CHAPTER 71

MEDICAID ONLY MANUAL

Authority

N.J.S.A. 30:4D–3, 7, 7a, 7b and 7c.

Source and Effective Date

R.1995 d.651, effective November 17, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Executive Order No. 66(1978) Expiration Date

Chapter 71, Medicaid Only Manual, expires on November 17, 2000.

Chapter Historical Note

The Medicaid Only Manual was adopted as R.1976 d.157 and originally codified as N.J.A.C. 10:94, effective July 1, 1976. See: 7 N.J.R. 464(d), 8 N.J.R. 287(d). Amendments became effective April 1, 1977 as R.1977 d.57. See: 8 N.J.R. 556(b), 9 N.J.R. 126(b). Further amendments became effective October 1, 1977 as R.1977 d.336. See: 9 N.J.R. 341(a), 9 N.J.R. 479(c).

Revisions for 1978: Revisions became effective April 1, 1978 as R.1978 d.73. See: 10 N.J.R. 13(c), 10 N.J.R. 153(a). Further amendments became effective June 22, 1978 as R.1978 d.212. See: 10 N.J.R. 190(c), 10 N.J.R. 344(c). Further amendments became effective August 23, 1978 as R.1978 d.296. See: 10 N.J.R. 106(a), 10 N.J.R. 443(a).

Revisions for 1979: Revisions became effective May 17, 1979 as R.1979 d.198. See: 11 N.J.R. 193(a), 11 N.J.R. 283(d). Further revisions became effective July 1, 1979 as R.1979 d.257. See: 11 N.J.R. 282(b), 11 N.J.R. 382(b). Further amendments became effective November 1, 1979 as R.1979 d.364. See: 11 N.J.R. 379(b), 11 N.J.R. 519(e). Further amendments became effective November 13, 1979 as R.1979 d.449. See: 11 N.J.R. 518(a), 11 N.J.R. 527(d).

Revisions for 1980: Revisions became effective January 16, 1980 as R.1980 d.27. See: 11 N.J.R. 557(b), 12 N.J.R. 86(b). Further revisions became effective May 1, 1980 as R.1980 d.187 and d.188. See: 12 N.J.R. 125(a), 12 N.J.R. 322(b). Further revisions became effective July 1, 1980 as R.1980 d.223. See: 12 N.J.R. 324(b).

Revisions for 1981: The text of Subchapters 4 and 5 was completely replaced effective June 4, 1981 as R.1981 d.177. See: 12 N.J.R. 663(a), 13 N.J.R. 364(b). An emergency amendment became effective July 1, 1981 as R.1981 d.276. See: 13 N.J.R. 501(a). The concurrent proposal of this emergency amendment was adopted effective September 24, 1981 as R.1981 d.385. See: 13 N.J.R. 501(a), 13 N.J.R. 773(a).

Revisions for 1982: Amendments became effective August 31, 1982 as R.1982 d.314. See: 14 N.J.R. 758(a), 14 N.J.R. 1058(a). Further amendments became effective October 18, 1982 as R.1982 d.354. See: 14 N.J.R. 816(a), 14 N.J.R. 1162(c).

Revisions for 1983: Amendments became effective June 6, 1983 as R.1983 d.167. See: 15 N.J.R. 422(a), 15 N.J.R. 925(b). Subchapter 3 was readopted effective July 20, 1983 as R.1983 d.317. See: 15 N.J.R. 948(a), 15 N.J.R. 1382(a). Subchapters 4 and 5 were readopted effective August 22, 1983 as R.1983 d.373. See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a). Further amendments became effective August 30, 1983 as R.1983 d.381. See: 15 N.J.R. 1187(a), 15 N.J.R. 1585(a). Further amendments became effective September 6, 1983 as R.1983 d.373. See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a). An emergency rule and concurrent proposal became effective December 19, 1983 (operative January 1, 1983). See: 15 N.J.R. 1733(a), 15 N.J.R. 2171(a).

Revisions for 1984: Amendments became effective June 18, 1984 as R.1984 d.244. See: 16 N.J.R. 684(a), 16 N.J.R. 1611(a). An emergency adoption became effective September 28, 1984 (operative October 1, 1984) as R.1984 d.467. See: 16 N.J.R. 2845(a). The concurrent proposal of this emergency amendment was adopted effective November 28, 1984 (with amendments effective January 1, 1985) as R.1984 d.566. See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).

Revisions for 1985: Amendments became effective April 15, 1985 (operative May 1, 1985) as R.1985 d.169. See: 17 N.J.R. 39(a), 17 N.J.R. 969(b). Amendments became effective September 16, 1985 as R.1985 d.474. See: 17 N.J.R. 1525(a), 17 N.J.R. 2274(a). An emergency amendment became effective December 27, 1985 (operative January 1, 1986, expires February 24, 1986) as R.1985 d.714. See: 18 N.J.R. 215(a).

Revisions for 1986: Subchapters 7, 8 and 9 were readopted effective January 6, 1986 with amendments effective February 3, 1986 as R.1986 d.5. See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a). Further amendments became effective February 24, 1986 as R.1986 d.74. See: 18 N.J.R. 215(a), 18 N.J.R. 565(a). Further amendments became effective March 3, 1986 as R.1986 d.53. See: 17 N.J.R. 2732(a), 18 N.J.R. 484(a). Further amendments became effective March 17, 1986 as R.1986 d.71. See: 17 N.J.R. 2522(a), 18 N.J.R. 564(b). Further amendments became effective April 7, 1986 (operative May 1, 1986) as R.1986 d.97. See: 17 N.J.R. 2954(a), 18 N.J.R. 691(a). Further amendments became effective May 5, 1986 (operative June 2, 1986) as R.1986 d.165. See: 17 N.J.R. 2524(a), 18 N.J.R. 985(b). An amendment to 10:71–4.2 and repeal of 10:71–4.3 became effective December 15, 1986 as R.1986 d.481. See: 18 N.J.R. 542(a), 18 N.J.R. 2457(a).

The Medicaid Only Manual, originally adopted as N.J.A.C. 10:94, was recodified as N.J.A.C. 10:71, effective March 16, 1987. See: 19 N.J.R. 466(e).

Pursuant to Executive Order No. 66(1978), Chapter 71 was readopted as R.1991 d.33, effective December 24, 1990. See: 22 N.J.R. 3357(a), 23 N.J.R. 215(a). Pursuant to Executive Order No. 66(1978), Chapter 71 was readopted as R.1995 d.651, effective November 17, 1995. See: Source and Effective Date. See, also, section annotations.

Law Review and Journal Commentaries

Healthy Financial Planning for Nursing Home Care. Michael K. Feinberg, 138 N.J.Law. 33 (Mag.) (Jan./Feb. 1991).

Nursing Homes in the Garden State: A Legal Perspective. Janice Chapin, 141 N.J.Law. 38 (Mag.) (July/August 1991).

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SUBCHAPTER 1. INTRODUCTION

10:71–1.1 General introduction

On January 1, 1974, Title XVI of the Social Security Act replaced previous Titles I (Old Age Assistance), X (Aid to the Blind) and XIV (Aid to the Disabled), which were repealed. The Social Security Administration administers Title XVI, Supplemental Security Income (SSI), which provides cash payments to the aged, blind and disabled. Individuals who desire medical care only apply through the county welfare board for the Medicaid Only program under Title XIX.

10:71–1.2 Choice of program by applicant

(a) An aged, blind or disabled person who desires Medicaid and does not wish to receive a money payment may apply for the Medicaid Only program. To qualify for this program, he/she must have financial eligibility as determined by the regulations and procedures set forth in this manual.

(b) Persons who are neither aged, blind nor disabled qualify for Medicaid benefits when they are determined by the county welfare board to be eligible for Title IV–A payments (Aid to Families with Dependent Children) or assistance to the families of the working poor (a State program). Persons whose eligibility is thus established may choose to receive Medicaid Only benefits without accepting money payments. Regulations governing these programs are set forth in the public assistance manual and assistance standards handbook.

10:71–1.3 Living arrangements

(a) Aged, blind and disabled persons who are living in the community and meet the requirements of the SSI program may receive Medicaid Only.

Cross References

Determination of continuing eligibility, see N.J.A.C. 10:71–8.1.

10:71–2.10 Collateral investigation

(a) "Collateral investigation" shall refer to contacts with individuals other than members of applicant's immediate household, made with the knowledge and consent of the applicant(s).

(b) The primary purpose of collateral contacts is to verify, supplement or clarify essential information.

(c) The applicants will usually be able to help select the most likely sources of information about themselves. If they are unwilling to have the necessary inquiries made and are unwilling to secure the required information from such sources themselves, then it shall be explained that the CWA will be unable to certify entitlement to Medicaid Only.

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

Home was non-liquid resource excluded from determining Medicaid eligibility as long as applicant agreed to liquidate within six months of application date. J.N. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 55.

10:71–2.11 Case recording

All pertinent information relating to the eligible applicant shall be recorded.

10:71–2.12 Recommendation for agency decision

The income maintenance (IM) worker is initially responsible for the recommendation for approval or denial. The IM worker will complete the work sheet and authorization for public assistance (PA–3A) and a copy will be sent to the Medicaid unit for preparation of the MAP–1. The statement of income available for nursing home payment (PA–3L) will be completed in appropriate cases.

10:71–2.13 Supervisory review and approval

(a) In most cases an IM worker will complete the investigation and processing of the application.

(b) All records shall be reviewed by a supervisory staff member prior to final disposition.

(c) Any difference of opinion between worker and supervisor shall be resolved by a conference, and, if necessary, the issue shall be referred to a higher administrative level for disposition.

(d) All records of application shall be approved in writing by the supervisor following review, either by signature or initialed transcript signature.

10:71–2.14 Disposition of application

(a) It is the intent of State law and policy that the normal method for disposing of applications recommended for approval shall be by the authority vested in the director of welfare to make decisions on eligibility for Medicaid Only. The director of welfare has the same authority to make case decisions other than approvals.

(b) The director may delegate such authority to any staff member or members as he/she may determine. He/she shall exercise this right of delegation in such a way as to assure the available at all times of some staff member possessing the requisite authority to make decisions and to authorize payment by the Division of Medical Assistance and Health Services.

(c) Applications which may be held for the welfare board are:

1. Those where immediate medical need is not indicated; or

2. Those where the director believes that there is valid cause to question the available evidence on any point of eligibility, or where the case presents a special problem;

3. If so held, the application shall be identified in the narrative portion of the minutes, and in each instance shall include a brief statement of the question or special problem involved and the decision of the board.

10:71–2.15 Notice of agency decision

Designation of personnel responsible for preparation of decision notices shall be at the discretion of the agency.

10:71–2.16 Retroactive eligibility for Medicaid

(a) All applicants for Medicaid Only shall be queried as to whether or not they have outstanding unpaid medical bills incurred within the three month period prior to the month of application for Medicaid Only. Those indicating the existence of such bills are to be supplied with an "Application for payment of unpaid medical bills," form FD–74, for completion. The intake worker will be responsible for assisting the applicant, where necessary, in the interpretation and completion of the application form (regardless of whether the individual is eventually determined to be eligible for public assistance). The intake worker will not be responsible for making a financial determination of eligibility for the three-month period in question.

(b) The applicant shall attach all outstanding unpaid medical bills to the FD–74 form and forward it to the:

Division of Medical Assistance and Health Services
Retroactive Eligibility Unit
CN 712 Mail Code 10
Trenton, NJ 08625–0712

(c) For individuals who are incapable of acting on their own behalf, an authorized agent can make application for retroactive Medicaid eligibility when there are outstanding medical bills. Such persons, at the time of application, should be provided with a form FD–74 for completion and submission to the retroactive eligibility unit with the unpaid medical bills attached.

(d) In the case of an individual who is deceased, an authorized agent, as defined above, may make application for retroactive Medicaid eligibility by obtaining an application form FD–74 from either the county welfare board or the Medicaid District Office.

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

Untimely application for three months retroactive benefits under Medicaid program was not waived and was properly denied. Estate of G.K. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 27.

SUBCHAPTER 3. ELIGIBILITY FACTORS

Law Review and Journal Commentaries

Protecting the Home in Government Benefits Planning. Gary Mazart, 164 N.J.Law. 34 (Mag.) (Oct. 1994).

10:71–3.1 General provisions

(a) Eligibility must be established in relation to each legal requirement to provide a valid basis for granting or denying medical assistance.

(b) The applicant's statements regarding his/her eligibility, as set forth in the application form, are evidence. The statements must be consistent and meet prudent tests of credibility. Incomplete or questionable statements shall be supplemented and substantiated by corroborative evidence from other pertinent sources, either documentary or nondocumentary:

1. Documentary sources of evidence present factual information recorded at some previous date by a disinterested party and filed as part of a record. Examples: certificates, legal papers, insurance policies, licenses, bills, receipts, notices of RSDI benefits, and so forth.

2. Nondocumentary sources of evidence are factual oral statements which appear to be reliable by individuals, based on the observation and personal knowledge of applicant's circumstances.

Case Notes

Comparison of Medicaid monthly income eligibility limits to those for the Medical Assistance to the Aged program; Medicaid income eligibility depends on participants' living arrangements (citing former N.J.A.C. 10:94–4.33 Table A). Texter v. Dept. of Human Services, 88 N.J. 376, 443 A.2d 178 (1982).

10:71–3.2 Citizenship; requirements

The applicant must be a resident of the United States who is either a citizen or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Case Notes

Medicaid regulation excluding illegal aliens from coverage not offensive to constitutional equal protection guarantee. Monmouth Medical Center v. Kwok, 183 N.J.Super. 494, 444 A.2d 610 (App.Div.1982).

10:71–3.3 Citizenship; definitions

(a) A person born in the United States is, by definition, a United States citizen. The United States is defined as the Continental United States, Alaska, Hawaii, Puerto Rico, Guam, and the Virgin Islands of the United States. Native-born persons of American Samoa and Swain's Island are also regarded as citizens of the United States.

(b) Naturalized citizens are those persons upon whom United States citizenship is conferred after birth. This may be accomplished through individual or collective naturalization or, under certain conditions, citizenship may be derived from a naturalized parent. Thus, a child(ren) of a naturalized parent(s) is automatically considered a naturalized citizen(s). Women who themselves could be lawfully naturalized and, prior to September 22, 1992, were married to citizens, or were married to aliens who became citizens before that date, automatically became citizens. On and after that date, standard immigration and naturalization service conditions have to be met before any person can become a naturalized citizen:

1. A naturalized citizen, unless automatically naturalized as outlined above, should have his/her naturalization certificate as proof of citizenship. If the applicant does not have this document, the county welfare board should contact the nearest Immigration and Naturalization Service district office to verify that the applicant meets the requirements of a naturalized citizen.

(c) The status of an alien shall be verified by means of one of the following:

1. An alien who is legally in the United States should have documentation to that effect since he/she is required by law to carry it. The alien should have in his/her possession a Form I–151, Alien Registration Receipt Card, or an older form AR–3 and AR–3a, Alien Registration Receipt Card, or a reentry permit. Any of those cards can be accepted as verification that the alien has been lawfully admitted to the United States for permanent residence. If the applicant does not have any one of these documents, the CWA should contact the nearest Immigration and Naturalization Service district office to verify that the applicant is lawfully admitted to the United States.

2. There are special sections of the Immigration and Nationality Act which allow the Attorney General discretion in allowing conditional entry into the United States. Entry into the United States may be for reasons of national catastrophe, persecution or fear of persecution on account of race, religion, or political opinion, and so forth. Individuals in these categories will have form I–94, Arrival–Departure Record, citing the section of the Immigration and Nationality Act under which admitted. This form will be acceptable evidence of permanent residence.

3. An alien who is lawfully admitted for a specific period of time only will be in possession of one of the following documents: Arrival–Departure Record (I–94) for aliens other than parolees or refugees; Canadian border crossing guard (I–185); Mexican border visitors permit (SW–434); crewman's landing permit (I–95A); crewman's landing permit and identification card (I–184). Such persons are not eligible for participation in the Medicaid Only program.

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

10:71–3.4 Residence requirement

An applicant for or recipient of Medicaid Only shall be a resident of the State of New Jersey.

10:71–3.5 Resident defined

(a) The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

(b) County residence is not an eligibility requirement and relates only to identification of the CWA charged by law with responsibility for the official receipts, registration, and processing of applications. The CWA is responsible for institutionalized (including nursing homes, intermediate care facilities, and sheltered boarding homes) applicants and recipients within its county regardless of previous county of residence.

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

10:71–3.6 Change of county residence

(a) Responsibility for case management shall be transferred from one county to the other when a recipient moves to another county.

(b) A temporary visit by the recipient shall not be considered to be a change of county residence until that visit has continued for more than a three month period.

1. Whenever it is determined that a recipient whose application has not been validated has changed or is planning to change his/her residence from one county to another the CWA of origin shall continue medical assistance while completing validation, subject to the time limits set forth in the application process, then transfer the case without delay to the receiving county in accordance with the next paragraph. If the CWA of origin is in the process of obtaining medical records, it shall complete the process and forward the medical records to the receiving county.

2. Whenever it is determined that a recipient whose application has been validated is planning to change his or her residence from one county to another, it shall be the responsibility of the CWA directors of the two counties concerned to effect the transfer without interruption of medical assistance.

3. The county of origin shall initiate and the receiving county shall, on request, immediately cooperate in accomplishing a full investigation of the circumstances surrounding the move.

4. If the move is permanent and the case warrants continued medical assistance, transfer of the case shall be accomplished expeditiously by discontinuance of medical assistance in the county of origin and award of medical assistance in the receiving county, to occur simultaneously in the first month for which the CWA directors mutually so arranged.

5. The welfare of the client shall not be adversely affected and his or her right to uninterrupted medical assistance if in need shall not be prejudiced by disagreement or other administrative difficulty between the counties. Any adverse change in grant resulting from transfer requires timely notice.

i. Since the Medicaid Only client retains the same Medicaid number when he or she moves from one county to another, the county of origin shall not terminate the client from the Medicaid status file, but only from its own register.

(c) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (d) and (e) below.

(d) Applicants: Applicants are those individuals applying for Medicaid in the county of origin who move to the receiving county before the eligibility determination has been completed.

1. County of origin: The county of origin has the responsibility to:

i. Complete the eligibility determination process;

ii. Accrete the individual to the Medicaid Status File (MSF) with the correct effective date of Medicaid eligibility and the new address (in the receiving county); and

iii. Within five working days of the eligibility determination, transfer the case record material to the receiving county in accordance with (e)1i through iv below.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative upon receipt of the case material to advise of the continued receipt of medical assistance; and

ii. Notify immediately in writing the county of origin of the date the case material was received.

(e) Recipients: Recipients include all individuals determined eligible for Medicaid Only.

1. County of origin: The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent PA–1G form (including all verification), Social Security numbers, the recipient's new address in the receiving county, and PA–3L form, completed with the individual's circumstances current as of the month of the transfer;

ii. Send with the above case material a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;

iii. Forward promptly to the receiving county copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any case material described in (e)1i or iii above.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative when case material is received. Such communication shall arrange for the client and/or the client's authorized representative to make application within 10 working days of the contact to ensure uninterrupted receipt of medical assistance;

ii. Notify immediately in writing the county of origin of the date the initial case material was received;

iii. Determine eligibility for the individual. Identify and resolve questions of the eligibility determination made by the county of origin and receiving county. Advise the county of origin of any discrepancies in the eligibility determinations between the two counties;

iv. Certify eligibility for medical assistance (provided application to transfer has been made) effective for the next month if the initial case material has been received before the 10th of the month;

v. Certify eligibility for medical assistance (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such material is received on or after the 10th of the month;

vi. Update the Medicaid Status File (MSF), if necessary. If the individual is determined eligible for Medicaid Only in the receiving county, there shall be no interruption of Medicaid eligibility and no change to the MSF is necessary. If the individual is determined ineligible for Medicaid Only in the receiving county, Medicaid eligibility shall be terminated, subject to timely and adequate notice, and the individual deleted from the MSF; and

vii. Notify the county of origin of the date eligibility for medical assistance will begin or will be terminated in the receiving county.

(f) Any case for which transfer procedures in (c) through (e) above are not begun within 30 days of the date of original referral, shall be promptly reported by the county of origin to the Division of Medical Assistance and Health Services by letter, setting forth the pertinent available facts. This does not mean that the actual transfer must be completed within 30 days, but rather that the procedures shall be commenced within that time.

Amended by R.1986 d.8, effective February 3, 1986.
See: 17 N.J.R. 2523(a), 18 N.J.R. 275(a).
Old (c) deleted; new (c)—(e) added; old (d) recodified to (f).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71–3.7 Eligibility of recipients who leave New Jersey

(a) Whenever a recipient wishes to leave New Jersey either to establish a permanent residence or for a temporary visit, he/she shall be advised of the effect of this plan on his/her eligibility for continued assistance. Particular care should be taken to advise the recipient how to present his/her New Jersey Medicaid validation stub and instruct the provider where to send the bill, should the recipient need medical care or hospitalization while out of the State on an approved temporary visit.

(b) It shall be the policy of this State that if a recipient leaves New Jersey with intent to establish a permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, or if he/she decides to remain indefinitely in the place outside New Jersey to which he/she had gone for a temporary visit, he/she ceases to be eligible to receive assistance.

(c) Visits by a recipient for a period of not more than 30 days will be permitted without affecting the recipient's eligibility. Absence for longer periods of time must be approved by the Division of Medical Assistance and Health Services.

10:71–3.8 Medicaid eligibility for individuals who enter New Jersey in order to secure medical care

(a) Federal and State statute and regulations expressly bar a duration-of-residence requirement as a condition of eligibility. The New Jersey Medical Assistance and Health Services Act authorizes a grant of medical assistance to a qualified applicant who is a resident of the State which " . . . means a person living, other than temporarily, within the State."