

SUBCHAPTER 8. RESPONSIBILITIES

10:71-8.1 Other agency responsibilities

(a) Determination of continuing eligibility: The eligibility of each case shall be redetermined at least once every 12 months. This redetermination provides an opportunity to evaluate the total situation and enables the Income Maintenance (IM) worker to ascertain whether the individual's eligibility has changed.

1. It shall be the agency's responsibility to review indications of ineligibility as they occur and to discontinue Medicaid Only eligibility when appropriate and without delay. The agency shall notify each applicant/recipient of any agency decision that relates to his or her eligibility status in accordance with the provisions of N.J.A.C. 10:71-8.1(e) and 8.3.

2. The individual, or his or her authorized representative, shall execute a formal written application, Form PA-1G, Application and Affidavit for Medical Assistance Only (Aged, Blind, or Disabled), for continuance of assistance at least once every 12 months.

(b) Process of redetermination:

1. Personal interview: The IM worker shall conduct a face to face interview regarding application for continuance of Medicaid Only and shall assist in the completion of the application form, Form PA-1G, if necessary.

2. Redetermination of financial and resource eligibility: The IM worker shall review all eligibility factors in accordance with the provisions set forth in N.J.A.C. 10:71-3, 4, and 5. Particular attention shall be directed to identification of any changes in resources and income.

3. Completion of Worksheet and Authorization for Public Assistance (Form PA-3A) and the Medicaid Eligibility Worksheet (Form PA-1E): It is the responsibility of the IM worker to complete a new Form PA-1E and Form PA-3A when eligibility is to be continued, or suspension of eligibility continues beyond one month or the case is terminated. A new Form PA-3L, Statement of Income Available for Long Term Care Facility Payment, should be prepared for persons in institutions only when there is a change with regard to the amount of income available for medical reimbursement.

4. Need for institutional care: Official review of this factor on a routine basis is not required, but when medical or social evidence indicates that specific determination should be made, the CWA shall institute such an investigation.

(c) Recording and recommendation: A Summary Report, Form PA-2D, concerning all pertinent information shall be completed for each contact with the individual, whenever it occurs. Whenever a change in circumstances affects any facet of eligibility, a Medicaid Eligibility Worksheet (Form PA-1E) and a Worksheet and Authorization for Public Assistance (Form PA-3A) shall be prepared. The summary shall clearly state the basis for any suspension of eligibility or termination. Following each redetermination of eligibility, it is the responsibility of the IM worker to recommend on form PA-3A that eligibility be continued, suspended, or terminated.

(d) Disposition of application for continuance: Following supervisory approval, an application for continuance shall be acted upon by one of the following methods:

1. Action by executive authority: The Director of Welfare (or his or her authorized representative) shall, by his or her legal authority, continue, suspend, or terminate eligibility when, in his or her judgment, such action should be taken in advance of welfare board action. Such cases shall thereafter be presented to the welfare board at its next meeting. In those counties not having welfare

boards, the authority for final action as to the disposition to continue, suspend or terminate eligibility shall rest with the Director of Welfare and the provisions of (d)2 below shall not apply.

2. Action by the welfare board: The following applications for Medicaid Only continuance shall be routinely presented to the welfare board for decision:

- i. Cases recommended for continuance;
- ii. Cases recommended for suspension or termination (for ratification if acted upon by the Director).

3. Whenever a special review results in a recommendation for suspension or termination, the case shall be presented to the welfare board for initial action or ratification of the Director's action, as appropriate.

(e) Notice of agency decision: Each applicant/recipient shall receive written notice of any agency decision which relates to his or her eligibility status at least 10 days prior to any change in his or her eligibility status.

Case Notes

Effective date of Medicaid eligibility was not date of patient's admission to long-term care facility, but was date of her subsequent submission of Medicaid application. E.M. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 63.

10:71-8.2 Redetermination of medical eligibility

(a) Redetermination of disability and blindness factors shall be done for every Medicaid Only recipient at intervals set by the Division of Medical Assistance and Health Services, Disability Review Unit, except those recipients who are currently receiving SSA Disability Insurance Benefits. The redetermination review date is designated on Form PA-8, Record of Action: Medical Eligibility Factor (see N.J.A.C. 10:71-3.13(g)).

(b) An individual who has been determined to be disabled or statutorily blind shall, if requested with reasonable notice, present himself or herself for and submit to examinations or tests, and shall submit medical and other evidence necessary for the purpose of determining whether he or she continues to be disabled or statutorily blind.

(c) In Medicaid Only cases, the CWA shall take into account the redetermination review date on Form PA-8 in scheduling both the annual review and interim visits. The CWA may adjust the date for case submittal to the Disability Review Unit, to coincide as closely as is practical with either the annual review or with an interim visit, but such adjustment shall assure that the case will be submitted not more than two months earlier and in no event later than the date originally set on Form PA-8.

(d) The Disability Review Unit will maintain a control file in order to ensure appropriate and timely reevaluation by the medical review team (MRT). The Disability Review Unit will notify county welfare agencies one month in

advance of cases scheduled for such review by means of Form PA-655, Cases for Medical Review Team Reevaluation Due During the Month.

(e) The IM worker shall organize his or her caseload controls (notebooks, index, and other related materials or equipment) so that he or she will be alerted sufficiently in advance of redetermination review dates to enable him or her to obtain any specific medical information or reports requested on the last Form PA-8. The data and reports so submitted must be "current".

(f) When a case is to be submitted to the Disability Review Unit, for redetermination review, the IM worker shall prepare Form PA-6A, Interim Medical-Social Report in detail. Form PA-6A shall be placed on top of all forms, reports and related data previously submitted.

(g) Medicaid coverage shall be continued, if financial and resource eligibility continues to exist, unless and until the CWA is advised by the Disability Review Unit that the individual no longer meets the disability and blindness requirements or the individual withdraws voluntarily.

(h) Upon receipt of records from the Disability Review Unit, the CWA shall follow the procedures as outlined in N.J.A.C. 10:71-13(g).

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-8.3 Notice of county welfare agency decision

The county welfare agency shall promptly notify, in writing, the applicant for, or recipient of, Medicaid Only of any agency decision. The policies and procedures outlined in N.J.A.C. 10:87-7.1 through 7.6 shall be followed.

10:71-8.4 Complaints and fair hearings

(a) It is the right of every applicant for, or recipient of, Medicaid Only to be afforded the opportunity for a fair hearing in the manner established by the policies and procedures set forth in N.J.A.C. 10:81-6, regarding complaints and fair hearings (see N.J.A.C. 1:1). Complaints and fair hearings regarding Medicaid Only eligibility should be referred to:

Division of Medical Assistance and Health Services
Office of Legal and Regulatory Liaison
CN 712
Mail Code #3
Trenton, New Jersey 08625-0712

(b) In situations where an applicant or recipient is denied medical services to which he or she feels that he or she is entitled, a request for a hearing and a brief explanation of the situation should likewise be sent to the Office of Legal and Regulatory Liaison.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Case Notes

Fair hearing barred by rule of limitations. Bridgeton Nursing Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 1.

10:71-8.5 Fraudulent receipt of assistance

To protect the assistance agency and the public against the commission of fraud, the policies and procedures as defined in N.J.A.C. 10:81-7.40 through 7.45 (fraudulent receipt of assistance) shall apply to the Medicaid Only program.

10:71-8.6 Reporting criminal offenses to law enforcement authorities

Investigation of new applications or investigations for redetermination or eligibility may on occasion present indications to the CWA that a crime may have been committed. In such a situation, the procedures outlined in N.J.A.C. 10:81-7.46 (reporting criminal offenses to law enforcement authorities) are to be followed.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-8.7 Safeguarding information

The Federal Social Security Act requires that a state must provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of public assistance. Therefore, the policies and procedures outlined in N.J.A.C. 10:81-7.30 through 7.35 (safeguarding information) apply to the Medicaid Only program.

10:71-8.8 Nondiscrimination in public assistance programs

Title VI of the Federal Civil Rights Act of 1964 (Public Law 88-352) and Section 504 of the Federal Rehabilitation Act of 1973 prohibit discrimination on the ground of race, color, national origin, or handicap in the administration of a program for which Federal funds are received. Therefore, the policies and procedures relating to those acts, as outlined in N.J.A.C. 10:81-7.36 through 7.38 (nondiscrimination in public assistance programs) are to be strictly observed.

SUBCHAPTER 9. MEDICAL ASSISTANCE FOR THE AGED CONTINUATION

10:71-9.1 General statement

The Medical Assistance for the Aged Continuation (MAAC) provides payment for the costs of medical services for certain former recipients of the program of Medical Assistance for the Aged (MAA). Eligibility is based on continued medical need and lack of eligibility for any other program through which the cost of medical care is provided. Recipients receive the full spectrum of Medicaid services.

10:71-9.2 Initial certification

(a) Certification begins for those persons and only for those persons who were in certified status in the MAA program at the close of business on June 30, 1982 and those persons that filed MAA applications on or before June 30, 1982 and whose eligibility was established in accordance with regulations and case circumstances in effect on that date. The initial certification period in MAAC consists of the remainder of the current MAA certification period (see N.J.A.C. 10:71-9.4(a)).

(b) Recertification: Eligible persons will be recertified by the CWA for such additional periods, usually for three months or as specified by DMAHS/DRU (see N.J.A.C. 10:71-9.4).

(c) Extension of certification periods: The CWA will extend initial or subsequent certification periods in units of one month as may be necessary, pending receipt of a medical need determination from DMAHS/DRU and/or, if applicable, to comply with requirements for timely notice of adverse action (see N.J.A.C. 10:71-8.3). Extensions shall not be made for any other reasons.

Amended by R.1986 d.5, effective February 3, 1986.
See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a).

Added text "and those persons . . . on that date."
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-9.3 Termination

Once terminated for any reason, including loss of medical certifications, a case shall not be reopened under the provisions of this subchapter.

10:71-9.4 Continuation of medical need

(a) Submittal of data to DMAHS/DRU: Thirty days prior to the end of each certification period, the CWA will forward to DPW/BMA photocopies of all forms and reports bearing on the individual's need for continued inpatient hospital services, skilled nursing home services, or home health care services required by reason of an illness necessitating confinement at home for a prolonged period.

(b) Response by DMAHS/DRU: The DMAHS/DRU will review the submitted material and notify the CWA of its determination. The determination will specify whether continuation does or does not exist.

(c) CWA Action: Upon receipt of the DMAHS/DRU determination the CWA will, as appropriate, move to terminate or recertify the case for such periods as may be required to make the review month become the final month of the new certification period.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-9.5 Eligibility for other programs

(a) Review: The CWA will review each MAAC case in accordance with (a)1 below for potential eligibility for other assistance programs through which the costs of medical care may be met. Those programs will not include General Assistance but will include such programs as SSI and Medicaid Only.

1. Review times: The CWA will conduct a review with respect to other program eligibility at time of initial certification, at the beginning of the review month, whenever any change in client income occurs and at the time of any change in standards of other appropriate programs.

(b) Referral: If eligibility is found for regular Medicaid Only, the CWA will convert the case accordingly. If potential eligibility is found for a program administered by another agency, the CWA will make referral promptly and will institute procedures for follow-up of the referral. Upon acceptance of the individual into any other program through which medical costs are met, the CWA will terminate the MAAC case.

Amended by R.1986 d.5, effective February 3, 1986.
See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a).