GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

New Jersey, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

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Version: 1.0 (November 2023)

This project is funded by the National Institutes of Health, National Institute of Aging, R01 AG030153.

Please cite as "Gateway to Global Aging Data (2024). *Gateway Policy Explorer: New Jersey, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2023*, Version: 1.0 (November 2023), University of Southern California, Los Angeles. https://doi.org/10.25553/gpe.ltc.kb.u34"

Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/app/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

New Jersey, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in New Jersey are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In New Jersey, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, New Jersey's Medicaid LTC system has been subject to two major policy reforms: the introduction of a new home and community-based LTC program in 2009, and the implementation of managed long-term services and supports in 2012, an LTC program that shifted most LTC services to managed care.

Key Dates

First law: 1965

Major changes since 1992: 2009, 2012

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* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2008

Overview

Long-term care (LTC) benefits in New Jersey are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in New Jersey is administered at the state level by the New Jersey Department of Human Services (NJDHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New Jersey are mostly provided through state plan benefit programs (Personal Care Assistant Program - PCAP, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Community Care Program for the Elderly and Disabled - CCPED).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCAP and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by the CCPED are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and social adult day care (SADC). Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for the CCPED program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. PCAP and Home Health require the individual to have a medical necessity for services, while Nursing Facility and CCPED beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration. In New Jersey, this became effective in 1998. Additionally, in 2006, New Jersey implemented the home equity limit. From February 2006, individuals applying for Medicaid coverage of nursing facility services or community-based LTC (state plan HCBS such as Home Health are excluded) are ineligible if the equity interest in the individual's home exceeds $750,000 (NJDHS, 2011a).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New Jersey Law for Medicaid

- New Jersey Medical Assistance and Health Services Act (N.J. Stat. § 30:4D)
- New Jersey Administrative Code Title 8: Health (N.J.A.C. Tit. 8)
- New Jersey Administrative Code Title 10: Human Services (N.J.A.C. Tit. 10)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for New Jersey Medicaid spending on beneficiaries in fiscal year 1992 was 50.00%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50.00% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New Jersey Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New Jersey.

Eligibility for Medicaid in New Jersey for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: From February 2006, the equity interest in the individual's home may not exceed $750,000, or else they will be ineligible for LTC services (NJDHS, 2011a).[3]
  - Citizenship/immigration requirements: The applicant must be a New Jersey resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[4] As of 1998, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1992, this was $1,266 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[7]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.

    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., CCPED).
- 2b. Federal poverty level (FPL) aged and disabled
    - Income requirements: Monthly income may not exceed 100% of the FPL. In 1992, this was $568 for an individual and $766 for a couple (NJDHS, 1992b). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
    - Asset requirements: Resources may not exceed $4,000 for an individual and $6,000 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[7]
        - Asset transfer & Home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, and disabled
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a six-month period to be equal to or less than the medically needy income level (MNIL). In 1992, this was $350 for an individual and $433 for a couple (HCFA, 1992). In July 1992, the standard increased to $433 for an individual, and $500 for a couple. Finally, on November 1, 1995, the standard changed to $367 for an individual and $434 for a couple, where it remains (NJDHS, 1992c). Valid expenses include medical care and other types of remedial care. From 1995, additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
    - Asset requirements: Same asset requirements as eligibility track 2b.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (NJDHS, 2023):

- Breast and Cervical Cancer program: Implemented in 2001, uninsured low-income women who have been screened for early detection may be eligible for Medicaid.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Assistant Program (PCAP), Home Health Services

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Nursing Facility Care

Beyond meeting minimum level of dependence requirements, applicants must be eligible for Medicaid through an eligibility track other than 3a (medically needy). From 1995, New Jersey expanded nursing facility care coverage to the medically needy population (NJDHS, 1995a).

Community Care Program for the Elderly and Disabled (CCPED)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 and eligible for Medicaid through an eligibility track other than 3a (medically needy) (Bovbjerg, et. al., 1998). If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care
- AIDS Community Care Alternatives Program

Benefit

Home care benefit

PCAP

PCAP provides personal care services, which include (NJDHS, 2023b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Personal care services are limited to 40 hours per week (standard maximum of 25 hours and an additional 15 if the physician's order states that it is needed). From 2006, the limit increased to 40 hours per week with no additional documentation needed for requests of 25 or more hours (38 N.J.R. 2810(a), 2006a). From 2008, PCAP offered the Personal Preference Program (PPP), an option that allows individuals to direct and manage their own services.

Home Health Services

Home Health provides (NJDHS, 2023b):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

When the cost of home health care is equal to or in excess of the cost of institutional care over a protracted period (six months or more), the New Jersey Medicaid may opt to limit or deny the provision of services on a prospective basis.

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

CCPED

CCPED provides the following services in addition to those offered under the state plan, unless otherwise noted (HCFA, 1992):

- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only) —this service may be received in addition to PCAP or Home Health services (i.e., if the individual requires more care than what is provided under the state plan programs)

Semi-residential care

PCAP, Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

CCPED

CCPED provides social adult day care (SADC), a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care (NJDHS, 1988).

Residential care

PCAP, Home Health Services, CCPED

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities (NJDHS, 2023b):

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment

From 1994, New Jersey removed distinctions between SNFs and ICFs in their administrative code, and instead referred to all LTC facilities as "nursing facilities." However, the New Jersey state plan still retains these distinctions.

Other benefits

New Jersey Medicaid provides additional benefits related to LTC (NJDHS, 2023b):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

CCPED

CCPED provides the following services in addition to those offered under the state plan, unless otherwise noted (NJDHS, 1988):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New Jersey Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PCAP

Personal care assistant services may be performed by a qualified individual in a recipient's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-3.9, 2019).

Home Health Services

Home health aide services must be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Registered professional nurses perform all skilled nursing services (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.1, 2019).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (42 CFR 483.30, 1992).

CCPED

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

PCAP services must be medically necessary and ordered by a physician in accordance with a plan of care (NJDHS, 2023b). From 2004, all PCAP provider agencies are required to obtain prior authorization before providing services. The authorization request details the days and number of hours of service needed by the beneficiary.

Home Health Services

Home Health services must be medically necessary and authorized by a physician (26 N.J.R. 364, 1994a).

Nursing Facility Care

The beneficiary must meet a nursing facility level of care (NFLOC), as determined by the Preadmission Screening (PAS) process, in order to be admitted to a nursing facility. Prior authorization is also required for all Medicaid-eligible individuals seeking admission to a Medicaid participating nursing facility (NJDHS, 2023). An NFLOC means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for a disease or related deficits. The beneficiary should also be dependent in several activities of daily living (ADLs) (N.J.A.C. 10:63-2.1-2, 1994; 38 N.J.R. 674a, 2006b; N.J.A.C. 8:85-2.1-2, 2018).

CCPED

The beneficiary must require at least one program service per month and meet an NFLOC in order to be admitted to the program, meaning they meet the clinical eligibility for nursing facility care but can be appropriately cared for in the community with supportive health care services (N.J.A.C. 10:63-1.11, 1994; NJDHS, 2009e).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months. Individuals eligible through eligibility track 3a (medically needy) must have eligibility renewed every 6 months (HCFA, 1992).

PCAP

Beneficiaries must be reassessed at least every 6 months or as needed based upon a change in condition (26 N.J.R. 364, 1994a; 50 N.J.R. 1992(b), 2018).

Home Health Services

The plan of care must be reevaluated by home health agency nursing staff at least every 2 months and revised as needed based upon a change in condition (26 N.J.R. 364, 1994a).

Nursing Facility Care

The need for care at a given level must be recertified as follows (NJDHS, 1985):

1. Recertification for SNF services, Level III must be conducted at least —
    - 30 days after the date of initial certification
    - 60 days after the date of initial certification
    - 90 days after the date of initial certification
    - Every 60 days days thereafter
2. Recertification for ICF services, Level IV-A or Level IV-B must be conducted at least —
    - 60 days after the date of initial certification (IV-A 30 days after initial certification)
    - 180 days after the date of initial certification
    - 12 months after the date of initial certification
    - 18 months after the date of initial certification
    - 24 months after the date of initial certification
    - Every 12 months thereafter

In 1994, the New Jersey Administrative Code (NJAC) was amended, and this section was repealed. Reassessment became required on a periodic basis, however, no timeline is provided (N.J.A.C. 10:63-1.12, 1994).

CCPED

The participant must be reassessed at least every 12 months.

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCAP, Home Health Services, Nursing Facility Care

There is no age requirement.

CCPED

The individual must be at least age 65, or age 18-64 and physically disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

Personal care is intended to accommodate beneficiaries with long-term, chronic, or maintenance health care, as opposed to short-term skilled care required for some acute illnesses (26 N.J.R. 364, 1994a). Eligibility is determined by the physician through the physician's order, and benefits are determined by a nurse's assessment from the providing agency.

Home Health Services

There are two levels of care for Home Health services provided upon request of the attending physician (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.1, 2019):

- Acute home health care —concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required
- Chronic home health care —either a long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required

Nursing Facility Care

Applicants must meet a Nursing Facility Level of Care (NFLOC). There are three tracks of care that qualify as an NFLOC, and the applicant's track is determined after the standardized assessment is completed (26 N.J.R. 3621, 1994). The track of care means the designation of the setting and scope of Medicaid services determined by the PAS process. In 2006, New Jersey added additional detail to the definitions for each track (38 N.J.R. 674a, 2006b). See Box 7 for the track of care definitions.

Applicants eligible for nursing facility admission are separated by level of care. Residential facility patients are those that do not require acute-level hospital care but, because of their mental or physical condition, require nursing care in an institutional setting. Eligible applicants are classified as either level III, "skilled nursing patient," or level IV-A or B, "intermediate care patient." A patient who is classified as level III will require more nursing care than a patient who is classified as level IV-A or level IV-B. The levels of care are defined as (16 N.J.R. 3621, 1984):

- SNF Level III: Patient requires continuous 24-hour availability of nursing personnel
- ICF Level IV-A: Patient requires substantial assistance with personal care needs involving ADLs
- ICF Level IV-B: Patient requires minimal assistance with personal care needs on a daily basis

From 1994, New Jersey removed distinctions between SNFs and ICFs in their administrative code, and instead referred to all LTC facilities as "nursing facilities." This removed the SNF/ICF definitions of dependence, but the three nursing facility tracks of care remained.

CCPED

Applicants for CCPED must meet an NFLOC for program admission. An NFLOC equates to Track III, meaning the applicant is eligible for long-term care services in a community setting. See Box 7 for more information on the tracks of care.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

Individuals must have a written physician's order (PA-4) that demonstrates a medical necessity for services. Once received, a registered nurse from the provider agency will perform an assessment, prepare a plan of care, and submit a prior authorization request. The plan of care includes the tasks assigned to meet the specific needs of the recipient, hours of service needed, and takes into consideration the recipient's strengths, the needs of the family, and short-term and long-term nursing goals (26 N.J.R. 364, 1994a).

Home Health Services

Individuals must obtain a written physician's order following a face-to-face encounter (telehealth included) with an authorized physician or practitioner (42 CFR 440, 1996). A plan of care will be developed by the attending physician and agency personnel following the physician's order (26 N.J.R. 364, 1994a). See Box 1 for more information on the plan of care. Once the physician approves and signs the plan of care, services will be authorized.

Nursing Facility Care

Individuals seeking admission to a Medicaid-covered nursing facility must complete the Preadmission Screening (PAS) process, where applicants receive a comprehensive needs assessment to determine their long-term care needs and the most appropriate setting for those needs to be met (N.J.A.C. 10:63-1.11, 1994).

The process begins with a referral to the New Jersey Department of Human Services (NJDHS) (or the New Jersey Department of Health and Senior Services - NJDHSS from 1996-2009) for PAS. The required documentation varies depending on where the applicant is being referred from.

- If the applicant is referred from a hospital, the hospital will identify potentially eligible individuals using the At-Risk Criteria for Nursing Facility Placement, a list of "at-risk" criteria to assist a hospital in determining if a referral for LTC services is indicated. See Box 2 for the at-risk criteria. If the patient is identified as potentially eligible for nursing facility care, the hospital will refer the patient for PAS by submitting the Hospital Preadmission Screening Referral (PAS-1a) form.
- If the applicant is referred from a nursing facility for Medicaid coverage of their care, nursing facility staff will refer the applicant by submitting the Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient (MCNH-33) form.
- If the applicant is referred from the community, a physician must submit the Certification of Need for Patient Care in Facility Other than Public or Private General Hospital (PA-4) form, or a physician statement that substantiates the individual's diagnosis and describes their care needs. See Box 3 for more information on the PA-4 form.

If the applicant is referred, Department staff conduct PAS using the PAS standardized assessment (PAS-1). The form assesses the applicant's functional and mental status, as well as medications, diagnoses, and other relevant medical information. See Box 4 for information on the PAS standardized assessment and N.J.A.C. 10:63 Appendix K (1994) to view the form. If the assessment indicates that they are clinically eligible for nursing facility care, they will be approved for coverage and the staff will develop a health services delivery plan (HSDP). If the assessment indicates that they are more suitable for a community setting, the applicant may be referred for assistance in accessing CCPED benefits or other community services (e.g., PCAP).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 5 for more information on the PASRR, and Box 6 for the MDS.

CCPED

CCPED follows the same evaluation process as Nursing Facility Care, described above (NJDHS, 2009e). Once an applicant is determined eligible, a plan of care will be created. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available. In 2006, the NJDHS began using the Minimum Data Set - Home Care (MDS-HC) for initial CCPED level of care evaluations. The MDS-HC assesses the cognitive and functional ability of the applicant, however, only certain assessment sections are used to determine level of care and program eligibility. The entirety of the assessment is used for both level of care and eligibility as well as to assist in the development of the applicant's plan of care. See Table 3 for more information on the MDS-HC, and Mass.gov (1999) to view the form.

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

A licensed physician must order personal care services. A registered nurse from the provider agency will conduct an initial nursing assessment and subsequent reassessments, and develop and periodically review the plan of care with the providing personal care assistant (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-3.9, 2019).

Home Health Services

A registered physician or practitioner must order home health services. A nurse from the provider agency will develop a plan of care, which will be reviewed and signed by the same physician (26 N.J.R. 364, 1994a; 38 N.J.R. 2810(a), 2006a; N.J.A.C. 10:60-2.2, 2019).

Nursing Facility Care, CCPED

A registered professional nurse employed by the New Jersey Department of Human Services conducts the standardized assessment (26 N.J.R. 3620, 1994b).

Benefit limitations

Can you mix LTC benefits?

Most New Jersey Medicaid beneficiaries receive the state plan benefit package. Individuals eligible for Medicaid under eligibility track 3a (medically needy) were ineligible for nursing facility care until 1995. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

In 1993, New Jersey implemented a Medicaid Estate Recovery program as required by federal law. Medicaid recovery allows the Medicaid agency to file a claim against the estate of a Medicaid recipient after their death. Estate recovery applies to those Medicaid recipients who were 65 years of age or older at the time of provision of the service. From November 9, 1995, the age was reduced to age 55 or older (NJDHS, 1995b).

PCAP, Home Health Services, CCPED

There are no copayments or similar charges imposed upon participants for program services (NJDHS, 1989; HCFA, 1992).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1992, the PNA was $35 per month (NJDHS, 2017).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2009-2011

Policy change in 2009
In 2009, the Community Care Program for the Elderly and Disabled (CCPED) was consolidated with two, smaller Home and Community-Based Services (HCBS) programs, the Assisted Living (AL) program and the Enhanced Community Options (ECO) program. The three programs were combined to form Global Options for Long-Term Care (GO LTC), a single, federally approved HCBS program.

Other reforms during this period:

- (2009) New Jersey began progressively increasing the transfer of asset look back period from 36 months to 60 months by 2011, where it remains for all assets (NJDHS, 2009c).
- (2010) The Minimum Data Set-Home Care (MDS-HC), or New Jersey Choice (NJ Choice) assessment tool was implemented statewide as the standardized assessment tool used in determining level of care for long-term care services. The assessment tool change resulted in slight modifications to other aspects of the level of care evaluation process, including expanded criteria and changes to the reevaluation form.
- (2011) Most individuals receiving care through the Personal Care Assistant Program (PCAP) began receiving these services through a managed care plan, rather than through the state plan fee-for-service system. While this changed the service delivery system and required individuals to enroll in managed care, it did not change the eligibility criteria for services.

Overview

Long-term care (LTC) benefits in New Jersey are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in New Jersey is administered at the state level by the New Jersey Department of Human Services (NJDHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New Jersey are mostly provided through state plan benefit programs (Personal Care Assistant Program - PCAP, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Global Options for Long-Term Care - GO LTC).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCAP and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by GO LTC are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and social adult day care (SADC). Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for the GO LTC program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. PCAP and Home Health require the individual to have a medical necessity for services, while Nursing Facility and GO LTC beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New Jersey Law for Medicaid

- New Jersey Medical Assistance and Health Services Act (N.J. Stat. § 30:4D)
- New Jersey Administrative Code Title 8: Health (N.J.A.C. Tit. 8)
- New Jersey Administrative Code Title 10: Human Services (N.J.A.C. Tit. 10)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for New Jersey Medicaid spending on beneficiaries in fiscal year 2009 was 61.59%. The federal government provided states with increased matching rates in response to the Great Recession, resulting in the higher FMAP for New Jersey during this time. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (61.59% in 2009), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New Jersey Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New Jersey.

Eligibility for Medicaid in New Jersey for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2009, the monthly federal benefit amount was $674 for an individual and $1,011 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[8]
    - Home equity limit: The equity interest in the individual's home may not exceed $750,000, or else they will be ineligible for LTC services (NJDHS, 2011a). As of 2011, this figure increased annually with inflation.[3]
  - Citizenship/immigration requirements: The applicant must be a New Jersey resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2023b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2009, this was $2,022 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in GO LTC and has a spouse residing in the community.[9]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized or enrolled in GO LTC and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., GO LTC).
- 2b. Federal poverty level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 2009, this was $903 for an individual and $1,215 for a couple (NJDMAHS, 2009). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in GO LTC and has a spouse residing in the community.[9]
  - Asset requirements: Resources may not exceed $4,000 for an individual and $6,000 for a couple. Additional asset disregards exist if a person is institutionalized or enrolled in GO LTC and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, and disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a six-month period to be equal to or less than the medically needy income level (MNIL). In 2009, this was $367 for an individual and $434 for a couple (NJDHS, 2023a). Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized or enrolled in GO LTC and has a spouse residing in the community.[9]
  - Asset requirements: Same asset requirements as eligibility track 2b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (NJDHS, 2023):

- Breast and Cervical Cancer program: Uninsured low-income women who have been screened for early detection may be eligible for Medicaid.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Assistant Program (PCAP), Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Global Options for Long-Term Care (GO LTC)

Beyond meeting minimum level of dependence requirements, applicants must be over age 65 or age 21-64 and physically disabled, and eligible for Medicaid through an eligibility track other than 3a (medically needy) (Medicaid.gov, 2011). If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care
- AIDS Community Care Alternatives Program
- Program of All-inclusive Care for the Elderly (PACE) —from 2009

Benefit

Home care benefit

PCAP

PCAP provides personal care services, which include (NJDHS, 2023b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Personal care services are limited to 40 hours per week (38 N.J.R. 2810(a), 2006a). PCAP offers the Personal Preference Program (PPP), an option that allows individuals to direct and manage their own services.

Home Health Services

Home Health provides (NJDHS, 2023b):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

When the cost of home health care is equal to or in excess of the cost of institutional care over a protracted period (six months or more), the New Jersey Medicaid may opt to limit or deny the provision of services on a prospective basis.

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

GO LTC

GO LTC provides the following services in addition to those offered under the state plan, unless otherwise noted (NJDHS, 2009e):

- Attendant care: Comprehensive home care benefit that provides physical assistance with ADLs and IADLs, as well as skilled nursing care as needed[11]
- Personal care services (as described above under the state plan)[12]
- Chore services: Non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual, such as cleaning appliances, washing windows, and scrubbing floors, and do not include normal everyday housekeeping tasks[13]

Semi-residential care

PCAP, Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

GO LTC

GO LTC provides social adult day care (SADC), a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care.

Residential care

PCAP, Home Health Services, GO LTC

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities (NJDHS, 2023b):

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board

- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment

From 1994, New Jersey removed distinctions between SNFs and ICFs in their administrative code, and instead referred to all LTC facilities as "nursing facilities." However, the New Jersey state plan still retains these distinctions.

Other benefits

New Jersey Medicaid provides additional benefits related to LTC (NJDHS, 2023b):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

GO LTC

GO LTC provides the following services in addition to those offered under the state plan, unless otherwise noted (NJDHS, 2009e):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Additional equipment and supplies that are necessary to address the participant's functional limitations
- Home-delivered meals: Nutritionally balanced meals delivered to the participant's home when meal provision is more cost effective than having a personal care provider prepare the meal
- Transportation: Additional coverage of non-medical transportation to community services and activities
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Caregiver training: Instruction provided to a participant or caregiver to teach a variety of skills necessary for independent living, such as the use of specialized or adaptive equipment and assistance with ADLs
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional community setting (e.g., moving expenses, housing deposits)
- Environmental accessibility and adaptations
- Transitional care management: Assistance in accessing HCBS for individuals currently reside in a nursing facility

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New Jersey Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PCAP

Personal care assistant services may be performed by a qualified individual in a recipient's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-3.9, 2019).

Home Health Services

Home health aide services must be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Registered professional nurses perform all skilled nursing services (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.1, 2019).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (42 CFR 483.30, 1992).

GO LTC

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

PCAP services must be medically necessary and ordered by a physician in accordance with a plan of care (NJDHS, 2023b). All PCAP provider agencies are required to obtain prior authorization from the beneficiary's MCO before providing services (NJDHS, 2015). The authorization request details the days and number of hours of service needed by the beneficiary.

Home Health Services

Home Health services must be medically necessary and authorized by a physician for the fee-for-service state plan benefit (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.2, 2018. If the beneficiary is enrolled in a managed care plan, they must obtain prior authorization from their MCO. Physician's orders are not required for MCO authorization, but must be readily available if requested by the plan (Horizon NJ Health, 2023).

Nursing Facility Care

The beneficiary must meet a nursing facility level of care (NFLOC), as determined by the Preadmission Screening (PAS) process, in order to be admitted to a nursing facility. Prior authorization is also required for all Medicaid-eligible individuals seeking admission to a Medicaid participating nursing facility (NJDHS, 2023). An NFLOC means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for a disease or related deficits. The beneficiary should also be dependent in several activities of daily living (ADLs) (N.J.A.C. 10:63-2.1-2, 1994; 38 N.J.R. 674a, 2006b; N.J.A.C. 8:85-2.1-2, 2018).

GO LTC

The beneficiary must require at least one additional program service beyond case management per month and meet an NFLOC in order to be admitted to the program (NJDHS, 2009e). An individual has met an NFLOC for the program if they meet one of the following:

- The individual requires limited assistance in three of the following ADLs —bathing, dressing, toileting, transferring, locomotion, bed mobility, and eating
- The individual has a cognitive deficit that affects short-term memory, procedural memory, and/or decision-making and judgment, requires supervision/cueing or a combination of limited assistance and supervision/cueing to complete three of the above-mentioned ADLs

From 2010, an NFLOC is met if the beneficiary receives an ADL index score of six or greater, or a Cognitive Performance Scale (CPS) score of three or greater, or requires a level of limited assistance or higher in all three of the following ADLs - bathing, dressing (upper or lower), and locomotion (indoors or outdoors) (CMS, 2011).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months. Individuals eligible through eligibility track 3a (medically needy) must have eligibility renewed every 6 months (HCFA, 1992).

PCAP

Beneficiaries must be reassessed at least every 6 months or as needed based upon a change in condition (26 N.J.R. 364, 1994a; 50 N.J.R. 1992(b), 2018).

Home Health Services

The beneficiary's physician must recertify and review the plan of care every 2 months (N.J.A.C. 10:60-2.2, 2018). Face-to-face encounters are not required for recertification.

Nursing Facility Care

Reassessment is required on a periodic basis, however, no timeline is provided (N.J.A.C. 10:63-1.12, 1994; 38 N.J.R. 674a, 2006b; N.J.A.C. 8:85-1.12, 2018).

GO LTC

The participant must be reassessed at least every 12 months (NJDHS, 2009e).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCAP, Home Health Services, Nursing Facility Care

There is no age requirement.

GO LTC

The individual must be at least age 65, or age 21-64 and physically disabled (NJDHS, 2009e).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

The PCA assessment tool determines the amount of PCA service hours that the applicant requires. The score given for each assessed area (i.e., score of 1-3) determines the amount of care hours the applicant will receive. Scores of 1, 2, and 3 directly correlate to the amount of service hours (e.g., score of 1 = 1 hour of service). See Horizon NJ Health (2013) to view the assessment form.

Home Health Services

There are two levels of care for Home Health services provided upon request of the attending physician (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.1, 2019):

- Acute home health care —concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required
- Chronic home health care —either a long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required

Nursing Facility Care

Applicants must meet a Nursing Facility Level of Care (NFLOC). There are three tracks of care that qualify as an NFLOC, and the applicant's track is determined after the standardized assessment is completed (26 N.J.R. 3621, 1994). The track of care means the designation of the setting and scope of Medicaid services determined by the PAS process (38 N.J.R. 674a, 2006b). See Box 7 for the track of care definitions.

GO LTC

Applicants must meet an NFLOC, which is defined as meeting either of the following:

- The individual requires limited assistance in three of the following activities of daily living (ADLs) —bathing, dressing, toileting, transferring, locomotion, bed mobility, and eating
- The individual has a cognitive deficit that affects short-term memory, procedural memory, and/or decision-making and judgment, requires supervision/cueing or a combination of limited assistance and supervision/cueing to complete three of the above-mentioned ADLs

From 2010, an NFLOC is met if the beneficiary receives an ADL index score of six or greater, or a Cognitive Performance Scale (CPS) score of three or greater, or requires a level of limited assistance or higher in all three of the following ADLs - bathing, dressing (upper or lower), and locomotion (indoors or outdoors) (CMS, 2011). ADL index means the RUG-III/HC case mix algorithms that include a summary measure of ADLs that combines scores for bed mobility, toileting, transferring and eating. Scores range from 4 (independent or supervision in all four areas) to 18 (severe impairment in all four areas). CPS means an assessment index with

the MDS-HC used to assess individuals on the basis of memory impairment, level of consciousness, and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

Individuals must have a written physician's order (PA-4) that demonstrates a medical necessity for services. Once received, a registered nurse from the provider agency will use the PCA Nursing Assessment Tool to determine need for services and amount of care required. The assessment collects information on the applicant's residence (e.g., barriers to mobility), and assesses cognition, ADLs, and IADLs. See Box 8 for more information on the PCA Nursing Assessment Tool, and Horizon NJ Health (2013) to view the assessment form.

Following the assessment, the nurse will submit the completed assessment and prior authorization request to the New Jersey Division of Disability Services (NJDDS), who will then make a determination regarding the hours of PCA services to be authorized (N.J.A.C. 10:60-3.9, 2019). If the beneficiary is receiving this service through a managed care plan, assessments and authorizations are conducted and coordinated by their managed care organization (MCO) (N.J.A.C. 10:60-3.4, 2019).

Home Health Services

Individuals must obtain a written physician's order following a face-to-face encounter (telehealth included) with an authorized physician or practitioner (42 CFR 440, 1996). A plan of care will be developed by the attending physician and agency personnel following the physician's order (26 N.J.R. 364, 1994a). See Box 1 for more information on the plan of care. Once the physician approves and signs the plan of care, services will be authorized. For individuals enrolled in managed care, all home health services must be determined to be medically necessary and prior authorized by the MCO before services are rendered (N.J.A.C. 10:60-2.2, 2019).

Nursing Facility Care

Individuals seeking admission to a Medicaid-covered nursing facility must complete the Preadmission Screening (PAS) process, where applicants receive a comprehensive needs assessment to determine their long-term care needs and the most appropriate setting for those needs to be met (26 N.J.R. 3620, 1994b).

The process begins with a referral to the New Jersey Department of Human Services (NJDHS) for PAS. The required documentation varies depending on where the applicant is being referred from.

- If the applicant is referred from a hospital, the hospital will identify potentially eligible individuals using the At-Risk Criteria for Nursing Facility Placement (LTC-D1), a list of "at-risk" criteria to assist a hospital in determining if a referral for LTC services is indicated. See Box 2 for the at-risk criteria. If the patient is identified as potentially eligible for nursing facility care, the hospital will refer the patient for PAS by submitting the Hospital Preadmission Screening Referral (LTC-4) form.
- If the applicant is referred from a nursing facility for Medicaid coverage of their care, nursing facility staff will refer the applicant by submitting the Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient (LTC-2) form.
- If the applicant is referred from the community, a physician must submit the Certification of Need for Patient Care in Facility Other than Public or Private General Hospital (PA-4) form, or a physician statement that substantiates the individual's diagnosis and describes their care needs. See Box 3 for more information on the PA-4 form.

If the applicant is referred, Department staff conduct PAS using the PAS standardized assessment (PAS-1). The form assesses the applicant's functional and mental status, as well as medications, diagnoses, and other relevant medical information. See Box 4 for information on the PAS standardized assessment and N.J.A.C. 10:63 Appendix K (1994) to view the form. If the assessment indicates that they are clinically eligible for nursing facility care, they will be approved for coverage and the staff will develop a health services delivery plan (HSDP). If the assessment indicates that they are more suitable for a community setting, the applicant may be referred for assistance in accessing GO LTC benefits or other community services (e.g., PCAP).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 5 for more information on the PASRR, and Box 6 for the MDS.

GO LTC

Applicants are evaluated using the Minimum Data Set - Home Care (MDS-HC). From 2010, the MDS-HC, renamed the NJ Choice assessment, was implemented statewide (CMS, 2011). The assessment evaluates the applicant's ability to perform ADLs and their

cognitive functioning, resulting in an ADL index score and Cognitive Performance Scale (CPS) score that determine level of care. See Table 3 for more information on the MDS-HC.

ADL index means the RUG-III/HC case mix algorithms that include a summary measure of ADL that combines scores for bed mobility, toileting, transferring and eating. Scores range from 4 (independent or supervision in all four areas) to 18 (severe impairment in all four areas). CPS means an assessment index with the MDS-HC used to assess individuals on the basis of memory impairment, level of consciousness, and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). See CMS (2001) for more information on how ADL index and CPS scores are calculated using the MDS. There are slight differences in item numbering between the MDS and MDS-HC, but scores are calculated similarly. Once an applicant is determined eligible, a plan of care will be created. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Only certain assessment sections within the MDS-HC are used to determine level of care and program eligibility. The entirety of the assessment is used for both level of care and eligibility as well as to assist in the development of the applicant's plan of care. The specific sections used to determine level of care are detailed in the Long-Term Care Re-Evaluation (WPA-1), the form used to reevaluate participants for program eligibility. The WPA-1 is a condensed assessment that only includes items from the MDS-HC that are calculated to determine level of care. The three sections include Functional Status, Social Support Network, and Physical Environment (MDSOAR, 2012; NJDHS, 2014). In 2011, the WPA-1 was modified slightly but remained substantively identical. See Box 9 for more information on the new WPA-1, and NJDHS (2014c) to view the form.

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

A licensed physician must order personal care services. A registered nurse from the provider agency will conduct an initial nursing assessment and subsequent reassessments, and develop and periodically review the plan of care with the providing personal care assistant (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-3.9, 2019).

Home Health Services

A registered physician or practitioner must order home health services. A nurse from the provider agency will develop a plan of care, which will be reviewed and signed by the same physician (26 N.J.R. 364, 1994a; 38 N.J.R. 2810(a), 2006a; N.J.A.C. 10:60-2.2, 2019).

Nursing Facility Care

A registered professional nurse employed by the New Jersey Department of Human Services conducts the standardized assessment (26 N.J.R. 3620, 1994b).

GO LTC

Initial MDS-HC/NJ Choice assessments are performed by a registered nurse or professional social worker. Case managers perform subsequent reevaluations (NJDHS, 2009e).

Benefit limitations

Can you mix LTC benefits?

All New Jersey Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, New Jersey enforces Estate Recovery. Medicaid recovery allows the Medicaid agency to file a claim against the estate of a Medicaid recipient after their death. Estate recovery applies to those Medicaid recipients who were 55 years of age or older at the time of provision of the service (NJDHS, 1995).

PCAP, Home Health Services, GO LTC

There are no copayments or similar charges imposed upon participants for program services (NJDHS, 1989; HCFA, 1992; NJDHS, 2009e).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2009, the PNA was $35 per month (NJDHS, 2017).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2012-2023

Policy change in 2012

In 2012, New Jersey received federal approval to implement a comprehensive, statewide reform that consolidated multiple home and community-based services (HCBS) programs and expanded coverage utilizing a managed care delivery system (NJDHS, 2014b). Most populations, including all aged, blind, and disabled coverage groups, were transitioned to managed care health plans that are coordinated by Medicaid-participating Managed Care Organizations (MCOs).

The new managed care system has two components. Individuals with a nursing facility level of care (NFLOC) may enroll in Managed Long-Term Services and Supports (MLTSS), while other enrollees requiring personal care or other state plan HCBS receive these services through their MCOs, which provide all state plan services including personal care services and adult day health care for those meeting the respective clinical eligibility criteria. Those enrolled in MLTSS receive acute, primary, and LTC services through a single MCO. By 2014, the Global Options for Long-Term Care (GO LTC) program was closed, and all participants were automatically enrolled in MLTSS.

Other reforms during this period:

- (2014) Medicaid expansion under the Affordable Care Act of 2010 (ACA) was implemented (NJDHS, 2014a). This expanded Medicaid coverage to adults between the ages of 19 and 64 under the newly adopted eligibility track 2c (ACA Expansion Adults). New Jersey briefly covered this group from 2011-2012 at a very low income threshold and did not cover LTC services.
- (2015) The Personal Care Assistant Program (PCAP) adopted a new PCA Nursing Assessment Tool statewide to determine eligibility for the program. The content of the new form was substantively identical to the form used in previous years, aside from time guidelines that were added to each assessment item (E.D. v. NJ Horizon Health, et. al., 2018).
- (2017) New Jersey raised the personal needs allowance (PNA) for nursing facility residents from $35 to $50 per month (NJDHS, 2017).
- (2018) Nursing reassessments for PCAP eligibility became required at least every 12 months, rather than every 6 months as in previous years (50 N.J.R. 1992(b), 2018).

Overview

Long-term care (LTC) benefits in New Jersey are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in New Jersey is administered at the state level by the New Jersey Department of Human Services (NJDHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in New Jersey are mostly provided through state plan benefit programs (Personal Care Assistant Program - PCAP, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Managed Long-Term Services and Suppors - MLTSS).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCAP and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by MLTSS are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Once a specific state plan benefit is determined to be medically necessary or an individual is determined eligible for MLTSS, the beneficiary may immediately receive care.

Benefit programs vary in dependence requirements. PCAP and Home Health require the individual to have a medical necessity for services, while Nursing Facility and MLTSS beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

During this policy period, the Global Options for Long-Term Care (GO LTC) program continued to operate until 2014, when it was closed and all participants were transitioned to MLTSS. For this reason, this program will not be detailed in this policy period (chapter). For information on GO LTC eligibility criteria and program details, please see the previous policy period (chapter).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)

New Jersey Law for Medicaid

- New Jersey Medical Assistance and Health Services Act (N.J. Stat. § 30:4D)
- New Jersey Administrative Code Title 8: Health (N.J.A.C. Tit. 8)
- New Jersey Administrative Code Title 10: Human Services (N.J.A.C. Tit. 10)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for New Jersey Medicaid spending on beneficiaries in fiscal year 2012 was 50.00%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50.00% in 2012), though there are exceptions for certain administrative functions and populations that may receive a higher federal matching rate.[14]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for New Jersey Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in New Jersey.

Eligibility for Medicaid in New Jersey for people needing LTC services is primarily attained by satisfying at least one of 5 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2012, the monthly federal benefit amount was $698 for an individual and $1,048 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[15]
    - Home equity limit: The equity interest in the individual's home may not exceed $786,000, or else they will be ineligible for LTC services. This figure increases annually with inflation.[3]

  - Citizenship/immigration requirements: The applicant must be a New Jersey resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2023b) for additional information.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2012, this was $2,094 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in MLTSS and has a spouse residing in the community.[16]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized or enrolled in MLTSS and has a spouse residing in the community.[17]
    * Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., GO LTC, MLTSS).
- 2b. Federal poverty level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 2012, this was $931 for an individual and $1,261 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in MLTSS and has a spouse residing in the community.[16]
  - Asset requirements: Resources may not exceed $4,000 for an individual and $6,000 for a couple. Additional asset disregards exist if a person is institutionalized or enrolled in MLTSS and has a spouse residing in the community.[17]
    * Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[5]
- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2014, this was $1,343 for an individual and $1,809 for a household of two.[18] See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * Applicants must be ages 19-64, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not pregnant at the time of application.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, and disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a six-month period to be equal to or less than the medically needy income level (MNIL). In 2012, this was $367 for an individual and $434 for a couple (NJDHS, 2023a). Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized or enrolled in MLTSS and has a spouse residing in the community.[16]
  - Asset requirements: Same asset requirements as eligibility track 2b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (NJDHS, 2023):

- Breast and Cervical Cancer program: Uninsured low-income women who have been screened for early detection may be eligible for Medicaid.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Assistant Program (PCAP), Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Medicaid Long-Term Services and Supports (MLTSS)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or under age 65 and blind or disabled (as determined by the SSA). Applicants also must have assets under $2,000 for an individual or $3,000 for a couple.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care
- AIDS Community Care Alternatives Program —until 2014
- Program of All-inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

PCAP

PCAP provides personal care services, which include (NJDHS, 2023b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Personal care services are limited to 40 hours per week (38 N.J.R. 2810(a), 2006a). PCAP offers the Personal Preference Program (PPP), an option that allows individuals to direct and manage their own services.

Home Health Services

Home Health provides (NJDHS, 2023b):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

When the cost of home health care is equal to or in excess of the cost of institutional care over a protracted period (six months or more), the New Jersey Medicaid may opt to limit or deny the provision of services on a prospective basis.

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

MLTSS

MLTSS provides the following services in addition to those offered under the state plan, unless otherwise noted (Medicaid.gov, 2011; Horizon NJ Health, 2022):

- Home-Based Supportive Care: Services that assist with household needs (e.g., meal preparation, laundry) —this is a different service with a narrower scope than what was provided under GO LTC, detailed in the previous policy period (chapter)
- Chore services: Non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual, such as cleaning appliances, washing windows, and scrubbing floors, and do not include normal everyday housekeeping tasks[13]
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent) and respiratory care for participants who are ventilator dependent

Semi-residential care

PCAP, Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

MLTSS

MLTSS provides (Medicaid.gov, 2011):

- Social adult day care (SADC): a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care
- Adult day health care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting

Residential care

PCAP, Home Health Services

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities (NJDHS, 2023b):

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment

From 1994, New Jersey removed distinctions between SNFs and ICFs in their administrative code, and instead referred to all LTC facilities as "nursing facilities." However, the New Jersey state plan still retains these distinctions.

MLTSS

MLTSS covers the first 30 days of nursing facility care, after which beneficiaries are transitioned to traditional state plan fee-for-service nursing facility care, described above. From July 2012, long-term nursing home stays were adding to MLTSS (Medicaid.gov, 2011). MLTSS covers the same types of residential care as the state plan.

Other benefits

New Jersey Medicaid provides additional benefits related to LTC (NJDHS, 2023b):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

MLTSS

MLTSS provides the following services in addition to those offered under the state plan, unless otherwise noted (Medicaid.gov, 2011):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Additional equipment and supplies that are necessary to address participant functional limitations
- Home-delivered meals: Nutritionally balanced meals delivered to the participant's home when meal provision is more cost effective than having a personal care provider prepare the meal
- Transportation: Additional coverage of non-medical transportation to community services and activities
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Caregiver training: Instruction provided to a participant or caregiver to teach a variety of skills necessary for independent living, such as the use of specialized or adaptive equipment and assistance with ADLs
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional community setting (e.g., moving expenses, housing deposits)

- Environmental accessibility and adaptations
- Transitional care management: Assistance in accessing HCBS for individuals currently reside in a nursing facility

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the New Jersey Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PCAP

Personal care assistant services may be performed by a qualified individual in a recipient's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-3.9, 2019).

Home Health Services

Home health aide services ,ust be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Registered professional nurses perform all skilled nursing services (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.1, 2019).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (42 CFR 483.30, 1992).

MLTSS

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

PCAP services must be medically necessary and ordered by a physician in accordance with a plan of care (NJDHS, 2023b). All PCAP provider agencies are required to obtain prior authorization from the beneficiary's MCO before providing services (NJDHS, 2015). The authorization request details the days and number of hours of service needed by the beneficiary.

Home Health Services

Home Health services must be medically necessary and authorized by a physician for the fee-for-service state plan benefit (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.2, 2018. If the beneficiary is enrolled in a managed care plan, they must obtain prior authorization from their MCO. Physician's orders are not required for MCO authorization, but must be readily available if requested by the plan (Horizon NJ Health, 2023).

Nursing Facility Care

The beneficiary must meet a nursing facility level of care (NFLOC), as determined by the Preadmission Screening (PAS) process, in order to be admitted to a nursing facility. Prior authorization is also required for all Medicaid-eligible individuals seeking admission to a Medicaid participating nursing facility (NJDHS, 2023). An NFLOC means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for a disease or related deficits. The beneficiary should also be dependent in several activities of daily living (ADLs) (N.J.A.C. 10:63-2.1-2, 1994; 38 N.J.R. 674a, 2006b; N.J.A.C. 8:85-2.1-2, 2018).

MLTSS

The beneficiary must meet an NFLOC in order to be eligible for MLTSS. An NFLOC is met if the applicant meets one of the following (Medicaid.gov, 2011):

- The individual requires limited assistance or greater with 3 or more ADLs
- The individual exhibits problems with short-term memory and is minimally impaired or greater with decision making ability and requires supervision or greater with 3 or more ADLs

- The individual is minimally impaired or greater with decision making, often understood or greater in making themself understood, and requires supervision or greater with 3 or more ADLs

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months. Individuals eligible through eligibility track 3a (medically needy) must have eligibility renewed every 6 months (HCFA, 1992).

PCAP

Beneficiaries must be reassessed at least every 6 months or as needed based upon a change in condition (26 N.J.R. 364, 1994a; 50 N.J.R. 1992(b), 2018). From 2018, beneficiaries must be reassessed at least every 12 months.

Home Health Services

The beneficiary's physician must recertify and review the plan of care every 2 months. Face-to-face encounters are not required for recertification (N.J.A.C. 10:60-2.2, 2019).

Nursing Facility Care

Reassessment is required on a periodic basis, however, no timeline is provided (N.J.A.C. 10:63-1.12, 1994; 38 N.J.R. 674a, 2006b; N.J.A.C. 8:85-1.12, 2018).

MLTSS

The MCO must redetermine clinical eligibility at least every 12 months (Medicaid.gov, 2011).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCAP, Home Health Services, Nursing Facility Care

There is no age requirement.

MLTSS

The individual must be at least age 65, or under age 65 and blind or disabled as determined by the SSA (Medicaid.gov, 2011).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

The PCA assessment tool determines the amount of PCA service hours that the applicant requires. Depending on the score for each assessed area (e.g., no assist, supervision, limited assistance, extensive/max assistance, or total dependence), the response will correlate to a guideline amount of time it should take to perform the task (e.g., 5-10 minutes for limited assistance). If the applicant takes more time to complete the task that what is provided in the guidelines, the assessor will provide a justification of need and allot additional time for the task. The amount of time for each item is totaled, resulting in the amount of service hours the applicant will receive. See Box 10 for time guideline definitions and Aetna (2014) to view the assessment form.

Home Health Services

There are two levels of care for Home Health services provided upon request of the attending physician (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-2.1, 2019):

- Acute home health care —concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required

- Chronic home health care —either a long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required

Nursing Facility Care

Applicants must meet a Nursing Facility Level of Care (NFLOC). There are three tracks of care that qualify as an NFLOC, and the applicant's track is determined after the standardized assessment is completed (26 N.J.R. 3621, 1994). The track of care means the designation of the setting and scope of Medicaid services determined by the PAS process (38 N.J.R. 674a, 2006b). See Box 7 for the track of care definitions.

MLTSS

Applicants must meet an NFLOC, which is defined as meeting one or more of the following criteria on the NJ Choice assessment (Medicaid.gov, 2021):

- The individual requires limited assistance or greater with 3 or more ADLs
- The individual exhibits problems with short-term memory and is minimally impaired or greater with decision making ability and requires supervision or greater with 3 or more ADLs
- The individual is minimally impaired or greater with decision making, often understood or greater in making themself understood, and requires supervision or greater with 3 or more ADLs

See Table 3 for more information on the assessment and scoring criteria.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

Individuals must have a written physician's order (PA-4) that demonstrates a medical necessity for services. Once received, a registered nurse from the provider agency will use the PCA Nursing Assessment Tool to determine need for services and amount of care required. The assessment collects information on the applicant's residence (e.g., barriers to mobility), and assesses cognition, ADLs, and IADLs. See Box 10 for more information on the PCA Nursing Assessment Tool, and Aetna (2014) to view the assessment form.

Following the assessment, the nurse will submit the completed assessment and prior authorization request to the New Jersey Division of Disability Services (NJDDS), who will then make a determination regarding the hours of PCA services to be authorized (N.J.A.C. 10:60-3.9, 2019). If the beneficiary is receiving this service through a managed care plan, assessments and authorizations are conducted and coordinated by their managed care organization (MCO) (N.J.A.C. 10:60-3.4, 2019).

Home Health Services

Individuals must obtain a written physician's order following a face-to-face encounter (telehealth included) with an authorized physician or practitioner (42 CFR 440, 1996). A plan of care will be developed by the attending physician and agency personnel following the physician's order (26 N.J.R. 364, 1994a). See Box 1 for more information on the plan of care. Once the physician approves and signs the plan of care, services will be authorized. For individuals enrolled in managed care, all home health services must be determined to be medically necessary and prior authorized by the MCO before services are rendered (N.J.A.C. 10:60-2.2, 2019).

Nursing Facility Care

Individuals seeking admission to a Medicaid-covered nursing facility must complete the Preadmission Screening (PAS) process, where applicants receive a comprehensive needs assessment to determine their long-term care needs and the most appropriate setting for those needs to be met (26 N.J.R. 3620, 1994b).

The process begins with a referral to the New Jersey Department of Human Services (NJDHS) for PAS. The required documentation varies depending on where the applicant is being referred from.

- If the applicant is referred from a hospital, the hospital will identify potentially eligible individuals using the At-Risk Criteria for Nursing Facility Placement (LTC-D1), a list of "at-risk" criteria to assist a hospital in determining if a referral for LTC services is indicated. See Box 2 for the at-risk criteria. If the patient is identified as potentially eligible for nursing facility care, the hospital will refer the patient for PAS by submitting the Hospital Preadmission Screening Referral (LTC-4) form.
- If the applicant is referred from a nursing facility for Medicaid coverage of their care, nursing facility staff will refer the applicant by submitting the Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient (LTC-2) form.

- If the applicant is referred from the community, a physician must submit the Certification of Need for Patient Care in Facility Other than Public or Private General Hospital (PA-4) form, or a physician statement that substantiates the individual's diagnosis and describes their care needs. See Box 3 for more information on the PA-4 form.

If the applicant is referred, Department staff conduct PAS using the PAS standardized assessment (PAS-1). The form assesses the applicant's functional and mental status, as well as medications, diagnoses, and other relevant medical information. See Box 4 for information on the PAS standardized assessment and N.J.A.C. 10:63 Appendix K (1994) to view the form. If the assessment indicates that they are clinically eligible for nursing facility care, they will be approved for coverage and the staff will develop a health services delivery plan (HSDP). If the assessment indicates that they are more suitable for a community setting, the applicant may be referred for assistance in accessing MLTSS benefits or other community services (e.g., PCAP).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 5 for more information on the PASRR, and Box 6 for the MDS.

MLTSS

Applicants are evaluated using the Minimum Data Set - Home Care (MDS-HC), or sometimes referred to as the NJ Choice assessment (CMS, 2011). The assessment evaluates the applicant's ability to perform ADLs and their cognitive functioning, resulting in an ADL index score and Cognitive Performance Scale (CPS) score that determine level of care. See Table 3 for more information on the MDS-HC.

ADL index means the RUG-III/HC case mix algorithms that include a summary measure of ADL that combines scores for bed mobility, toileting, transferring and eating. Scores range from 4 (independent or supervision in all four areas) to 18 (severe impairment in all four areas). CPS means an assessment index with the MDS-HC used to assess individuals on the basis of memory impairment, level of consciousness, and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). See CMS (2001) for more information on how ADL index and CPS scores are calculated using the MDS. There are slight differences in item numbering between the MDS and MDS-HC, but scores are calculated similarly. Once an applicant is determined eligible, a plan of care will be created.

Only certain assessment sections within the MDS-HC are used to determine level of care and program eligibility. The entirety of the assessment is used for both level of care and eligibility as well as to assist in the development of the applicant's plan of care. The specific sections used to determine level of care are detailed in the Long-Term Care Re-Evaluation (WPA-1), the form used to reevaluate participants for program eligibility. The WPA-1 is a condensed assessment that only includes items from the MDS-HC that are calculated to determine level of care. The three sections include Functional Status, Social Support Network, and Physical Environment (MDSOAR, 2012; NJDHS, 2014). See Box 9 for more information on the new WPA-1, and NJDHS (2014c) to view the form.

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

PCAP

A licensed physician must order personal care services. A registered nurse from the provider agency will conduct an initial nursing assessment and subsequent reassessments, and develop and periodically review the plan of care with the providing personal care assistant (26 N.J.R. 364, 1994a; N.J.A.C. 10:60-3.9, 2019).

Home Health Services

A registered physician or practitioner must order home health services. A nurse from the provider agency will develop a plan of care, which will be reviewed and signed by the same physician (26 N.J.R. 364, 1994a; 38 N.J.R. 2810(a), 2006a; N.J.A.C. 10:60-2.2, 2019).

Nursing Facility Care

A registered professional nurse employed by the New Jersey Department of Human Services conducts the standardized assessment (26 N.J.R. 3620, 1994b).

MLTSS

MDS-HC/NJ Choice assessments may be performed by a registered nurse employed by the state or care managers from the beneficiary's managed care plan.

Benefit limitations

Can you mix LTC benefits?

All New Jersey Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, New Jersey enforces Estate Recovery. Medicaid recovery allows the Medicaid agency to file a claim against the estate of a Medicaid recipient after their death. Estate recovery applies to those Medicaid recipients who were 55 years of age or older at the time of provision of the service (NJDHS, 1995).

PCAP, Home Health Services, MLTSS

There are no copayments or similar charges imposed upon participants for program services (NJDHS, 1989; HCFA, 1992; Medicaid.gov, 2021).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2012, the PNA was $35 per month (NJDHS, 2017). In 2017, the PNA was raised to $50 per month.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: New Jersey Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	50.00%
1993	50.00
1994	50.00
1995	50.00
1996	50.00
1997	50.00
1998	50.00
1999	50.00
2000	50.00
2001	50.00
2002	50.00
2003	51.48
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	60.19
2010	61.59
2011	56.81
2012	50.00
2013	50.00
2014	50.00
2015	50.00
2016	50.00
2017	50.00
2018	50.00
2019	50.00
2020	54.65
2021	56.20
2022	56.20
2023[1]	54.98

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201). [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical New Jersey Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422.00	$633.00	$1,266.00	$1899.00	$568.00	$766.00		
1993	434.00	652.00	1,302.00	1,956.00	581.00	786.00		
1994	446.00	669.00	1,338.00	2,007.00	614.00	820.00		
1995	458.00	687.00	1,374.00	2,061.00	623.00	836.00		
1996	470.00	705.00	1,410.00	2,115.00	645.00	864.00		
1997	484.00	726.00	1,452.00	2,178.00	658.00	885.00		
1998	494.00	741.00	1,482.00	2,223.00	671.00	905.00		
1999	500.00	751.00	1,500.00	2,253.00	687.00	922.00		
2000	513.00	769.00	1,539.00	2,307.00	696.00	938.00		
2001	531.00	796.00	1,593.00	2,388.00	716.00	968.00		
2002	545.00	817.00	1,635.00	2,451.00	739.00	995.00		
2003	552.00	829.00	1,656.00	2,487.00	749.00	1,010.00		
2004	564.00	846.00	1,692.00	2,538.00	776.00	1,041.00		
2005	579.00	869.00	1,737.00	2,607.00	798.00	1,070.00		
2006	603.00	904.00	1,809.00	2,712.00	817.00	1,100.00		
2007	623.00	934.00	1,869.00	2,802.00	851.00	1,141.00		
2008	637.00	956.00	1,911.00	2,868.00	867.00	1,167.00		
2009	674.00	1,011.00	2,022.00	3,033.00	903.00	1,215.00		
2010	674.00	1,011.00	2,022.00	3,033.00	903.00	1,215.00		
2011	674.00	1,011.00	2,022.00	3,033.00	908.00	1,226.00		
2012	698.00	1,048.00	2,094.00	3,144.00	931.00	1,261.00		
2013	710.00	1,066.00	2,130.00	3,198.00	958.00	1,293.00		
2014	721.00	1,082.00	2,163.00	3,246.00	973.00	1,311.00	1,343.00	1,809.00
2015	733.00	1,100.00	2,199.00	3,300.00	981.00	1,328.00	1,354.00	1,832.00
2016	733.00	1,100.00	2,199.00	3,300.00	990.00	1,335.00	1,367.00	1,843.00
2017	735.00	1,103.00	2,205.00	3,309.00	1,005.00	1,354.00	1,387.00	1,868.00
2018	750.00	1,125.00	2,250.00	3,375.00	1,012.00	1,372.00	1,397.00	1,893.00
2019	771.00	1,157.00	2,313.00	3,471.00	1,041.00	1,410.00	1,437.00	1,945.00
2020	783.00	1,175.00	2,349.00	3,525.00	1,064.00	1,437.00	1,468.00	1,983.00
2021	794.00	1,191.00	2,382.00	3,573.00	1,074.00	1,452.00	1,482.00	2,004.00
2022	841.00	1,261.00	2,523.00	3,783.00	1,133.00	1,526.00	1,564.00	2,106.00
2023	914.00	1,371.00	2,742.00	4,113.00	1,215.00	1,643.00	1,677.00	2,268.00

Source: SSA (2023a)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2014, corresponding to the implementation of the new eligibility track under the Affordable Care Act.

Box 1: Home Health Services: Plan of Care

Under Home Health services, home health agency personnel and the applicant's attending physician create a plan of care that outlines the services the applicant requires. The plan of care includes the following:

1. Impairments and diagnoses
2. Summary of case history, including medical, nursing, and social data
3. Number and nature of service visits to be provided by the home health agency
4. Additional health related services supplied by other providers
5. Copy of physician's orders and their updates
6. Medications, treatments and personnel involved
7. Equipment and supplies required
8. Goals, long and short-term
9. Preventive, restorative, maintenance techniques to be provided, including the amount, frequency and duration
10. The recipient's, family's, and interested person's involvement
11. Discharge planning in all areas of care, coordinated with short and long-term goals

Source: 26 N.J.R. 364 (1994a)

Box 2: Hospital At-Risk Criteria (LTC-D1)

- Medical —Has the patient experienced any of the following:
  1. Catastrophic illness requiring major changes in lifestyle and/or living conditions (e.g., multiple sclerosis, stroke, AIDS)
  2. Debilitation and/or chronic illness causing progressive deterioration of self-care skills (e.g., diabetes, fractures, several chronic diseases)
  3. Multiple hospital admissions within the past six months
  4. Previous nursing facility admissions within the past two years
  5. Major health needs (e.g., tube feedings, special equipment or treatments, rehabilitative/restorative services)
- Social —In addition to the medical criteria, does the patient meet any of the following social situations:
  1. Homeless
  2. Lives alone and/or has no immediate support system
  3. Primary caregiver is not able to provide required care services
  4. Lack of adequate support systems
- Financial —The form includes criteria related to the applicant's income and assets to identify whether they may be eligible for Medicaid coverage of nursing facility services. These vary by year and are detailed in the *Coverage* section of each policy period.

Source: N.J.A.C. 10:63 Appendix J (1994b); 26 N.J.R. 3620, Appendix J (2006)

Box 3: Certification of Need for Patient Care in Facility Other than Public or Private General Hospital (PA-4)

The PA-4 is a certification by a physician that the individual requires long-term care (LTC) services. The physician must substantiate the individual's diagnosis, describe their related care needs, and justify a referral by detailing the medical status of the patient. It is used to assist the assessor of the standardized assessment in determining whether home and community based LTC services can best meet the needs of the individual, however, it is unclear how information on the PA-4 directly impacts the eligibility determination. Sections of the PA-4 are detailed below.

1. Diagnosis
2. Medication and/or treatment
3. Other therapy contemplated
4. Functional capacity of the patient —the physician must identify the applicant's functional capacity to complete the following activities as (Independent), (Needs Assistance), or (Potential for Independence):
    - Bathing and personal hygiene
    - Dressing
    - Eating
    - Toiletry
    - Communication
    - Ambulation
    - Nursing care
5. Instructional needs —the physician must identify whether any of the following instructional needs are required:
    - Teaching for independence in ADLs
    - Self-administration of drugs and medications
    - Diet and nutrition
    - Self care for special condition (e.g., colostomy)
    - Understanding medical conditions
    - Prevention care and treatment or complication
    - Counseling, emotional, and motivation support
6. Emotional, behavior, or social problems of the patient (explain)
7. Characteristics of major disability: (Static or stable), (Progressive), or (Improving)
8. Is patient now receiving any medication or treatment? (Yes/No)
9. Is surgery or other therapy contemplated? (Yes/No)
10. Is care in a nursing home or public medical institution now necessary? (Yes/No)
11. Could this patient be adequately cared for now in:
    - A boarding home? (Yes/No)
    - Their own home? (Yes/No)
    - Other facility (describe)?
12. Certification that the patient does not require treatment for active tuberculosis or a mental disease, defect, or impairment in an instituional for the mentally ill or mentally deficient

Source: N.J.A.C. 10:63 Appendix H (1994); 26 N.J.R. 3620, Appendix J (1994b); NJDHS (2009d)

Box 4: Pre Admission Screening (PAS) Standardized Assessment Form

The PAS standardized assessment form has three medical assessment sections, detailed below:

- Clinical Assessment: Assessors document clinical information about the applicant, including recent hospitalizations, primary and secondary diagnoses, and whether the applicant has a history with a specified list of medical complications (e.g., glaucoma, deafness, diabetes)
- Treatments and Diagnostic Studies: Assessors list results and dates of any lab or other diagnostic studies, medications administered, treatments, rehabilitative therapies, and special equipment, and nutritional status (e.g., diet, weight, appetite)
- Mental and Behavioral Status: Assessors document whether the applicant experiences, doesn't experience, or sometimes experiences mental and behavioral complications from a specified list (e.g., disorientation, confusion, delusions), and whether the applicant's cognitive functions are intact or impaired, from a list of specified functions (e.g., long-term memory, judgement)

Source: N.J.A.C. 10:63 Appendix K (1994); 26 N.J.R. 3620, Appendix K (2006)

Box 5: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 6: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Table 3: Minimum Data Set-Home Care (MDS-HC) Version 2.0 Assessment Sections

Section and Assessment Items	Section and Assessment Items
B. Cognitive Patterns 1. Memory recall ability 2. Cognitive skills for daily decision-making 3. Indicators of delirium	J. Disease Diagnoses 1. Diseases 2. Other current or more detailed diagnoses and ICD-9 codes
C. Communition/Hearing Patterns 1. Hearing 2. Making self understood (expression) 3. Ability to understand others (comprehension) 4. Communition decline	K. Health Conditions and Preventative Health Measures 1. Preventative health (past two years) 2. Problem conditions present on 2 or more days 3. Problem conditions 4. Pain 5. Falls frequency 6. Danger of fall 7. Lifestyle (drinking/smoking) 8. Health status indicators 9. Other status indicators
D. Vision Patterns 1. Vision 2. Visual limitation/difficulties 3. Visual decline	L. Nutrition/Hydration Status 1. Weight 2. Consumption 3. Swallowing
E. Mood and Behavior Patterns 1. Indicators of depression, anxiety, sad mood 2. Mood decline 3. Behavioral symptoms 4. Changes in behavioral symptoms	M. Dental Status (oral health) 1. Oral status
F. Social Functioning 1. Involvement 2. Change in Social Activities 3. Isolation	N. Skin Condition 1. Skin problems 2. Ulcers (pressure/stasis) 3. Other skin problems requiring treatment
G. Informal Support Services 1. Two key informal helpers 2. Caregiver status 3. Extent of informal help (hours of care, rounded)	O. Environmental Assessment 1. Home environment 2. Living arrangement
H. Physical Functional (IADL performance in 7 days; ADL in 3 days) 1. IADL self-performance and difficulty 2. ADL self-performance 3. ADL decline 4. Primary modes of locomotion 5. Stair climbing 6. Stamina 7. Functional potential	P. Service Utilization (in last 7 days) 1. Formal care 2. Special treatments, therapies, programs 3. Management of equipment (in 3 days) 4. Visits in last 90 days or since last assessment 5. Treatment goals 6. Overall change in care needs 7. Trade offs
I. Continence (in last 7 days) 1. Bladder continence 2. Bladder devices 3. Bowel continence	Q. Medications 1. Number of medications 2. Receipt of psycho-tropic medication 3. Medical oversight 4. Compliance/adherence with medications 5. List of all medications

Source: Mass.gov (1999)

Notes: The MDS-HC is the comprehensive assessment used to determine eligibility for home and community-based services (HCBS) programs, including Global Options for Long-Term Care (GO LTC) and Managed Long-Term Services and Supports (MLTSS). The assessment tool is used to determine level of care, and to assist in developing the applicant's plan of care. Only certain sections and assessment items are used in the level of care determination. For those assessment items, see Box 9 for the WPA-1. Omitted MDS-HC sections in this table are purely administrative (e.g., name and identification numbers).

Box 7: Nursing Facility Tracks of Care

In order to be admitted to a nursing facility, applicants must meet a nursing facility level of care (NFLOC). There are three tracks of care that qualify as an NFLOC, and the applicant's track is determined after the standardized assessment is completed. The track of care means the designation of the setting and scope of Medicaid services determined by the Preadmission Screening (PAS) process. The three tracks are as follows:

- Track I: Long-term nursing home care —designated for individuals that require long-term placement because clinical prognosis is poor, and where PAS results in a determination that short-term stays are neither realistic nor predictable and that the individual is eligible for nursing facility level of nursing care
- Track II: Short-term nursing home care —designated for individuals where PAS results in a determination that the individual requires comprehensive and coordinated nursing facility services, provided in a therapeutic setting that assures family counseling and teaching in preparation for discharge to the community setting and to achieve at least one of the objectives below:
  - Stabilize medical conditions
  - Promote rehabilitation
  - Restore maximum functioning levels
- Track III: Long-term care services in a community setting (e.g., CCPED, GO LTC, MLTSS, PCAP) —designated for individuals where PAS results in a determination of clinical eligibility for nursing facility care, but who can be appropriately cared for in the community with supportive health care services; these individuals may be eligible for Medicaid State Plan services or Home and Community-Based Services programs

Source: 26 N.J.R. 3621 (1994b); 38 N.J.R. 674a (2006b)

Box 8: Personal Care Assistant (PCA) Nursing Assessment Tool (Pre-2015)

A registered nurse employed by the PCA provider agency must complete a face-to-face evaluation of the beneficiary using the PCA Assessment form (FD-410), which includes information regarding the beneficiary's:

1. Supportive service/living environment needs
2. Cognitive/mental status
3. Ambulation/mobility
4. Ability to transfer (for example, from wheelchair to bed)
5. Ability to feed himself or herself
6. Ability to bathe himself or herself
7. Ability to toilet himself or herself
8. Ability to perform grooming and dressing tasks
9. Ability to perform shopping
10. Ability to perform laundry tasks

Prior to 2015, each Activity of Daily Living (ADL) —items 3-8 —was given a score of 1, 2, or 3, corresponding to the applicant's ability to perform the task and required service hours (e.g., score of 1 = 1 hour of service). After 2015, the assessment was substantively identical to the FD-410 apart from added time guidelines for each category. See Horizon NJ Health (2013) to view the full form and score definitions.

Source: Aetna (2014); E.D. v. NJ Horizon Health, et. al. (2018); Horizon NJ Health (2013)

Box 9: Long-Term Care Re-Evaluation (WPA-1)

The WPA-1 is a condensed assessment used for reevaluation of long-term care (LTC) services and program eligibility. The WPA-1 has three assessment sections: functional status, social support network, and physical environment. The criteria is taken directly from the MDS-HC/NJ Choice assessment, but only takens the criteria that is used to determine a nursing facility level of care.

The Functional Status section assesses cognitive functioning and ADL self performance. The following questions are included in this section, and may yield a Yes or No response, or a score according to an established scale:

- Can participant recall 3 items from memory after 5 minutes? (Yes/No)
- Can participant perform or verbalize all or almost all steps in a multi-task sequence? (Yes/No)
- How well does participant make decisions about organizing the day? (Independent; Modified Independence; Minimally Impaired; Moderately Impaired; Severely Impaired)
- Does participant receive nourishment through an enteral tube feeding? (Yes/No)
- ADL Self Performance (score over past 3 days unless noted)
  - ADLs assessed —bed mobility, eating, transfer, locomotion in home/building, locomotion outside home/building, upper body dressing, lower body dressing, bathing (score over past 7 days)
  - Responses for each ADL and corresponding scores —Independent (0); Set Up (1); Supervision (2); Limited Assistance (3); Extensive Assistance (4); Maximal Assistance (5); Total Dependence (6); Did Not Occur (8)
- Nursing Facility Level of Care Criteria (select one or more based on Functional Status scores)
  - Does participant meet the ADL Index criteria of 6 or greater and have any 3 ADLs at limited assistance or greater? (Yes/No)
  - Does participant meet the Cognitive Performance Scale Score criteria of 3 or greater and have any 3 ADLs at supervision or greater? (Yes/No)
  - Does participant meet the ADL Assistance criteria by requiring limited assistance or greater in Locomotion, Dressing, and Bathing? (Yes/No)

The Social Support Network section requires the assessor to describe and identify social support concerns in areas such as the following: Involvement of participant, change in social activities, isolation, informal supports, and caregiver status.

The Physical Environment section requires the assessor to describe the participant's living arrangement. This may include information such as the number of individuals living in participant's home, recent moves, and type of residence (e.g., house, apartment, Assisted Living Facility). This section also asks the assessor to identify environmental problems, such as hazardous or uninhabitable living space, inadequate lighting, and difficulty in entering or leaving the home (i.e., accessability of home).

Source: NJDHS (2012); NJDHS (2014c)

Box 10: Personal Care Assistant (PCA) Nursing Assessment Tool (2015-2023)

The new PCA Nursing Assessment Tool, while introduced earlier in some areas, became used statewide in 2015. The major change between the new form and the previous form is the added time guidelines for certain items. See below for assessment items and scores, and Aetna (2014) to view the full assessment form and dependence definitions for all items.

1. Supportive service/living environment needs and limitations
2. Cognitive/mental status, decision making ability: No impairment (0 minutes); Minimally impaired, i.e., cuing in new or specific situations (60 minutes per week); Moderately impaired, i.e., repeated reminders to initiate, perform, or self direct activities (120 minutes per week); Severely impaired, i.e., never or rarely makes decisions, unable to initiate or self direct any activity (180 minutes per week)
3. Activities of Daily Living (ADLs): For each ADL, the assessor can select one of five options to convey the applicant's ability to perform the task (no assist, supervision, limited assistance, extensive/max assistance, and total dependence). However, time guidelines are not provided for every response. Some may have limits per day, while others will provide exact guidelines for each answer. Every ADL assessed will have a "Justification of need" section that must be completed by the assessor. For every ADL, if no assistance is needed, the assessor must input 0 minutes.
    - Ambulation/mobility assistance —the process of moving between locations (e.g., room to room): Up to 30 minutes per day
    - Transferring —the movement from one stationary position to another (toilet transferring not included): Supervision/limited assisted (up to 15 minutes per day); Extensive/max assistance (up to 30 minutes per day); Mechanical lift/non-weight bearing, limited assistance or more (up to 45 minutes per day)
    - Bathing —bathing or washing in tub/shower/bed/chair (includes washing hair, drying hair, and applying lotion): Upper body only (up to 15 minutes per day); Lower body only (up to 15 minutes per day); Full bath (up to 30 minutes per day)
    - Feeding/eating —the process of getting food into the digestive system (excluding meal preparation): 10-20 minutes per meal
    - Positioning —adjusting or changing position in a chair or bed: 5 minutes per episode, limit of 6 episodes per day
    - Toileting —bowel and bladder elimination (including use of commode, emptying appliances, cleansing and adjusting clothing; toilet transferring is assessed here): Continent (Yes/No); 5-10 minutes per occurrence if continent; 15-20 minutes per occurrence if incontinent; Up to 90 minutes per day
    - Personal hygiene/grooming —combing or brushing hair, shaving, brushing teeth, nail care: Limited assist (5-10 minutes); Extensive assist or higher (15 minutes)
    - Dressing and adaptive equipment : Limited assist (5-10 minutes per episode); Extensive assist or higher (15 minutes per episode)
4. Instrumental ADLs (IADLs): Each of the following items assessed is provided a time guideline based on the applicant's ability to perform the task, as well as a "Justification of need" section. However, there are no response options aside from the justification and numerical inputs (e.g., minutes, days). If no assistance is needed, the assessor must input 0 minutes.
    - Housekeeping —services are integral to personal care (includes changing bed linens, vacuumin, keeping personal space clean): Up to 120 minutes per week, dependent on the size of the household
    - Soiled bed linen changes (routine bed changes are assessed under housekeeping): Up to 10 minutes per occasion, with a limit of up to 30 minutes per day Shopping for groceries and incidentals (includes travel time): Up to 60 minutes per week
    - Meal preparation (includes meal planning, storing, preparing, serving, and clean up): Breakfast (10-15 minutes); Lunch (10-15 minutes); Dinner (20-25 minutes)
    - Laundry: Home washer (45 minutes per week); Out of home washer (75 minutes per week)

Source: Aetna (2014); E.D. v. NJ Horizon Health, et. al. (2018)

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This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/app/policy-explorer).

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

ADL Index score: The RUG-III/HC case mix algorithms that include a summary measure of ADL that combines scores for, bed mobility, toileting, transferring and eating. Scores range from four (independent or supervision in all four areas) to 18 (severe impairment in all four areas).

Adult Day Health Care (ADHC): Sometimes referred to as Medical Day Care, ADHC is a community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services

are provided according to the assessed needs of the beneficiary. New Jersey provides this as a state plan benefit. However, ADHC is not detailed in this policy document due to low enrollment.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Assisted Living (AL) program: A New Jersey Medicaid HCBS program that provides home care services in an Assisted Living Facility. This program was consolidated with the Enhanced Community Options program and the Community Care Program for the Elderly and Disabled to create the Global Options for Long-Term Care program in 2009.

At-Risk Criteria for Nursing Facility Placement (LTC-D1): A list of criteria that indicates whether an individual may be suitable for nursing facility placement in New Jersey. This form is used in the Preadmission Screening process if the applicant is referred by a hospital. Prior to 2006, the LTC-D1 did not have a form number.

Capitation: A payment arrangement for health care services where an entity (e.g., a managed care organization - MCO) receives a risk adjusted amount of money for each Medicaid beneficiary enrolled in the plan. States typically pay MCOs for managed care services through fixed, periodic payments (capitation payments) for a defined package of benefits.

Care Management: MI Choice (called "supports coordination" under the program) benefit that provides service management for the enrollee. A coordinator will develop an individual plan of service, assist with access to benefits, and provide overall case management for a program beneficiary.

Certification of Need for Patient Care in Facility Other than Public or Private General Hospital (PA-4): The referral form used to refer an individual for the Preadmission Screening standardized assessment in New Jersey if the applicant is referred from the community (by a physician). This is also the standard physician's order form for other Medicaid services, including personal care under the Personal Care Assistant Program (PCAP) and Home Health services.

Cognitive Performance Scale (CPS): An assessment index with the MDS-HC used to assess individuals on the basis of memory impairment, level of consciousness, and executive function, with scores ranging from zero (intact) to six (very severe impairment).

Community Care Program for the Elderly and Disabled (CCPED): New Jersey federally-approved home and community-based services (HCBS) program providing services such as personal care and adult day health care to Medicaid beneficiaries over age 65 and disabled adults that meet a nursing facility level of care. In 2009, this program was consolidated with the Assisted Living (AL) and Enhanced Community Options (ECO) programs into one HCBS program named Global Options for Long-Term Care (GO LTC). In 2012, GO LTC, along with most other HCBS programs, was consolidated again into a managed care delivery system. LTC recipients under managed care received all these services and more through the Managed Long-Term Services and Supports (MLTSS) plan.

Community Spouse Resource Allowance (CSRA): Upper limit on disregarded assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Enhanced Community Options (ECO) program: A New Jersey Medicaid HCBS program for older people and people with physical disabilities that covered community residential options and made self-directed services available for older people. This program was consolidated with the Assisted Living program and the Community Care Program for the Elderly and Disabled to create the Global Options for Long-Term Care program in 2009.

Estate recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Federally Approved Home and Community-Based Services (HCBS) Program: Specialized Medicaid programs providing home and community-based care to individuals at risk of institutionalization. These programs must be approved by the federal Medicaid-governing agency (Health Care Financing Administration - HCFA, and later the Centers for Medicare and Medicaid Services - CMS) and reapproved every 3-5 years. Individuals must meet a nursing facility level of care (NFLOC) in order to be admitted. New Jersey's specialized HCBS programs include Community Care Program for the Elderly and Disabled (CCPED), Global Options for Long-Term Care (GO LTC), and Managed Long-Term Services and Supports (MLTSS). Other programs not covered in this policy document include the AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and the NJ Community Care Program.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Global Options for Long-Term Care (GO LTC) Program: New Jersey federally-approved home and community-based services (HCBS) program providing services such as personal care and adult day health care to Medicaid beneficiaries over age 65 and disabled adults that meet a nursing facility level of care. In 2009, this program consolidated and replaced the Community Care Program for the Elderly and Disabled (CCPED) and several other HCBS programs.

Great Recession: National economic downturn from 2007 to 2009 that resulted in increased FMAPs to states.

Health Services Delivery Plan (HSDP): The plan of care prepared by professional staff designated by the Department during the Preadmission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid mandatory health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Hospital Preadmission Screening Referral (LTC-4): The referral form used to refer a hospital patient for the Preadmission Screening standardized assessment in New Jersey. Prior to 2006, the form number for the referral was PAS-1(a).

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Care Facility (ICF): A long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility (SNF), but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

Long-Term Care Re-Evaluation (WPA-1): The New Jersey assessment tool used to reevaluate GO LTC and MLTSS beneficiaries for continued eligibility.

Managed Care Organizations (MCOs): Health plans that administer Medicaid services and contract with providers to deliver services. MCOs receive a capitated per member per month fee from the state and reimburse providers for services enrollees receive.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Managed Long-Term Services and Supports (MLTSS): Health plan that provides all long-term care services through a managed care delivery system. This system was approved in 2012, and by 2014, all existing home and community-based services programs (e.g., GO LTC) were closed, and participants were transitioned to MLTSS.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically needy income level (MNIL): The income standard that an individual must "spend down" to reach if their income is above eligibility limits. They may pay medical bills out-of-pocket until their income meets this standard.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set - Home Care (MDS-HC): The standardized assessment tool used to determine clinical eligibility for long-term care programs in New Jersey, including GO LTC and MLTSS. This is sometimes referred to as the NJ Choice assessment.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

New Jersey Department of Health (NJDOH): The New Jersey state Department responsible for overseeing health facilities and licensure.

New Jersey Department of Health and Senior Services (NJDHSS): The renamed Department of Health from 1996 to 2012, when it reverted back to the Department of Health.

New Jersey Department of Human Services (NJDHS): The New Jersey state agency responsible for administering the state Medicaid program.

New Jersey Division of Disability Services (NJDDS): New Jersey division within the Department of Human Services that administers the Personal Care Assistant Program (PCAP).

Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient (LTC-2): The referral form used to refer an individual for the Preadmission Screening standardized assessment in New Jersey if the applicant is referred by a nursing facility. Prior to 2006, the form number for the LTC-2 was MCNH-33.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: Groups that states may choose to cover through Medicaid, which may include aged and disabled individuals not receiving SSI and some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Assistant Program (PCAP): New Jersey Medicaid State Plan service for individuals who need assistance with aspects of their daily living due to functional impairment. PCAP provides personal care services to eligible Medicaid beneficiaries.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility. In New Jersey, personal care services are provided through the state plan Personal Care Assistant Program (PCAP).

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Preference Program (PPP): The Personal Preference Program (PPP) is an option under the Personal Care Assistance Program (PCAP) that allows individuals to direct and manage their services. It uses what is called a cash and counseling approach. Operating within a monthly cash allowance, participants in the program 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 hire to provide the services.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening (PAS) process: Individuals seeking financial assistance from New Jersey Medicaid for long-term care services must meet the program's medical (clinical) and financial eligibility requirements. The steps necessary to attain Medicaid approval are known as the Preadmission Screening (PAS) process, and include referral, standardized assessment, PASRR assessments, and service plan development.

Preadmission Screening (PAS) standardized assessment (PAS-1): The assessment form used to determine level of care and eligibility for nursing facility care in New Jersey.

Preadmission Screening and Annual Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for

mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service. Authorization may be given by the Department of Human Services staff or by a managed care plan.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Program of All-inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

RUG-III/HC case mix: The Resource Utilization Group (RUG)-III/Home Care (HC) case-mix system is a method of grouping patients in long-term and post-acute care settings. RUG-III groups patients by relative per diem resource consumption and may be used as the basis for prospective payment systems to ensure that facility reimbursement is commensurate with patient acuity. In New Jersey, this system is also used to determine a nursing facility level of care, as the level of care standard uses scores from the RUG-III/HC ADL index and Cognitive Performance Scale (CPS).

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Adult Day Care (SADC): A structured program that provides functionally impaired older adults with socialization, supervision and monitoring, personal care, and nutrition in a protective setting.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Social Security Disability Insurance (SSDI): Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In New Jersey, it is provided to all aged, blind, and disabled recipients, including children, except those in publicly operated community residences or facilities where Medicaid pays less than 50 percent of the cost of care. Supplementation provided to recipients in approved residential facilities.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

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1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See SSA (2023c) for more information.
2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
3. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
4. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).
5. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023e) for more information on these requirements.
6. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in New Jersey was $984 until July 1, 1992, when it was raised to $1,149 (NJ DHHS, 1991; NJDHS, 1992a). Authors were unable to verify whether New Jersey extended spousal impoverishment rules to CCPED during this time.
7. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992. In New Jersey, the community spouse's share of the couple's countable resources in 1992 is the greater of $13,740 or one-half of the couple's total resources, not to exceed the federal CSRA (NJDHS, 1992). Countable assets/property are real and personal property that are counted to determine eligibility. Authors were unable to verify whether New Jersey extended spousal impoverishment rules to CCPED during this time.
8. From 2009, New Jersey progressively added months to the standard 36 month look back rule until 2011, when the full 60 month look back period was in effect for all assets (NJDHS, 2009).
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in GO LTC and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2009, the MMNA in New Jersey was $1,821.25 (NJDHS, 2009a).
10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $109,560 in 2009 (NJDHS, 2009b). Countable assets/property are real and personal property that are counted to determine eligibility.
11. Attendant care is limited to 40 hours per week, and the attendant must be a participant-employed provider (PEP), meaning that the participant must hire and manage the caregiver of their choice.
12. Personal care services are limited to 40 hours per week, and are referred to as Home-Based Supportive Care under GO LTC. If a participant selects Home-Based Supportive Care, they are then excluded from receiving services under PCAP. If the participant requires more than 40 hours of care per week, the case manager must provide written justification for the increase and projected cost of additional services for approval and implementation by Department staff.
13. Chore services are provided only when neither the participant, nor anyone else in the household is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or third party payer capable or responsible to complete this chore.
14. The ACA provided 100% matching for newly eligible individuals with incomes up to 138% of the FPL between 2014-2016, and phased down to 90% matching until 2020 where it remains.
15. The look back period is 60 months prior to the date of application for all assets (NJDHS, 2009).

16. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in MLTSS and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2012, the MMNA in New Jersey was $1,838.75 (NJDHS, 2011b).

17. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $113,640 in 2012. Countable assets/property are real and personal property that are counted to determine eligibility.

18. Eligibility track 2c (ACA expansion adults) uses federal tax filing concepts to determine household size, unlike other tracks where households are limited to an individual or couple. See NJDHS (2014) for an explanation of household composition determinations under this track.

Version information

Current Version: 1.0 (November 2023)

Version History

- 1.0 (November 2023): First version.