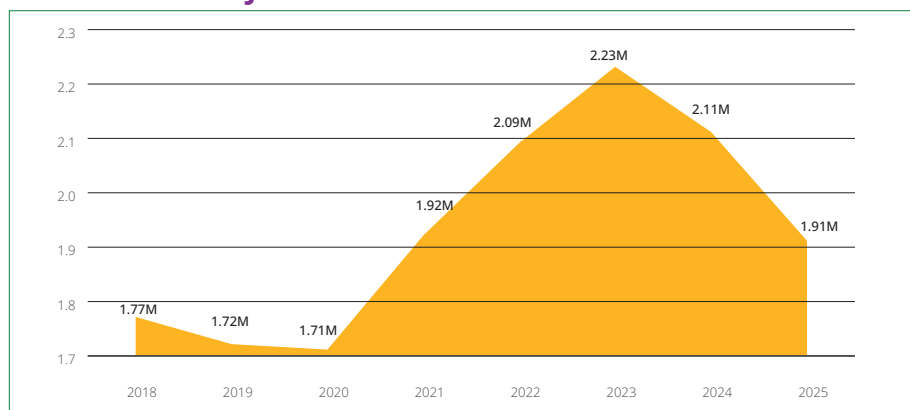
The following analysis briefly examines the problem—Medicaid's rising costs and declining federal support for Medicaid, and proposes three practical reforms to make NJ FamilyCare more fiscally sustainable:

1. Cost containment
2. Long-term care reform
3. Workforce investment (nurses)

## The Problem: Rising Medicaid Costs and Declining Federal Funding

New Jersey’s Medicaid costs have been climbing due to record-high enrollment and rising health-care expenditures, as shown in Figure 1 below. This surge was driven by economic strain and federal continuous coverage mandates during the pandemic. Even as the state resumes eligibility redeterminations and the [unwinding of the continuous enrollment criteria](#), NJ FamilyCare enrollment is still expected to hover close to 1.9 million people in FY2025—over 200,000 more individuals than the pre-pandemic time period. At about 20% of the state’s population, more enrollees translate to higher costs.

**FIGURE 1: NEW JERSEY MEDICAID ENROLLMENT**



*Figure 1: NJ FamilyCare (Medicaid) enrollment spiked during COVID-19 and remains above historical norms with projections showing stabilization around 2.1 million in 2024.<sup>1</sup>*

Medicaid spending is putting pressure on the state budget. Governor Murphy’s recently passed FY 2026 budget allocates [\\$22.8 billion](#) to NJ FamilyCare, a [16% increase year-over-year](#). Several factors contribute to this rise. First, the expiration of temporary federal enhancements has shifted costs back to states. Specifically, a bonus federal match rate ended in 2023, forcing NJ to allocate an extra \$144 million in state funds for Medicaid in FY2025. Second, healthcare inflation has continued to climb, with [provider rates and prescription drug prices](#) steadily rising. While unwinding the pandemic-era enrollment requirements may trim enrollment, many individuals shift to subsidized coverage through programs like [GetCoveredNJ](#), limiting potential state savings.

<sup>1</sup> Data is from NJ’s Department of Human Services FY 2023-2024 report. [https://pub.njleg.state.nj.us/publications/budget/governors-budget/2024/DHS\\_response\\_2024.pdf#:~:text=reimbursement%20rates%20during%20the%20federal,1%20million%20in%20FY%202024](https://pub.njleg.state.nj.us/publications/budget/governors-budget/2024/DHS_response_2024.pdf#:~:text=reimbursement%20rates%20during%20the%20federal,1%20million%20in%20FY%202024)

The state's share of Medicaid spending is sizable and growing substantially, but state general funds are finite. Growing Medicaid needs to compete with other public priorities like education, and transportation. At the same time, federal lawmakers have passed the Big Beautiful Bill, which includes nearly \$1 trillion in Medicaid cuts over the next decade. For New Jersey, where the federal government reimburses over 50% of Medicaid costs, this means the state would face an average federal funding gap of \$1.23 billion annually if it chose to maintain coverage at current levels without cuts, according to [estimates](#) from the Kaiser Family Foundation. The urgency for reform is clear.

# The Solutions: Achievable Goal #1: Contain Medicaid Costs

Controlling costs while maintaining care quality should be a top priority for NJ FamilyCare. Several policy levers can make the program more efficient:

## Eligibility Oversight

During COVID-19, eligibility checks were suspended. Now, redeterminations are resuming, and the state should maintain regular eligibility audits to ensure qualified individuals remain enrolled. NJ FamilyCare also covers children in households up to [350%](#) of the federal poverty level, which is one of the most generous thresholds in the nation.<sup>2</sup> New Jersey should assess whether current eligibility thresholds remain fiscally sustainable and adjust them to balance access with budget realities.

Beginning in 2027, federal policy will require able-bodied adults without dependents to meet work or community engagement requirements to maintain Medicaid eligibility. While New Jersey is not unique in this mandate, implementation will require administrative oversight. Rather than duplicating efforts or introducing new compliance structures, the state should work to minimize the cost of enforcing this mandate.

## Managed Care Oversight

Most FamilyCare recipients received benefits through private managed care plans (MCOs), but stronger accountability is needed. Pennsylvania has operated an independent Health Care Cost Containment Council ([PHC4](#)) since 1986 to track healthcare costs and quality. For example, Law Enforcement Health Benefits Inc., a Pennsylvania health plan, used PHC4's public data on hospital pricing and quality to audit its claims. They [recovered](#) over \$60 million in improperly paid medical expenses. By contrast, New Jersey only established its Office of Health Care affordability and Transparency and a Cost Containment Commission in [March 2025](#)—meaning this oversight work is just beginning.

This commission must act quickly. MCOs should not be overstating their provider networks or delaying disenrollment of ineligible individuals. They must also process and pay claims appropriately. Improved oversight can reduce waste and ensure patients get timely, adequate care. Transparency alone won't fix rising costs—but it is essential to getting better value from the \$6 billion NJ taxpayers pay for Medicaid. As Medicaid continues to consume a larger share of the state budget, holding MCOs accountable for outcomes, not just access, must be central to any cost containment strategy.

<sup>2</sup> Neighboring states of PA, CT, MA, NY, and others have much lower income limits for Medicaid (between 100%-200% of the federal poverty line) and most states do not cover undocumented children. Since 2023, immigration status is not a factor in Medicaid payments in New Jersey.

## Prescription Drug Spending

Rising pharmacy costs continue to drive Medicaid spending and more aggressive action is needed to contain them. New Jersey has made progress on drug price transparency, but exemptions for [hospitals](#) remain. This should be reconsidered.

The state should consider joining a [multi-state drug purchasing pool](#) to increase its negotiating power and help reduce Medicaid pharmacy costs, especially for high-cost brand-name drugs. Evidence from other [states](#) and pooled procurement programs suggest these models lower prices when properly designed. While research on long-term impacts to pharmaceutical innovation is limited, any potential to hinder drug development must be weighed carefully. In addition, pooled purchasing programs can raise other concerns, including possible effects on patient access, patient choice, and providers' preferred prescribing decisions. To protect access to new therapies, New Jersey should structure contracts with flexibility for breakthrough drugs and transparency requirements to ensure public accountability. When designed well, pooled purchasing can cut costs without stalling innovation.

NJ should also explore adopting a unified pharmacy benefit model, like the one New York implemented [in 2023](#), to streamline purchasing and improve oversight. Additionally, it should consider reforms modeled after Arkansas' [new law](#), which bans pharmacy benefit managers (PBMs) from owning pharmacies. This helps address cost inflation caused by vertical integration and could be a model for New Jersey. PBMs play a major role in determining what the state pays for medications. NJ cannot afford inefficient purchasing practices that cost the state millions in unnecessary spending.

## Value-Based Payment Reform

New Jersey is still largely paying for Medicaid services through volume-based, fee-for-service models that reward quantity, not quality. This approach drives up costs without ensuring that patients are healthier after receiving care.

By contrast, value-based payment models—such as bundled payments, care coordination incentives, or Medicaid Accountable Care Organizations—can improve patient outcomes while reducing unnecessary or duplicative services.

While some managed care plans have [piloted](#) value-based models, many have not. NJ should require MCOs to increase the share of provider contracts tied to quality metrics, such as hospital readmissions or preventive care benchmarks. Embedding these expectations in MCO contracts would move New Jersey toward a system that rewards better care, not just more of it.

## Spending Discipline

Medicaid spending in New Jersey continues to outpace state revenue growth, straining the budget. To maintain stability, the state should consider a formal growth cap tied to revenue or healthcare inflation. Public funds are finite, and unchecked Medicaid growth will eventually crowd out other core priorities.

Even though per capita caps would come from the federal level, New Jersey should prepare for potential changes that might constrain Medicaid funding growth. A per capita cap on Medicaid, if enacted and if NJ did not offset the federal cuts, could reduce NJ's Medicaid costs by [\\$12.3 billion](#)

over the next decade and lower enrollment by [320,000 individuals](#). These are large numbers, but they underscore the importance of reform. Any future budget surpluses should also be directed towards building a Medicaid reserve fund to cushion against future downturns or enrollment surges without jeopardizing coverage.

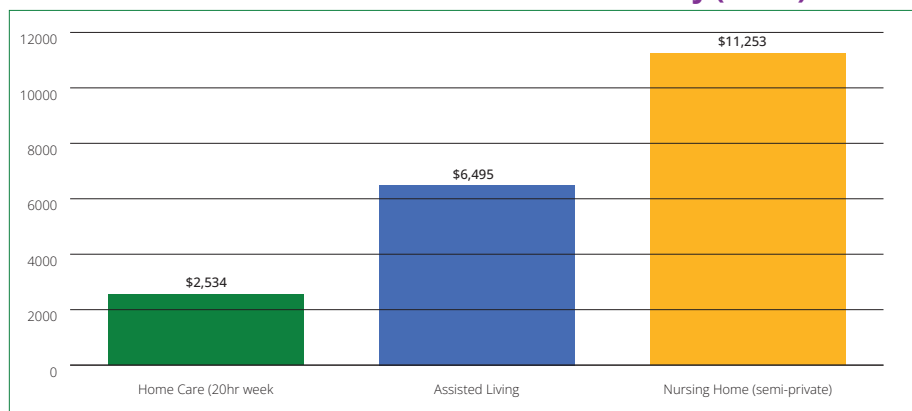
Altogether, these proposals, in addition to the strides New Jersey has made in finding Medicaid waste and fraud (about [\\$100 million](#) annually), could save hundreds of millions each year. But cost containment alone won't secure Medicaid's future. Without long-term care reform and workforce investment, the system will remain financially strained and structurally unsustainable

## Achievable Goal #2: Long-Term Care Reform

Long-term care services are among the most expensive components of Medicaid. It includes nursing homes, assisted living, and home health care. Most seniors prefer home care, and it's [significantly less expensive](#) than nursing home care.

Despite this, [79%](#) of New Jersey's long-term care spending goes to nursing homes, and the state ranks 35<sup>th</sup> nationally in the share of spending devoted to home and community-based services. Nursing home costs in New Jersey are much higher than home care, as shown in Figure 2 below.

### AVERAGE MONTHLY LONG-TERM COSTS IN NJ (2022)



*Figure 2: Average monthly long-term care costs in New Jersey (2022). Nursing homes are more expensive than in-home care. A semi-private nursing home averages about \$11,253 per month, whereas part-time home care (20 hours/week) costs about \$2,534 per month.<sup>3</sup>*

In response to the state's overreliance on institutional care, the New Jersey Task Force on Long-Term Care Quality and Safety<sup>4</sup> has recommended a shift towards home and community-based care. In its [2024 report](#), the Task Force set a goal to reduce the percentage of nursing home residents from 37% to 20% and to encourage new care models like small-home "Green House" [facilities](#) where a nursing home is designed for 10-12 residents with a private room.

Rebalancing long-term care won't solve Medicaid's fiscal challenges alone, but it is essential for aligning spending with resident preferences and improving quality of care. This shift should also be supported through payment reform. New Jersey's fee-for-service structure often incentivizes institutional care by reimbursing volume over value. Aligning long-term care payments with patient outcomes would further accelerate the move toward lower-cost, higher-quality care options.

<sup>3</sup> This data is from the AARP as noted on the following website: <https://www.thechamberlainlawfirm.com/blog/understanding-the-costs-of-long-term-care-in-new-jersey/#:~:text=The%20costs%20of%20long,New%20Jersey%20as%20of%202022>

<sup>4</sup> This task force was established after the large amount of nursing homes death in NJ during the pandemic.

While [recent federal restrictions](#) in the Big Beautiful Bill limit New Jersey's ability to reduce payments to poorly performing nursing homes, the state can still design value-based payment models to reward better care. The key difference is that outright payment cuts on quality scores are restricted, but incentive-based add-ons for better outcomes are permitted. Governor Murphy [vetoed](#) a resolution in this year's budget to extend bonus payments to poorly rated nursing homes, affirming that incentivizes should only go to high-quality care facilities.

These reforms can deliver better outcomes for older adults while helping to stabilize long-term Medicaid costs.

## Achievable Goal #3: Workforce Investment (More Nurses)

None of the above reforms are possible without a stronger healthcare workforce. New Jersey is already facing a crisis with nursing home staffing [down by nearly 15%](#) since the pandemic and by 2030, according to the US Department of Health and Human Services, New Jersey is projected to face a deficit of 11,400 registered nurses.

Governor Murphy's FY2025 budget dedicated \$7.2 million to raise wages for nursing home staff, but this is just a start on how to incentivize more workers in this field. These jobs are physically demanding yet pay near minimum wage. While physician shortages also deserve attention, NJ's most immediate gaps, and the reforms proposed in this report, require a stronger nursing pipeline, especially in long-term care settings.

New Jersey can expand training pipelines for nurses through scholarships, certification programs, and high school career technical education. The state should also explore recruiting nurses from out of state or internationally, with a focus on long-term retention through structural improvements, like reduced entry barriers, clearer advancement opportunities, and supportive workplace practices, rather than mandates or broad financial incentives.

One effective strategy is to create clear career pathways—such as programs that support aides in becoming licensed practical nurses (LPNs) and LPNs in becoming registered nurses (RNs). Building a ladder of advancement within the long-term care workforce not only helps fill staffing gaps but also improves retention and care quality.

## Conclusion

Medicaid is one of New Jersey's most pressing budget challenges. Enrollment and spending are both at record highs, and the state faces difficult tradeoffs as healthcare costs continue to outpace revenue growth. While NJ FamilyCare continues to provide essential coverage to about two million residents, its long-term sustainability requires urgent reform.

This report outlines a three-part solution to stabilize the problem:

- 1.** Cost containments- Enforce eligibility rules, improve oversight of managed care plans, reform prescription drug purchasing, and expand value-based payment models to reward better outcomes not just volume.
- 2.** Reform long-term care- Shift funding toward home and community-based services, which are more affordable and better aligned with patient preferences than institutional care.
- 3.** Strengthen the healthcare workforce- Address the severe healthcare workforce shortages, especially in long-term care settings, that threaten the entire system by investing in training pipelines, removing barriers to entry for nurses, and supporting career advancement.

Without action, rising Medicaid costs will crowd out other public priorities or force painful cuts to coverage. With this clear, practical three-part strategy, New Jersey can deliver better care and place NJ FamilyCare on a more fiscally sustainable path forward.