



## **Medicaid in New Jersey**

New Jersey Medicaid, administered by the Division of Medical Assistance and Health Services, covers certain medical and health care services for individuals who meet eligibility requirements. Medicaid is a medical assistance program for persons on limited fixed incomes and for some medically needy persons. SSI recipients are automatically eligible and need not apply separately. To be eligible for New Jersey Medicaid, an individual must meet these requirements: be a resident of New Jersey, be a U.S. citizen or qualified alien, and meet criteria for financial income and resources. In addition, a person must be a member of one of the following groups: (1) families with children up to age 18, (2) aged, blind or permanently disabled, (3) pregnant, (4) children. Alternatively, some persons may qualify through Medicaid expansion criteria.

**Medicaid eligibility through Supplemental Security Income (SSI):** Individuals receiving SSI are automatically eligible for Medicaid and need not make a separate application. As of 2015, the New Jersey Medicaid eligibility criteria for a single individual to receive Medicaid through SSI are a maximum monthly income of \$733 and maximum resources of \$2,000.

**Medicaid eligibility through NJ Care:** Other individuals with low incomes may be covered by the NJ Care program, which provides full Medicaid coverage but no cash assistance. As of 2014, the New Jersey Medicaid eligibility criteria for a single individual to receive Medicaid through NJ Care are a maximum monthly income of \$1,294.00 and maximum resources of \$2,000.

**Medicaid eligibility through Aged, Blind and Disabled (ABD):** Individuals who are blind or “permanently and totally disabled” (as defined by Social Security) can qualify through ABD. These individuals can receive Medicaid even if they also receive Social Security and Medicare. In addition, their monthly Medicare Part B premium will be paid through the program. As of 2014, the New Jersey Medicaid

eligibility criteria for a single individual to receive Medicaid through ABD, are a maximum monthly income of \$973 and maximum resources of \$2,000.

**Medicaid eligibility through Medicaid Expansion:** The Affordable Care Act funded nationwide Medicaid expansion. Adults without dependent children, between the ages of 19-64, can qualify through Medicaid Expansion even if they do not fall into another eligibility category. As of 2015, the New Jersey Medicaid eligibility criteria to receive Medicaid through Medicaid Expansion is a maximum monthly income of \$1273 (for individuals) or \$1719 (for couples). The program does not consider resources. Due to the high maximum income, this option is helpful for individuals receiving Social Security Disability (SSD) who would otherwise be ineligible for this program. However, individuals can't qualify if they have Medicare, so once the individual receives Medicare (24 months after qualifying for SSD), they'll lose this Medicaid coverage.

**For more info on New Jersey Medicaid, call 800-356-1561 (hotline) or 800-701-0720 (TTY).**

**Medicaid Medically Needy “Spend Down” Program**

Many individuals who need Medicaid are medically needy but do not qualify for Medicaid due to excess income or resources. They may qualify through the “Medically Needy Spend Down” program. Spending down means subtracting certain medical expenses from one’s income to equal the required limit for Medicaid. To qualify, you must be: pregnant, a needy child (under 21), aged (65 or older), and blind or disabled, and your income must meet certain limits:

**Medically Needy Income and Asset Limit**

<b>Family size</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
<b>Max income</b>	<b>\$367</b>	<b>\$434</b>	<b>\$567</b>	<b>\$659</b>	<b>\$742</b>	<b>\$825</b>
<b>Max assets</b>	<b>\$4,000</b>	<b>\$6,000</b>	<b>\$6,100</b>	<b>\$6,200</b>	<b>\$6,300</b>	<b>\$6,400</b>

Families with needy children have the opportunity to subtract certain items to meet eligibility requirements. For example, families with needy children can subtract \$90 of wages from each employed person. To understand “spending down”, suppose you are applying for a family of 1 (yourself). According to the chart, your monthly income can't be more than \$367 and your assets can't be more than \$4,000. If your total assets

are \$3,100, you qualify. However, your monthly income is \$417, which is over the limit by \$50. Eligibility is determined every six months, so you have time to spend down. Over the next six months you will be able to spend down \$300 (\$50 per month over 6 months). After spending down you'd be eligible for the program. However, you need to meet the same criteria each month. If there is a month in which you need Medicaid coverage but your medical expenses are too low to meet the "spend down" level you need, talk to a social worker at the county Board of Social Services to let them know about this.

Numerous services are provided to eligible individuals, including but are not limited to: doctors, home health services, laboratory and x-ray services, psychological services, and medical transportation. Additional services are provided for pregnant women, needy children, and aged, blind and disabled individuals. Pregnant women can receive inpatient hospital, medical day care services, prescribed drugs and chiropractic services. Needy children can receive prescribed drugs. Aged, blind, or disabled persons can receive podiatry services, medical day care services.

### **Medicaid HMO Enrollment**

New Jersey Medicaid requires that everyone who has Medicaid, including people who also have Medicare or private health insurance, must enroll in a Medicaid HMO. The five plans are: Aetna Better Health of New Jersey (Bergen, Camden, Essex, Hudson, Middlesex, Passaic, Somerset, Union) Amerigroup (all counties but Salem), Horizon NJ Health (all counties), United HealthCare Community Plan (all counties) and Wellcare (Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex, and Union). This list is subject to change as new HMOs open plans in New Jersey and other HMOs change their coverage.

Anyone who is newly enrolled in a Medicaid HMO can switch HMOs if they do so within 90 days of enrollment. After that, enrollees can change HMOs once a year during the Open Enrollment Period, from October 1st to November 15th. The new enrollment starts January 1st. However, enrollees can change HMOs at any time if there is a "good cause" reason. Possible "good causes" include: poor quality of care, lack of access to needed specialty services, denial or unreasonable delay of services, or fraudulent enrollment. The HMO can develop criteria for "good cause" disenrollment for the chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through a different providing HMO.

**Enrollees may change HMO with “good cause” reason, by calling NJ Medicaid/Family Care at 1-800-701-0710.**

Care management services are available at all of the Medicaid HMOs. Care managers can facilitate individual, out-of-network contracting with medical, dental, and mental health providers who are not in the HMO’s network, when the HMO does not have in-network providers with the same expertise as the out-of-network provider. These arrangements are made on a case-by-case basis, if the health care professional is willing to make such an arrangement.

<b>Medicaid HMO care management phone numbers:</b>	
Aetna Better Health of New Jersey	1-855-232-3596
Amerigroup Community Care	1-800-425-7101
Horizon NJ Health	1-800-682-9094 x89385
United Health Community Plan:	1-800-645-9409
WellCare	1-888-453-2534

**For more information about Medicaid HMO enrollment, call NJ Medicaid at 866-472-5338. To report a problem with a Medicaid HMO, call the Brain Injury Alliance of New Jersey at 800-669-4323 and ask to speak with a Helpline Specialist for further assistance.**

**Medicaid Managed Long Term Services and Supports**

As of July 1, 2014, participants who were enrolled in the various Medicaid Waiver programs (which included the Global Options for Long-Term Care, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and the Traumatic Brain Injury Waivers) have been automatically enrolled in the Managed Long Term Services and Supports program (MLTSS) provided through their current Medicaid managed care organization.

If an individual seeks Medicaid Waiver services for brain injury residential or day services, they must apply for MLTSS. To qualify, you must meet Categorical, Clinical, and Financial criteria:

- **Categorically**- an individual must be aged (65 or older), or under 65 years of age, and blind or disabled as deemed by the Social Security Administration or the State of New Jersey.
- **Clinical eligibility**- based on an assessment of what an individual can and cannot do for themselves. An individual must meet a **nursing home level of care**, which means the person requires assistance with activities of daily living such as bathing, toileting and mobility. The assessment of clinical eligibility will be performed by a nurse or social worker working for the HMO. Some considerations entering into the determination of clinical eligibility include:
  - **Medical Needs**- How often does that patient need to be seen by a physician- daily, weekly, monthly or less often?
  - **Nursing care needs**- What, if any, services must be provided on a daily basis by a registered nurse, a licensed nurse and/or a nursing assistant?
    - Will short-term intensive physical, occupational and/or speech therapy result in a marked improvement in the patient's functional ability?
    - Is the patient demonstrating steady progress toward the rehabilitation goal?
    - Is therapy needed to maintain the patient's current level of functioning? Will the patient benefit at all from therapy?
    - What assistance does the patient need to complete activities of daily living?
  - **Financial eligibility**- for a single individual, an income equal to or less than \$2,199 a month and resources of \$2,000 or less (as of 2015). For children who meet a **nursing home level of care**, parental income and resources are not counted in determining financial eligibility.

Many individuals with brain injury have cognitive needs. Due to deficits in memory, attention and executive function, they need guidance to complete activities of daily living. However, they may not have any nursing care needs. **Being at a nursing home level of care is a requirement to qualify for MLTSS.** The Brain Injury Alliance of New Jersey can provide you with more information on this topic, and can also discuss supports and services that may benefit persons with brain injury who do not qualify for MTLSS as they don't meet a nursing home level of care.

**For more information of nursing home level of care eligibility for MLTSS, call the Brain Injury Alliance of New Jersey at 800-669-4323.**

To begin the MLTSS application process, you may want to use a service known as Options Counseling. This is a process by which prospective applicants can receive assistance from the Aging and Disability Resource Connection, a program that coordinates county offices on aging and disability services. Options Counseling includes these steps: 1) a one-on-one discussion and a screening for any public programs, 2) a facilitated decision making process that will help weigh the pros and cons, and 3) the development of an action plan tailored to individual needs. Through the Options Counseling program you can apply for MLTSS and other disability-related services.

**For more information on Options Counseling, contact the Aging and Disability Resource Connection (ADRC) at 877-222-3737.**

Once enrolled, services provided by MLTSS include but not are limited to Respite, Personal Emergency Response Systems, and Home and Vehicle Modifications, as well as assisted living, behavioral health services, residential and nursing home care. These services may be provided by the individual's existing Medicaid HMO. In regards to an individual's existing HMO, it is important to know that not every care provider accepts every HMO, even under the MLTSS. The enrollee must choose a doctor and other health care providers that are in-network for their HMO. Exceptions may be made on a case-by-case basis, mainly for new enrollees who are in the transition period with a new managed care plan, or for existing enrollees who cannot otherwise obtain the services they need from a participating doctor or other health care provider.

### **Appeals**

If for any reason the Medicaid recipient feels it necessary to file an appeal, they are entitled to a written notice and fair hearing. Some reasons an enrollee may be entitled to a written appeal and fair hearing include: a denial or limited authorization of a requested service, including the type and level of service; reduction, suspension, or termination of a previously authorized service; denial- in whole or part- of payment of a service, and failure to provide services in a timely manner. In the case that an individual wants to file an

appeal, their current HMO will provide them with a Member Handbook with the HMO-specific steps for the appeal process.

**To report a problem with MLTSS or Medicaid appeals, contact the Brain Injury Alliance of New Jersey at 800-669-4323.**

**NJ WorkAbility**

The Work Ability program offers people with disabilities who are working, and whose income would otherwise make them ineligible for Medicaid, the opportunity to receive full NJ Medicaid coverage. People with disabilities who are employed, and who are between the ages of 16 to 64, can qualify for the program with annual gross earned income up to \$58,236 and resources up to \$20,000 for an individual. Please be aware that the program eligibility is tied to employment and if the individual stops working, they will no longer be eligible.

**For more information on NJ WorkAbility, contact the Division of Disability Services at 888-285-3036.**

**NJ Personal Preference Program**

The Personal Preference Program allows Medicaid recipients who need personal care assistance direct their own care. Through a monthly cash allowance, participants work with a consultant to develop a cash management plan by which they decide the services they need and the individuals and/or agencies they wish to provide those services. The program requires greater consumer responsibility but offers participants greater control, flexibility and choice.

**For more information on the Personal Preference Program, contact the Division of Disability Services at 888-285-3036.**