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DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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MEDICAID COMMUNICATION NO. 86-4

TO: County Welfare Agency Directors DATE: May 26, 1986

SUBJECT: Comparison of the Home and Community-Based Services Waiver with the Medically Needy Program

The Division of Medical Assistance and Health Services will implement the Medically Needy Program on July 1, 1986. Many questions have been asked about how the Medically Needy Program relates to our Home and Community-Based Services Waivers, known as the Community Care Program for the Elderly and Disabled (CCPED) and the Model Waiver Programs.

Attached for your information are charts which compare CCPED and the Model Waiver to the Medically Needy Program. These charts address such factors as the purpose, authority, target population, eligibility, service package, and program limitations of the three programs. Separate fact sheets list the advantages and disadvantages as seen from a recipient perspective.

We anticipate that this material will assist your staff to better understand the parameters of these programs, and therefore, will enable them to more appropriately serve our elderly and disabled population.

Sincerely yours,

Thomas M. Russo

Thomas M. Russo, Director
Division of Medical Assistance
and Health Services

TMR:Kw
Attachment
cc: Larry J. Lockhart
Deputy Commissioner

Audrey Harris, Director
Division of Public Welfare

Thomas Blatner, Director
DYFS Management Team

Norma Krajczar, Director
Commission for the Blind

Case Management Sites

Medicaid District Offices

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

COMPARISON OF COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED AND MEDICALLY NEEDY PROGRAMS AS RELATED TO AGED AND DISABLED ONLY

Feature	CCPED	Medically Needy
Purpose	To provide a package of home care services to nursing home eligible individuals to enable them to remain at home.	To provide certain Medicaid services to individuals whose income makes them ineligible for regular Medicaid, but who cannot afford adequate health care.
Authority	Special Federal Medicaid Waiver; not an entitlement program.	Optional coverage under Title XIX; an entitlement program.
Target Population	Individuals 65 and older and receiving Social Security and eligible for Medicare. Individuals determined disabled by SSA and receiving Social Security disability payments and eligible for Medicare (includes those awaiting the 24-month eligibility period).	Individuals 65 and older and individuals who are blind or disabled, as determined by SSA or by the DPW's Bureau of Medical Affairs.
Medical Eligibility	Must meet Medicaid's nursing home level of care criteria, as determined by MDO staff.	No institutional medical criteria.
Income Eligibility	An individual's monthly income must exceed the appropriate SSI community standard up to $1008.00, the institutional cap (as of 1/1/86).	Medically Needy Income Levels (MNIL) are based on 133-1/3% of AFDC payment levels (family size 2 or more). "Excess" income may be reduced to MNIL using incurred medical expenses.
	Spousal and parental income are <u>not deemed</u> to be available to the applicant.	Spousal and parental income are deemed to be available to the applicant.

January, 1986

Assets	An individual's own assets may not exceed $1,700 (as of 1/1/86). Additional funds may be set aside for burial, with the amount above the ($1,500) burial exclusion counted toward the resource limit. Spousal and parental assets are <u>not</u> deemed to be available to the applicant.	Asset limits are set at 200% of SSI standard, at $3,400 for an individual and $5,100 for a couple. Spousal and parental assets <u>are</u> deemed to be available to the applicant.
Cost-Share Liability or Spend-Down	Individuals may be required to share in the cost cost of care, after program eligibility has been established. The individual's monthly income is reduced by: . $367.25 (SSI maintenance standard) . $ 75.00 (State funds) . Individual's monthly medical/remedial deductions. After the above allowable deductions, the individual is billed for the monthly cost-share liability.	For applicant(s) with income above the appropriate MNIL, incurred medical expenses may be used to spend down to the standard. Prospective eligibility is calculated for the entire 6-month period. Incurred medical expenses of individuals as well as those incurred by an ineligible spouse or parent will be counted toward the spend-down liability when income is deemed.
Financial Eligibility	Financial eligibility is determined initially by the county welfare agency and redetermined annually. Individuals remain on the program until determined otherwise.	Financial eligibility is determined initially by the county welfare agency for a six-month period. An individual's eligibility is then terminated and reapplication must take place.
Retroactive Eligibility	Individual is eligible for services from the date of enrollment. There is no three-month retroactivity allowed under this program.	Coverage will be provided for unpaid services included in the program in the three-month period prior to the month of application. Unpaid medical bills can <u>either</u> be included as incurred expenses to establish eligibility or paid retroactively for covered services.

Service Package	Home Health Medical Day Care Medical Transportation Social Adult Day Care Respite Care (at home or in LTCF) Homemaker Case Management* * A health care professional plans, locates, coordinates, monitors services selected to meet an individual's health needs, and assists with cost-share requirements. (These services complement the Medicare Programs.)	Physicians Psychologists Freestanding Clinics Optometric Services Optical Appliances Medical Supplies and Equipment Laboratory and X-ray Podiatrist Dentist Medical Transportation Home Health Personal Care Assistant Medical Day Care Hearing Aids
Service Limits	The cost of community services reimbursed by Medicaid must be 70% or less than the cost of nursing home care, individually determined. The total service plan is prior authorized by Medicaid staff in the MDO and monitored by the case manager, assigned to each individual.	Normal Medicaid service limits apply. Normal prior authorization by Medicaid staff of certain services is required. Costs of total care is not monitored on an individual basis.
Program Limits	Limited to 1,800 slots. Program is renewed every three years upon request of the State and approved by the HCFA.	No limits; Medically Needy is an expansion of the regular Medicaid Program.

FACT SHEET

Showing Advantages/Disadvantages

Community Care Program for the Elderly and Disabled vs. Medically Needy

Advantages to Recipient

CCPED

Provides long-term care.

Provides a case manager for each recipient.

No deeming of spousal or parental income/assets.

Although there is a cost-share requirement the State assumes up to $75 per month and medical/remedial expenses are deducted.

"Anyone" can pay the cost-share.

If the recipient has no income/asset change, financial eligibility for program continues indefinitely.

Provides respite care services.

Medically Needy

Larger service package with no cap on most services.

No cost-share liability after spend-down to establish eligibility. Individuals are responsible for medical expenses used to satisfy spend-down liability.

Higher asset standard for eligibility.

Ineligible parental or spousal incurred medical bills can be used for spend-down, in most instances.

Medical bills paid retroactively for three-month period, once eligibility is established.

Disadvantages to Recipient

Limited service package.

Cost-share liability for some recipients.

Service cap (70%of nursing home costs).

Medical eligibility requirement that individuals meet nursing home care criteria.

Asset standard lower.

No retroactive eligibility.

Limited number of program slots (1,800)

Service packages are designed for the specific needs of the different covered groups.

Financial eligibility determination process is administratively cumbersome because of spend-down.

Eligibility terminates after six months and reapplication is required.

Parental/spousal income/assets are deemed to applicant.

There is no professional assigned to assist in coordinating/monitoring spend-down or service plan (as in CCPED case management).

Individual must spend-down to $333/month, which is lower than the $367.25 minimum standard for CCPED.

January 1986

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

COMPARISON OF MODEL WAIVER AND MEDICALLY NEEDY PROGRAMS AS RELATED TO BLIND OR DISABLED CHILDREN AND ADULTS

Feature	Model Waiver	Medically Needy
Purpose	To enable individuals with long-term care needs to remain in the community or to return to the community rather than be cared for in a hospital or nursing home.	To provide certain Medicaid services to individuals whose income makes them ineligible for regular Medicaid but who cannot afford adequate health care.
Authority	Special Federal Medicaid Waiver; not an entitlement program.	Optional coverage under Title XIX; an entitlement program.
Target Population	Individuals must be blind or disabled children and adults, as determined by Social Security Administration or by the DPW's Bureau of Medical Affairs.	Individuals must be blind or disabled children and adults, as determined by Social Security Administration or by the DPW's, Bureau of Medical Affairs.
Medical Eligibility	Individuals must meet, at a minimum, Medicaid's nursing home level of care criteria, as determined by MDO staff.	No additional medical criteria other than above.
Income Eligibility	An individual's monthly income must exceed the appropriate SSI community standard up $1,008, the institutional cap (as of 1/1/86) or be ineligible in the community because of SSI Deeming Rules.	The Medically Needy Income Level (MNIL) for all categories of eligibles, for household sizes of 2 and above, is based on 133-1/3% of the AFDC payment level.
	Spousal and parental income are <u>not deemed</u> to be available to the applicant.	Spousal and parental income is deemed.

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Assets	An individual's own assets may not exceed $1,700 (as of 1/1/86). Additional funds may be set aside for burial, with the amount above the ($1,500) burial exclusion counted toward the resource limit. Spousal and parental assets are not deemed to be available to the applicant.	The asset limit is set at 200% of the current level under SSI; $3,400 for an individual (as of 1/1/86), $5,100 for a couple, plus $100 for each additional member of the filing unit. Spousal and parental assets are deemed to be available to the applicant.
Cost-Share Liability or Spend-Down	Individuals may be required to share in the cost of care after program eligibility has been established. The individual's monthly income is reduced by: . $367.25 (SSI maintenance standard) . $ 75.00 (State funds) . Individual's monthly medical/remedial deductions. After the above allowable deductions, the individual is billed for the monthly cost-share liability.	Individuals with income and resources within the MNIL limits (non-spend-down) are automatically eligible; for applicants with excess income, eligiblity is established when incurred medical expenses equal the difference between income and the MNIL for the budget period. Incurred medical expenses of individuals, as well as those incurred by an ineligible spouse or parent may be counted toward the spend-down liability.
Prescreening	Inquires are directed to the Office of Home Care Programs in DMAHS' Central Office as the initial step in determining an individual case's applicability for the program.	There is no prescreening.
Financial Eligibility	Formal application is made to the county welfare agency. Eligibility is determined initially and redetermined annually.	Eligibility is determined initially by the county welfare agency for a six-month period. An individual's eligibility is then terminated and reapplication must take place.

Retroactive Eligibility	Individual is eligible for services from the date of enrollment. There is no three-month retroactivity allowed under this program.	Coverage will be provided for unpaid services included in the program in the three-month period prior to the month of application. Unpaid medical bills can either be included as incurred expenses to establish eligibility or paid once eligibility is established, either prospectively or during the three-month retroactive period.
Service Package	All Medicaid State Plan services are covered except for nursing home care. In addition case management* service is provided to each individual. * A health care professional plans, locates, coordinates, monitors services selected to meet an individual's health needs, and assists with cost-share requirements.	BASIC PACKAGE Physicians Psychologists Freestanding Clinics Optometric Services Optical Appliances Laboratory and X-ray Dentists Medical Transportation Home Health Personal Care Assistant AGED, BLIND DISABLED Podiatry Medical Supplies/ Equipment Medical Day Care Hearing Aids CHILDREN Prosthetics Orthotics Prescribed Drugs
Service Limits	Each individual's service package must be no more than the cost of comparable institutional care.	Normal Medicaid service limits apply.
	The total service plan is prior authorized by Medicaid staff in the MDO and monitored by the case manager, assigned to each individual.	Normal prior authorization by Medicaid staff of certain services is required. Cost of total care is not monitored on an individual basis.
Program Limits	Limited to 50 individuals statewide per waiver program. The DMAHS presently has two approved Model Waivers and one more in process. Program is renewed every three years upon request of the State and approval by HCFA.	No limits; Medically Needy is an expansion of the regular Medicaid Program.

FACT SHEET

Showing Advantages/Disadvantages

Model Waiver vs. Medically Needy

Advantages to Recipient

Model Waiver	Medically Needy
Provides all State Plan services, including inpatient hospital care.	Limited service package, but no cap on most services.
Provides a case manager for each recipient	No cost-share liability after spend-down to establish eligibility.
No deeming of spousal or parental income/ assets.	Higher asset standard for eligibility.
Although there is a cost-share requirement, the State assumes up to $75 a month and medical/remedial expenses are deducted.	Ineligible parental or spousal incurred medical bills can be used for spend-down.
"Anyone" can pay the cost-share.	Covered medical bills paid retroactively for three-month period, once eligibility is established.
If the recipient has no income/asset change, financial eligibility for program continues indefinitely.	

Disadvantages to Recipient

Cost-share liability for some recipients.	Financial eligibility determination process is administratively cumbersome because of spend-down.
Service cap (100% of institutional costs).	
Medical eligibility requirement that individuals meet nursing home care criteria.	Eligibility terminates after six months and reapplication is required.
Asset standard lower.	Parental/spousal income/assets are deemed available to applicant.
No retroactive eligibility.	No case management services.
Limited number of program slots (50).	Individual must spend-down to $333/month which is lower than the $367.25 minimum standard for Model Waiver.

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