



2025 Beverly Roberts Memorial Healthcare Symposium

“Navigating the Medical Insurance Maze for
Adults with Intellectual and Developmental
Disabilities (IDD)”



November 6th, 2025

Zoom Reminders

- Slides and the recording will be available on The Arc of New Jersey website:
<https://www.arcnj.org/programs/health-care-advocacy/beverly-roberts-health-care-symposium.html>
- Each presentation will have brief Q&A at the end.
- In order to ask a question, use the Q&A box.
- You will not be able to unmute.
- Certificates of attendance will be included in a Zoom email, sent out 24 hours after today's event concludes.

Kim Musheno
Senior Director of
Medicaid Policy
The Arc of the U.S.



KEEPING THE PROMISE OF NJ FAMILYCARE: WHAT P.L. 119- 21 MEANS FOR NEW JERSEY

November 6, 2025



Medicaid is important!

- It pays for early intervention (EPSDT), school-based services, employment support, respite
- Covers health care and long-term services and supports -- essential for financial security
- Creates jobs in the health care sector and increases employment for people with disabilities
- Provides critical funding for rural hospitals and other critical health care infrastructure

Medicaid – New Jersey Family Care

- Medicaid and CHIP programs—covers about 1.8 million New Jerseyans:
 - **over 823,000 children**
 - **683,000 non-disabled adults**
 - **more than 307,000 individuals who are aged, blind, or disabled.**
- 62,306 people are receiving services in home- and community-based waiver programs
- 2,688 are on a waitlist to receive Medicaid-funded HCBS



Budget Law P.L. 119-21

- Budget reconciliation bill signed into law on July 4
- Senate passed HR 1 on July 1 on a 51-50 vote
- House passed the Senate-passed bill on July 3 (218-214)
- The law includes numerous provisions related to Medicaid, CHIP, ACA, SNAP, and school vouchers

The myths

- Just eliminating Fraud Waste and Abuse
 - Few provisions that enhance existing fraud detection programs
 - Bill labels the highly regulated, legal, provider tax provisions "abuse"
 - Bill labels frequent eligibility checks as fraud provisions

Myths

- Doing this to protect the most vulnerable people and sustain Medicaid
 - Only 2% addressed fraud and abuse
 - Bill does **not** reinvest savings into the Medicaid program
 - Savings used for other federal priorities
 - Cuts will hurt the Medicaid program
 - Hospitals and other providers rely on Medicaid to keep health care system intact and cuts to coverage or general Medicaid mean more uncompensated care and threaten closures of health care facilities and fewer providers accepting Medicaid
 - Changes will likely require more cuts in Medicaid
 - Cuts will hurt vulnerable people
 - People will lose health coverage which means the doctor visits, medications, therapies, and other health care costs must be absorbed by individuals and families

Big Budget Law Impacts

- Congressional Budget Office (CBO) estimates the Medicaid cuts total **\$1 trillion** over 10 years, an historic cut (20%)
- CBO estimates the number of uninsured individuals will increase by at least **10 million** in 2034
 - 5.1 million people lose coverage because it does not extend the advanced premium tax credits (APTC)
- In NJ KFF estimates **300K** could lose coverage (3%) taking into account Medicaid, CHIP and ACA cuts
- Only 2.5% address waste, fraud, and abuse

Targets the Medicaid Expansion



Adds work requirements



Reduces flexibility to raise revenue



Requires eligibility checks at least every 6 months



Adds up to \$35 dollar copays



Eliminates an incentive for states that have not yet expanded Medicaid (10 states)



10 states are: AL, FL, GA, KS, MS, SC, TN, TX, WI, WY

Provider tax limits – Financing

- Expansion states: hold-harmless threshold steps down from 6% to 3.5% by FY 2032
- NJ implications:
 - Relies on hospital, nursing home, MCO, and other assessments
 - If cap tightens, state must backfill or cut eligibility, services, or rates
- Modeling suggests multi-billion-dollar exposure in current financing architecture

Directed payments caps

- Caps state-directed payments at 100% of Medicare for expansion states
- NJ implications:
 - Constrain value-based add-ons used to stabilize access
 - Potential pressure on programs like Quality Improvement Program–New Jersey (QIP–NJ), Medicaid Access to Physician Services Program (MAPSP), behavioral/maternal health incentives
- Reduces key “levers” New Jersey uses to stabilize safety-net care and reward quality
- Caps that tie these payments to Medicare levels can constrain how strongly the state can support hospitals and physician access through these programs

Community Engagement (Work Requirements)

- "Able-bodied" narrative
- Most in Medicaid expansion already working
- Starting 2027, requires proof of 80 hrs/mo community engagement as condition for Medicaid
- Administrative churn causing loss of coverage even among eligible people – 5 million expected to lose coverage (700,000 in NJ)
- People with IDD, "medically-frail", caregivers exempt
- Design choices (exemptions, reporting pathways, grace periods) will determine harm

Who Are "Able Bodied"

- Summary of an analysis published in the Milbank Quarterly
 - Consistent with other research (including KFF), the vast majority of people on Medicaid are either working, caregiving or exempt because of disability.
 - For the people who are not working, they primarily are middle-to older age women, who left the workforce due to caregiving, are very low income, and have a high school education or lower.

Cost-Sharing and Retroactive Eligibility

- New cost-sharing required for expansion adults of up to \$35 (starting Oct 1, 2028) with service protections
- Retroactive eligibility reduced to 1 month (expansion adults) and 2 months (others) (from 3 months)
- Financial risk for families after emergencies; harder transitions into HCBS and post-acute care

Eligibility Changes and Program Integrity

- Pauses key CMS 2024 streamlining pieces; increases identity and duplication checks
- Fewer categories of non-citizens are eligible for coverage
- Reduces Medicaid match for emergency care
- Raises administrative load on counties and state eligibility staff
- Higher risk of erroneous terminations for paperwork reasons

New Waiver Option

- Adds new 1915(c) waiver to provide HCBS to individuals who do not require an institutional level of care
- Authorizes \$50 million in FY 2027 for implementation and \$100 million in FY 2028 for states
- New waivers may not be approved until July 1, 2028
- Unclear if states will take up this new waiver with new budget restraints
- Lots of questions about implementation

People with IDD Will Be Impacted

- Cuts to Medicaid in one area affect all others—cascading effect
- People with IDD are found in all parts of the Medicaid program
- Overall cut in federal funding and more uninsured will challenge hospitals and other medical providers.
- While the bill does not directly target HCBS spending --history shows that a loss of Medicaid funding hurts HCBS – see [study](#)



What Can We Do?

How to reduce harm

- Design exemptions & protections aggressively. Ensure people with disabilities clearly qualify for mandatory or optional exemptions
- If the state elects more frequent compliance checks, adopt broad “good cause” policies, multiple reporting pathways (phone, mail, online, in-person), and reasonable grace periods to prevent erroneous terminations
- Invest in eligibility infrastructure. Simplify forms, expand language access, co-locate navigators at hospitals, clinics, schools, ADRCs, and I/DD provider agencies, and fund community partners for assisted enrollment and redeterminations.

How to reduce harm

- Proactive churn prevention. Use text reminders, pre-populated renewals, address-update campaigns, and data matches to avoid mail-return terminations—especially for people with I/DD and HCBS participants who are most harmed by service interruptions.
- Protect HCBS first. Prioritize rate stabilization for DSPs, crisis teams, and behavior supports; fast-track CCP slots for those at highest risk; and keep Supports Program access swift for everyone eligible.
- Measure what matters. Publish a quarterly, county-level dashboard: churn rates, HCBS service interruptions, wait-time indices for therapies, DSP vacancy and turnover, hospital financial distress indicators. Run rapid-response fixes where metrics flash red.

What to advocate for with Congress/CMS

- Relief on provider-tax step-down and directed-payment caps tied to access outcomes
- Work-requirement guardrails (or repeal): simple reporting, presumptive exemptions, grace periods
- Restore 3-month retroactive eligibility
- Lift streamlining moratorium so states can reduce red tape

Advocate to reverse cuts

- Protecting Healthcare and Lowering Costs Act introduced (HR 4849) & (S2556)
- Sen Hawley (MO) introduced a bill to repeal provider tax provisions and increase funds for rural health
- Opportunity to get Members on record for supporting health care
- Continue to educate federal policymakers



New Resources: In chapter toolkit

- Law overview (also in plain language)
- Updated state fact sheets
- Update Q&A/Myth buster
- New SNAP fact sheet
- Updated action alert to share impact stories





Advocates from The Arc have contacted Congress over 600,000 times this year! A record.

Together we are powerful!





**Thank you.
Questions?**



Break



Craig Ismaili
Supervising Attorney
Disability Rights New
Jersey





Medicaid Appeals - How to Approach the Reduction or Termination of Medicaid Benefits and Eligibility



ADVANCING JUSTICE. ADVOCATING INCLUSION.



Meet the Presenter



Craig Ismaili, Supervising Attorney



About Disability Rights New Jersey

Disability Rights New Jersey is a private, non-profit, consumer-directed organization established to:

- Advocate for and advance the human, civil and legal rights of residents of New Jersey with disabilities;
- Promote public awareness and recognition of individuals with disabilities as equally entitled members of society;
- Advise and assist persons with disabilities, family members, attorneys and guardians in obtaining and protecting the rights of individuals with disabilities; and
- Provide education, training and technical assistance to individuals with disabilities, the agencies that serve them, advocates, attorneys, professionals, courts and others regarding the rights of individuals with disabilities.



Housekeeping Items

- This webinar is being recorded. The presentation and recording will be shared.

AUDIO AND VIDEO

Your audio and video are muted.

TO ASK OR RESPOND TO QUESTIONS

Use the chat for panelists and all attendees

ACCESSIBILITY

Subtitles are available. To see subtitles: **“more> show subtitles”**

Contact me with accessibility concerns



Legal Disclaimer

- Information provided for informational purposes only and does not constitute legal advice
- No contract or attorney-client relationship
- No promise or warranty
- *We have tried to use language that is person-centered, and affirms the individual with a disability's rights, but we recognize that the disability community has varied preferences on terminology.*



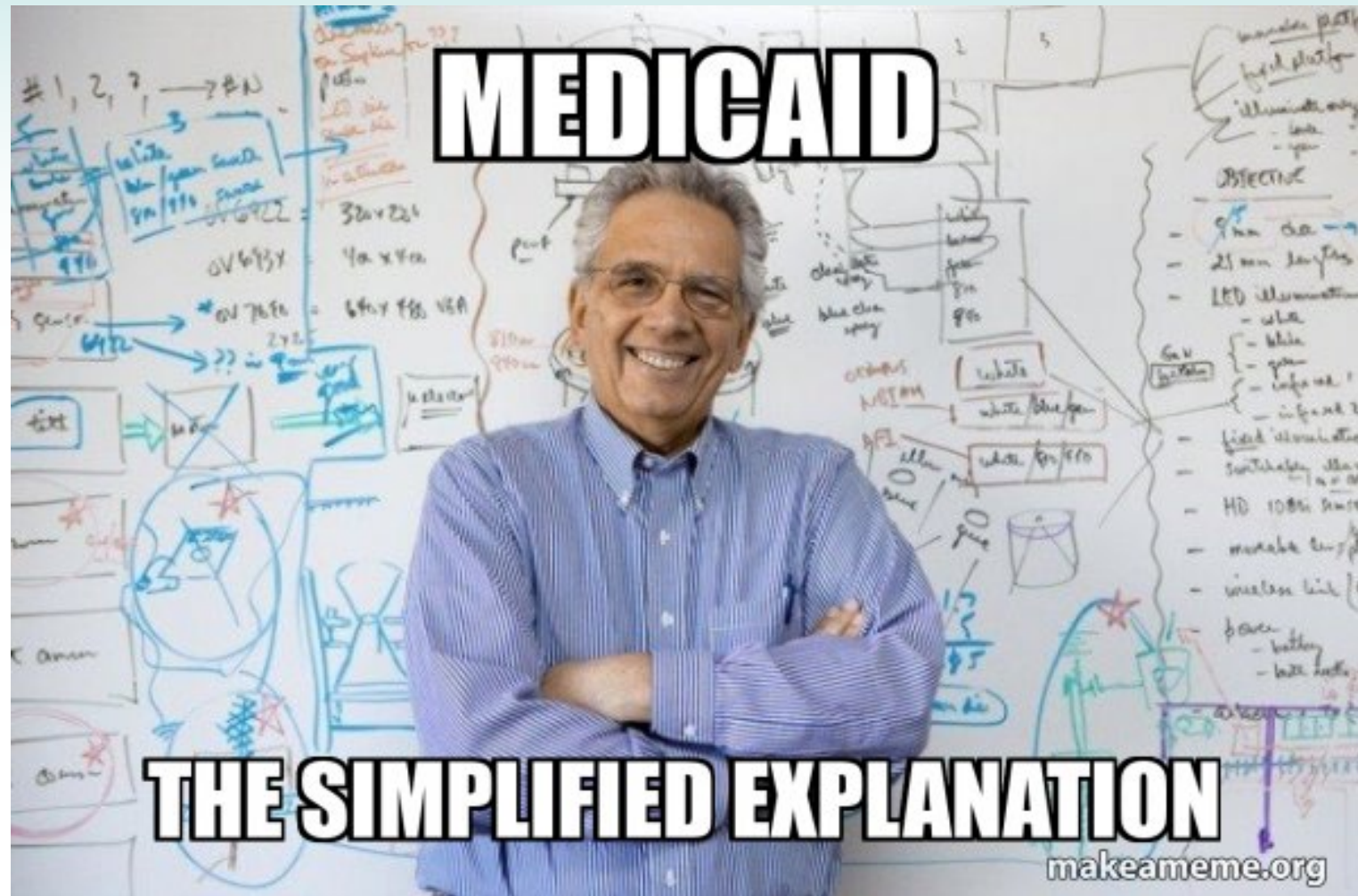
Agenda – 45 Minutes & 15 Minute Q&A

- Medicaid & MLTSS PDN & PCA overview - 15 min.
- Appeal rights & steps (internal appeals, fair hearings) - 25 min
- One Big Beautiful Bill Act Medicaid Cuts: expected changes & NJ impact - 5 min
- Wrap Up/Questions – 15 min.



Acronyms and Initialisms

- MCO – Managed Care Organization (ie: Horizon, UnitedHealthcare,, Aetna Better Health, Wellpoint, Fidelis Care)
- ABD – Adverse Benefit Determination
- COB – Continuation of Benefits. This means, if you already receive an ongoing Medicaid service, it is possible to continue receiving the service during the appeal
- PDN – Private duty nursing
- PPP – Personal Preference Program
- PCA – Personal Care Assistance





Medicaid in NJ — quick primer

- Administered by NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS).
- DMAHS manages eligibility and benefits, which are set according to the NJ Managed Care contract
- MLTSS: Managed Care Organizations (MCOs) authorize long-term supports and services (including PCA & PDN) for beneficiaries
- Eligibility (financial & categorical) vs. medical necessity for service authorization
- This presentation is going to focus on PDN and PCA services



Private Duty Nursing Services

- Individual, continuous nursing care to beneficiaries who exhibit a severity of illness that requires complex Skilled Nursing Interventions on a continuous ongoing basis
- Available to Supports Plus PDN (SPPDN), MLTSS, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) beneficiaries
- No cap for children, 16 hour cap for adults (age 21)
 - DRNJ currently contesting cap
- Need a capable adult primary caregiver residing with individual who accepts ongoing 24-hour responsibility for health and welfare of beneficiary
 - N.J.A.C. 10:60-5.3



Medical Necessity Qualification Criteria for PDN

- Medical necessity for MLTSS/PDN & SPPDN services measured using Assessment and Acuity tool, based upon the following criteria:
 - A requirement for **all** of the following medical interventions: Dependence on mechanical ventilation; the presence of an active tracheostomy; the need for deep suctioning
 - or **any** of the following medical interventions:
 - The need for around-the-clock nebulizer treatments, with chest physiotherapy; or
 - Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or
 - a seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsants; or
 - The need for other skilled nursing interventions on an ongoing basis
- (N.J.A.C. 10:60-5.9.d)



PCA and PPP services

- PCA services are non-emergent, on-going health related care performed by qualified staff in a NJ FamilyCare eligible beneficiary's home
- PCA participants receive services through an agency hired by their managed care plan.
- Personal Preference Program (PPP)
- PPP participants receive a monthly cash allowance to hire their own care provider, including friends, family, or professionals. Participants are responsible for becoming the employer of record and managing their budget

Eligibility Criteria

- Obtain a doctor's order to receive the service (do not have to be permanently disabled)
- Live in a community-based residence (private home, apartment, rooming house, or boarding home) or group home, skill development home, supervised apartment or other congregate living program where personal care is not provided as a part of the service package included in the living arrangement
- Have a documented need for hands-on personal care based on state-wide assessment tool



PCA services may include assistance with the following:

Activities of Daily Living (ADLs) - Fundamental self-care tasks needed for basic personal care and survival.

- **Examples:**

- Bathing/showering; Dressing; Eating; Transferring (moving from bed to chair, for example); Toileting; Personal hygiene

Instrumental Activities of Daily Living (IADLs) - More complex tasks that support independent living in a community.

- **Examples:**

- Meal preparation; Housekeeping; Managing finances; Medication management; Using transportation; Shopping for essentials; Communication (phone, mail)

Any unused PCA hours of service cannot be saved or carried over for use on a subsequent date



NJ Specific Issues RE: Overlap of PDN/PCA

- *T.M. v. Division of Medical Assistance and Health Services*
- PDN regulations hold that MCO may only approve for a maximum of 16 hours of PDN daily
- Appellate Division Case law precedent that PCA hours were duplicative of PDN hours, limited COMBINED total of PDN and PCA services to 16 hours.
- Disability Rights NJ is currently reviewing challenging *T.M.* and related case law.



Appealing a Denial, Reduction or Termination of Services: The ABD



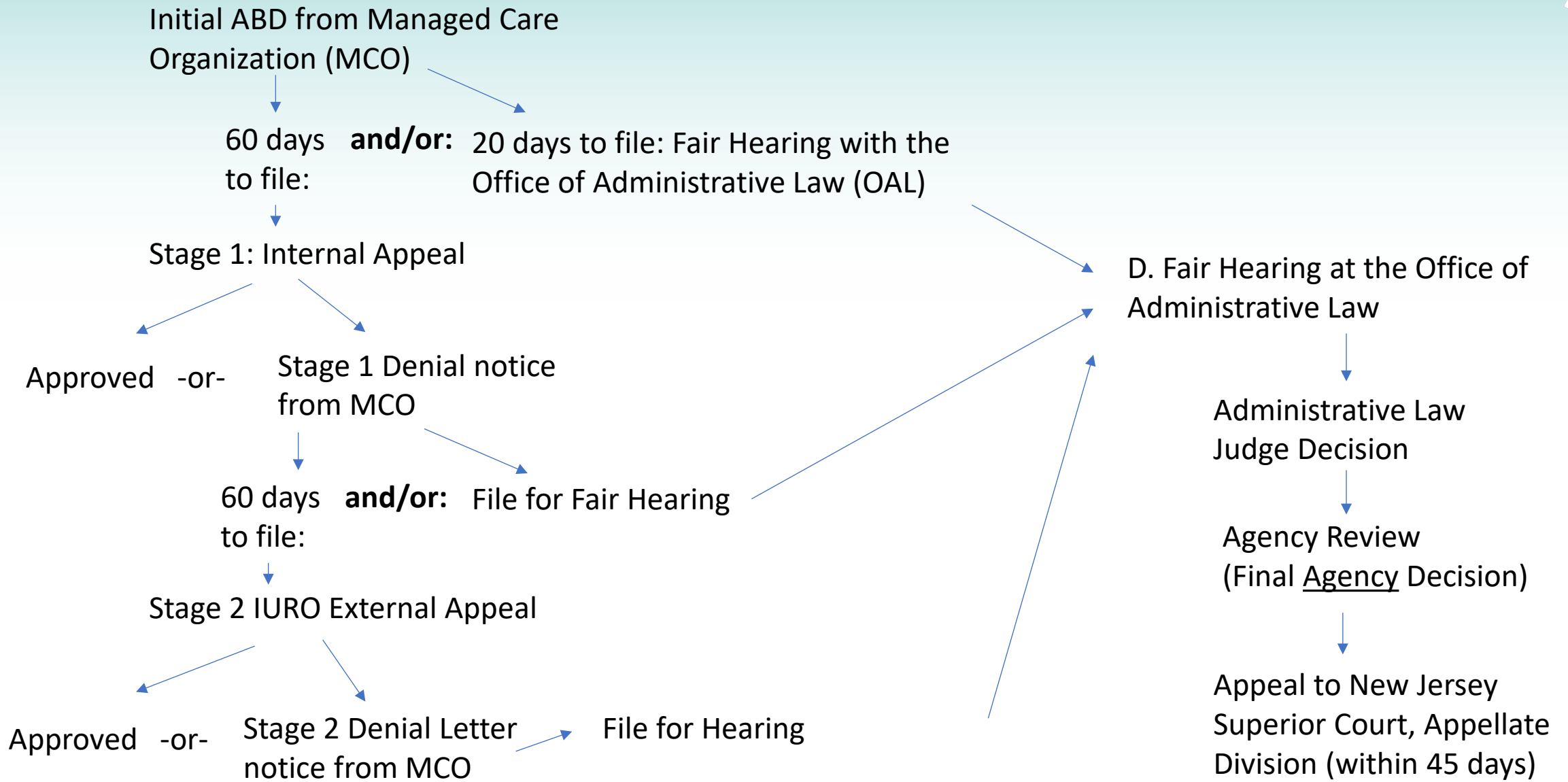
- MCO must provide a written notice of a denial, reduction or termination of service, called a “Notice of Adverse Benefit Determination” (ABD)
- MCO must mail the ABD at least 10 days before the date of the action.
 - 42 CFR § 431.211
- When an MCO makes an adverse Medicaid decision, it must notify the Medicaid member in writing of:
 - The action it intends to take;
 - Why it wants to take that action;
 - What regulations or laws support the action;
 - Your right to appeal;
 - When and how you can continue your benefits during appeal.
 - 42 CFR § 435.917



What are your rights regarding filing your appeal?

Your MCO must provide:

- reasonable assistance to help you file an appeal (i.e. Interpreters, teletypewriter, auxiliary aids, etc.);
- Confirmation that the MCO received your appeal;
- A copy of your entire case file from the MCO in advance of the deadline to file an appeal;
- The opportunity to submit new documents that were not considered at the time of the initial decision;
- The opportunity to present documents, testimony and arguments in person;
- Have the assistance of a representative of your choosing in the appeal.





First Step: Informal Reconsideration

- Most MCOs allow you to discuss the decision with the health care professional responsible for the adverse determination by calling the Utilization Management Department
- Typically within 7 business days
- Extremely unlikely to be successful in overturning adverse decision
- Typically only available during normal business hours 9-5 M-F.
- Not on the flowchart, because unlike internal appeal, do not need to exhaust to proceed to next appeal level



Internal Appeal

- An internal appeal is the first step in the administrative appeal process.
- The internal appeal is asking the MCO to take a second look at its decision.
- You may request an internal appeal to the MCO within 60 calendar days of the date on the Notice of Adverse Benefit Determination.
- An appeal made by telephone establishing the date of the appeal, but must be confirmed in writing.
 - Ask for reference number of your call requesting appeal.
- Timely file appeal and keep proof of filing (certified mail and/or fax receipt)



Continuation of Benefits (COB)

To keep your current services during the appeal process, you must file an appeal to your MCO either:

- **10 days** from the date on the Notice of Adverse Benefit Determination; **OR**
- Before the effective date of the proposed Notice of Adverse Benefit Determination.
 - Check in with Medicaid case manager to find out what day the appeal must be submitted by.
- **Continuation of Benefits NOT automatic during the appeal process.**
- If the ultimate State Fair Hearing decision isn't in your favor, you may have to pay for the services you asked to continue pending the resolution of your appeals.



Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	ABD	X	X	X	X
X	X	X	X	X	COB APPEAL DUE DATE	19
20	21	22	23	24	25	26
27	28	29	30	31		



Example of Written Follow-Up to Request Internal Appeal

Dear Managed Care Organization,

I received a notice that my personal care services were being reduced effective November 15, 2025. The notice was dated November 1, 2025. I called to file an internal appeal on November 6, 2025. All of my/my loved one's personal care services remain medically necessary, my condition has not improved, and I/my loved one will be at risk of harm if the services. I also requested a continuation of my current benefits pending appeal. I am attaching a letter of medical necessity from my doctor, and a letter from my caregiver agency documenting that my need for service remains the same. Please reverse the reduction/termination of services.

Sincerely,
Jane Doe



Expedited Appeals

- You or your service provider may request an expedited appeal when you or your service provider feel that taking the time for a standard resolution could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- If the expedited appeal is approved, your MCO must make a decision within 72 hours of receiving the expedited appeal request.



External Appeal

- Independent Utilization Review Organization
 - After Internal Appeal is Denied, have 60 days to file an appeal to IURO
 - The IURO will decide your appeal within 45 calendar days.
- Expedited Appeals also available for External Appeals, if the normal 45-day decision time will harm your health.
- Expedited Appeal decision within 48 hours



External Appeal Sample Letter

- Example Format of Letter
 - Paragraph 1: Description of client (age, your relationship with her, and a brief sentence or two of why she needs PDN)
 - Paragraph 2: Diagnoses and medications
 - Paragraph 3: Functional or Medical Needs
 - Paragraph 4: Extenuating Circumstances: No assessor from the MCO did an in-person or virtual assessment to make the determination; that her doctors care team continue to believe the PDN services are medically necessary. Explain why the decision is incorrect
 - Paragraph 5: summarize the amount of PDN doctors say is medically necessary, the reason why, and request they reverse the decision to terminate PDN services
 - Paragraph 5: Conclusion and requested relief



Medicaid Fair Hearing

- Must exhaust internal appeal procedure, but **NOT** External Appeal.
- Must submit a written request to DMAHS within 120 calendar days of the date on the MCO's ABD, or within 20 days of receipt of the adverse agency decision, by mail or by fax.
- Your ABD will explain how to properly request a Medicaid Fair Hearing.
- You can either ask for the external appeal BEFORE fair hearing, or can ask for BOTH SIMULTANEOUSLY
- Request will operate as a stay of any adverse agency action pending resolution of the fair hearing.



Medicaid Fair Hearing Request Form

2

Reason for our action:
The reason for our action is: This is a member with history of multiple falls and requires assistance for bathing, dressing, meal preparation and household tasks. As per documentation submitted, the prior and current assessments conclude 22 hours of care. The member should continue to get 22 hours of care as determined by the nursing assessment.

APPEAL RIGHTS

If you disagree with this decision, you (or your provider, with your written consent) now have the right to request a Medicaid Fair Hearing with the State of New Jersey.

Medicaid Fair Hearing Process:
You now have 120 calendar days from the date of this letter to send in your request to the State of New Jersey for a Medicaid Fair Hearing.

If you are currently receiving these services and want your services to continue during the Medicaid Fair Hearing process, you must ask that the services continue while the Fair Hearing is taking place.

- **IMPORTANT:** Although you have 120 calendar days to request a Medicaid Fair Hearing, you only have ten (10) calendar days from the date of this letter or until the end of the prior approved authorization, whichever is later, to request that your services continue during the Medicaid Fair Hearing process. If you do not request that services continue during this timeframe, the services will not continue.

If you request that your services continue while your appeal is taking place and your Medicaid Fair Hearing outcome is not in your favor, you may be required to pay for the cost of the services.

If you would like to file for a Medicaid Fair Hearing, please fill out the section below and return a copy of this **ENTIRE** letter, including **ALL** the pages, to:

State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712; **OR**

fax this **ENTIRE** letter, including **ALL** the pages, to 1-609-588-2435.

Your name (print) _____

NJ-MEM-0718-17 NJAP01 Internal Appeal Recurring Services PCA A, ABP, FC ENG

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Your phone # _____ Date _____

I would like to request a Medicaid Fair Hearing because: (Please state here why you disagree with the action taken above or attach a separate letter.)

_____ Check here if you would like to request a continuation of services while this appeal is taking place.

You have the right to an interpreter for the Medicaid Fair Hearing. You can request an interpreter from Amerigroup. If you would like to request an interpreter from Amerigroup, check below and indicate the language you need. You may also bring a relative or friend to interpret for you. (You do not need to check the box if you will bring your own interpreter.)

_____ I am requesting an interpreter for the Medicaid Fair Hearing in the following language: _____

 **Right to Representation:**
You have the right to represent yourself, have someone else represent you, or have legal representation. If you would like legal representation and are not able to pay for it, you can contact one of the following:

- Legal Services of New Jersey at www.LSNJLawHotline.org or call Legal Services of New Jersey at 1-888-576-5529;
- Disability Rights New Jersey (DRNJ) at advocate@drnj.org or call DRNJ at 1-800-922-7233 (TTY: 711) for free legal and advocacy services for people with disabilities; or
- Community Health Law Project (CHLP) at chlpinfo@chlp.org or call CHLP at 1-(973) 275-1175 to be directed to the appropriate office serving your county. A list of CHLP offices can also be found at www.chlp.org.

Additional help is available if you are disabled or LEP (Limited English Proficient). If you need help in other languages, please see the attached notice. If you are blind or otherwise disabled and need help with this letter, please call Amerigroup at 1-800-600-4441 (TTY 711).

NJ-MEM-0718-17 NJAP01 Internal Appeal Recurring Services PCA A, ABP, FC ENG



Medicaid Fair Hearing

- Presented in front of Administrative Law Judge (ALJ)
- Settlements = frequent before and during hearing
- Often remote via Zoom, rather than in person now
- Proceeding to a fair hearing
 - Relaxed evidence rules, but can make relevant objections
 - Witness list
 - Exhibit list
 - Experts – limit the scope when possible
 - Procedural violations must be raised (or you lose the opportunity to do so on appeal)
 - **ALL Fair Hearing on MCO/DMAHS decisions are de novo!**



Preparing for Fair Hearing

- Review the Appeal Decision carefully
- Gather documentation
- Create a strong record
- Subpoena witnesses
- Provider orders and letter/statement of medical necessity.
- Opening and closing Remarks
- Preparing witnesses in advance of the hearing
- Witness statements

TIME	SKILLED NURSING ACTIVITY	AMOUNT OF TIME SPENT ON ACTIVITY
6:15 am - 6:30 am	Nurse checks vitals – deploys oxygen as necessary	15 minutes
6:30 am-7:45 am	Changes diaper, checks rash on groin and administers medicated cream, cleans around g-tube and applies packing, assists with changing for school to ensure the g-tube doesn't fall out, prepares formula for morning feed	90 minutes



After Fair Hearing Next Steps

- Additional document Submissions & Post-Hearing Briefs
- ALJ decision sent to DMAHS for review
- Initial Decision and Filing Exceptions
- Final Agency Decision



Appeal to Appellate Division?

- Appellants may appeal adverse fair hearing decisions to the Appellate Division for review.
 - N.J.A.C. § 10:60C-9.3(g)
- These reviews must be filed within 45 days of the final agency decision
 - N.J.S.A. 2:4-1(b).
- Appellate Division must review agency decision on clear error standard
- May lead to settlement with MCO due to continued cost to litigate matter.

One Big Beautiful Bill Act & Medicaid Cuts Incoming

- Reconciliation bill with large Medicaid funding and policy changes (work requirements, cost-sharing)
- Analyses project significant enrollment and coverage reductions
- Creates administrative burdens and barriers to access to care for disabled and non-disabled Medicaid beneficiaries
- Likely to drive increased terminations/reviews at state level





Potential NJ Impacts to OBBBA

- Work requirements in Medicaid leading to disenrollment and reenrollment bars.
- Increased state administrative reviews & documentation requests
- Risk of narrower coverage or higher state cost-sharing choices
- Pressure on provider payment rates and MLTSS authorizations
 - Potential increase in “paper denials” and overreach from algorithmically-generated service cuts.



MCO Contact Information

(Accurate as of 11/05/2025)

- United Healthcare Community Plan - 1-800-941-4647
- Horizon NJ Health - 1-800-701-0710
- Aetna Better Health NJ - 1-855-232-3596
- Wellpoint - 1-855-232-3596
- Fidelis Care - 1-888-453-2534

Always document your phone calls with the MCO – time, name, employee name, ID number, and reference number for the call.



Contact Us for More Information:

We are located at:

**210 South Broad Street, Third Floor
Trenton, New Jersey 08608**

We can be reached at:

800-922-7233 (NJ Only)

609-292-9742

advocate@disabilityrightsnj.org



Visit us online: DisabilityRightsNJ.org



@disabilityrightsnewjersey



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@disability-rights-nj



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Questions?



Break



Kelly Ott

NJ SHIP Program Specialist &
Certified Counselor
NJ Division of Aging Services



Michele Lee

NJ SHIP Program Specialist &
Certified Counselor
NJ Division of Aging Services





Dual Eligibility

Understanding Medicare + Medicaid Enrollment & Coordination of Benefits

Kelly Ott & Michele Lee, NJ SHIP



SHIP

State Health Insurance
Assistance Program

Navigating Medicare

State Health Insurance Assistance Program (SHIP)

SHIP provides free help to New Jersey Medicare beneficiaries who have problems with, or questions about their health insurance. SHIP is a statewide program administered by the New Jersey Department of Human Services and funded in part by a grant from the U.S. Administration for Community Living.

Medicare beneficiaries frequently have questions about benefits, claims, coordination of benefits and supplement policies.

Volunteer counselors, trained and certified in areas of health insurance coverage and benefits that affect Medicare beneficiaries, provide information and assistance for dealing with claims and in evaluating health insurance options.

Medicare Different from MEDICAID

Medicare is federal health insurance for aged(65+) & disabled(collecting SSDI)



Medicaid is medical assistance program administered by the states under federal rules for people with very low incomes.



***Some people have both Medicare and Medicaid: referred to as “**dual eligible**” or “**dual**”.
Federal term is **Qualified Medicare Beneficiary (QMB)*****

Medicare

- Medicare is a federal health insurance program for people age 65 or older and for people who have been getting SSDI for at least 2 years.
- There are 2 exceptions to this rule to receive Medicare benefits sooner:
End-Stage Renal Disease or Lou Gehrig's disease(ALS)
- Social Security Administration(SSA) is responsible for Medicare enrollment and eligibility
- [Call 1-800-772-1213](tel:1-800-772-1213) or visit www.ssa.gov for more information

What does Medicaid cover for duals?

- All Medicare cost-sharing
 - Part A and Part B monthly premiums and late enrollment penalties
 - Part A, Part B & MA deductibles and co-insurance
- **Automatic enrollment in Low Income Subsidy for Part D Drug Plan costs (LIS drug copays apply)**
- Provides many services not covered by Medicare:
 - Dental
 - Eyeglasses
 - Chiropractors
 - Hearing aids
 - Medical Day Care
 - Non-emergency medical transportation
 - Personal Care Assistance
 - Adult diapers
 - Home Health Aides
 - Care Management

➤ Above benefits provided thru the Medicaid MCO plan

For Medicare Covered Services

- Medicare primary
 - Provider does NOT need to be Medicaid provider
 - Claim goes to Medicare, provider gets same reimbursement as non-duals
- Medicaid MCO will consider additional payment of Medicare cost sharing (deductibles, co-insurance)
 - Provider may need to manually submit claim to Medicaid MCO
 - Usually Medicaid will only make additional payment if Medicaid rate higher than Medicare rate for service (rare)
- Dual Eligible Client NOT responsible for balance
 - Medicare payment (and Medicaid payment if any) must be considered “payment in full”

Cost Sharing and Balance Billing Issues

- Provider must accept Medicare payment and Medicaid payment (if any) as payment in full
 - Medicare provider has right not to treat dual eligibles
 - If agrees to treat, cannot bill the patient for any balances after Medicare pays
 - Billing dual eligible patient for balance after Medicare pays is called “balance billing” and prohibited under federal and state laws
- A Medicare provider **CANNOT** ask dual to sign “waiver” or private contract to pay privately.

Balance Billing Issues

If client is being billed cost share by their doctor for Medicare covered service:

- call provider's billing office to explain patient is dual eligible (referred to as Qualified Medicare Beneficiary: QMB)
- Educate them that provider must accept Medicare payment as payment in full.
- Call 1-800-Medicare to file complaint against the provider

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Coordination of Benefits

- The goal is to provide dually eligible individuals seamless, high quality health care while keeping the system as cost effective as possible.
- Providing dual eligible individuals full access to the benefits to which such individuals are entitled to under the Medicare and Medicaid programs.
- Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
- Improving the quality of health care and long-term services for dual eligible individuals.
- Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
- Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
- Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.
- Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.
- Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

Coordination of Benefits Overview

Each type of health insurance coverage is called a “payer”

When there's more than one payer, coordination of benefits rules determine which pays first

There may be primary and secondary payers, and in some cases, there may also be a third payer

- Medicare may be primary payer or secondary payer
- Medicare may make no payment in some cases

Primary and Secondary Payers

How other insurance works with Medicare-covered services

- Insurance that pays first (primary payer) pays up to the limits of its coverage
- Insurance that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs

If your employer insurance is the secondary payer, you usually need to enroll in both Medicare Parts A and B before your insurance will pay

Possible Health Claims Payers Other than Medicare



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Who is Dual Eligible?

- Dual Eligible individuals are eligible for both, Medicaid and Medicare.
- The federal term for a dual eligible is “Qualified Medicare Beneficiary Plus” or QMB+
- Dual Eligibles are automatically eligible for **Low Income Subsidy (LIS)**, also called Part D “**Extra Help**”, which provides assistance to pay prescription drug costs.
- Most dual eligibles receive their prescription drugs from **Medicare Part D – not from Medicaid**.
 - **The exception is dual eligibles who also have private health insurance, usually through a parent’s employer.**

What happens when someone on Medicaid becomes eligible for Medicare?

- If on **SSI** or **MLTSS**, or **Medicaid for Aged, Blind, Disabled** first, will automatically become a dual eligible:
 - By turning age 65 or
 - Under age 65 and getting Social Security Disability for 24 months
- Will automatically be enrolled into Medicare A and B
 - Medicare becomes PRIMARY insurance for hospital and medical
 - Medicare monthly premiums for A and B will be paid by Medicaid
 - May be delay of 1-3 months. Person will be reimbursed by SSA.
- Will automatically be enrolled into Part D Drug Plan with Extra Help (LIS)
 - Medicare now pays for Rx, NOT Medicaid
 - Copays may apply
- No change to the Medicaid MCO enrollment

If an individual with Medicare and Medicaid also has private health insurance...

- Usually not permitted to have drug coverage from both private health insurance and Medicare Part D.
- If private health insurance drug coverage is as good as (or better than) Medicare Part D, employer should provide a letter of “creditable coverage.”
- **You need to Opt out/Disenroll from Medicare Part D.**
- When a dual eligible also has private health insurance (and is not enrolled in Medicare Part D), NJ Medicaid should continue to cover the drug co-pay costs.
- If your pharmacy needs help billing both your private drug plan and Medicaid, call NJ Medicaid Pharmacy Unit for help at 609-588-2732.

HEALTH CARE ADVOCACY

Advocating for quality health care for people with intellectual and developmental disabilities

WHAT IS A DAC?

A Section 1634 "Disabled Adult Child" or "DAC" is a designation under the Social Security Administration (SSA) whereby an adult individual with blindness or a disability, who previously received Supplemental Security Income (SSI), is eligible to receive Medicaid as long as the individual is determined blind or disabled. If the individual receives income from another source or exceeds resource limits, the individual could lose Medicaid coverage.

WHO IS ELIGIBLE?

An individual who was receiving SSI benefits and:
Is at least 18 years old;

- Has blindness or a disability that began prior to age 22;
- Has been receiving SSI based off blindness or disability; and
- Has lost SSI due to receipt of Social Security benefits from a parent's work record resulting from a parent's retirement, disability, or death.

FREQUENTLY ASKED QUESTION (FAQS) ABOUT SECTION 1634 DISABLED ADULT CHILD (DAC)

HOW IS DAC STATUS INITIATED?

When a parent retires or becomes disabled and starts collecting Social Security benefits, or the parent passes away, the adult child eventually begins receipt of a monthly SSDI or disability benefit (a Survivor's Benefit, if the parent passed away) based upon the parent's work record. The child could receive a monthly benefit that is equivalent to 50% of the monthly benefit amount that the parent receives.

WHEN DOES THE CHILD RECEIVE SSDI AFTER THE PARENT STARTS COLLECTING SOCIAL SECURITY BENEFITS?

The child does not necessarily receive SSDI and DAC status immediately after a parent begins collecting Social Security benefits. There can be a delay of months or even years. At some point, Social Security will contact you about completing a new application for your child to receive SSDI and be considered a DAC. In the meantime, the child's current benefits would continue as long as they remain eligible.

DOES MY CHILD RECEIVING SSDI AFFECT MY SOCIAL SECURITY BENEFITS?

No, if a parent retires or becomes disabled and starts collecting Social Security benefits, the benefit amount is not affected by the child receiving SSDI benefits based on the parent's work record.

HEALTH CARE ADVOCACY

Advocating for quality health care for people with intellectual and developmental disabilities

WHAT IF MY CHILD IS ALREADY RECEIVING SSI AND THEN I START COLLECTING SOCIAL SECURITY BENEFITS?

If the parent only has a small work record and is not receiving a large Social Security benefit, then the DAC may be able to keep their SSI while receiving SSDI. For most individuals, however, the SSDI amount from the parent is too high to also keep SSI, resulting in SSI termination. If the DAC has Medicaid through SSI, then Medicaid will also terminate. The DAC may continue to receive Medicaid, however, but will need to fill out a request for information (RFI) packet from either the Division of Developmental Disabilities (DDD) or the local County Board of Social Services. This flyer has more information about the DAC process and renewing eligibility with Medicaid.

WHAT IF MY CHILD IS ALREADY WORKING AND RECEIVING HIS OR HER OWN SSDI?

When a child is working and receiving SSDI upon his or her own work record, and a parent retires, the individual can only receive one form of SSDI. If the SSDI benefit under the parent is higher, the child will receive that benefit. If the child's SSDI benefit is higher than the amount under the parent, the child will remain on their SSDI benefit. Either way, a new application with Social Security is required.

WHAT IF MY CHILD IS RECEIVING AN SSDI BENEFIT UNDER MY WORK RECORD BUT THEN MY SPOUSE RETIRES AND STARTS COLLECTING A HIGHER BENEFIT AMOUNT?

The child can receive the higher SSDI benefit amount, but a new application with Social Security is required.

HOW DO I KNOW THE OPTIMAL AGE TO RETIRE IN ORDER TO RECEIVE THE MAXIMUM SOCIAL SECURITY BENEFIT FOR MYSELF AND MY CHILD?

You can get a personalized retirement benefit estimate on the SSA website if you have a my Social Security account. The SSA website has a wealth of information about planning for retirement. Maximize my Social Security is another website that helps calculate the optimal age of retirement to start collecting benefits (this website does charge a fee).

IF MY CHILD STARTS RECEIVING AN SSDI AMOUNT THAT IS EQUAL TO OR EXCEEDS \$2,000 A MONTH, WHAT HAPPENS?

When a child is considered a DAC, the SSDI benefit amount from the parent's work record is disregarded. But, NJ Medicaid has a \$2,000/month resource limit, so it may be prudent to utilize an ABLE account and/or Special Needs Trust (SNT) if the child is receiving a higher SSDI amount and there are difficulties in keeping under the \$2,000 monthly resource limit.

For More Information:



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NEW JERSEY HUMAN SERVICES
DoAS
Division of Aging Services

Social Security Disability Insurance (SSDI) benefits for adults with disabilities since childhood

The SSDI program pays benefits to adults who have a disability that began before they became 22-years-old.

This is considered a “child’s” benefit because it is paid on a parent’s Social Security earnings record.

For an adult with a disability to become entitled to this “child’s” benefit, one of their parents must:

- Be receiving Social Security retirement or disability benefits.
- Have died and had worked to earn enough to be eligible for Social Security benefits.

Social Security Disability Insurance (SSDI) benefits for adults with disabilities since childhood

Children, who were receiving benefits as a minor child on a parent's Social Security record, may be eligible to continue receiving benefits on that parent's record upon reaching age 18 if they are determined to have a disability. SSA makes the disability determination using the disability rules for adults.

SSDI Disabled Adult Child (DAC) benefits continue for as long as they have a disability.

Marriage of the DAC may affect eligibility for this benefit.

Your child doesn't need to have worked to get these benefits

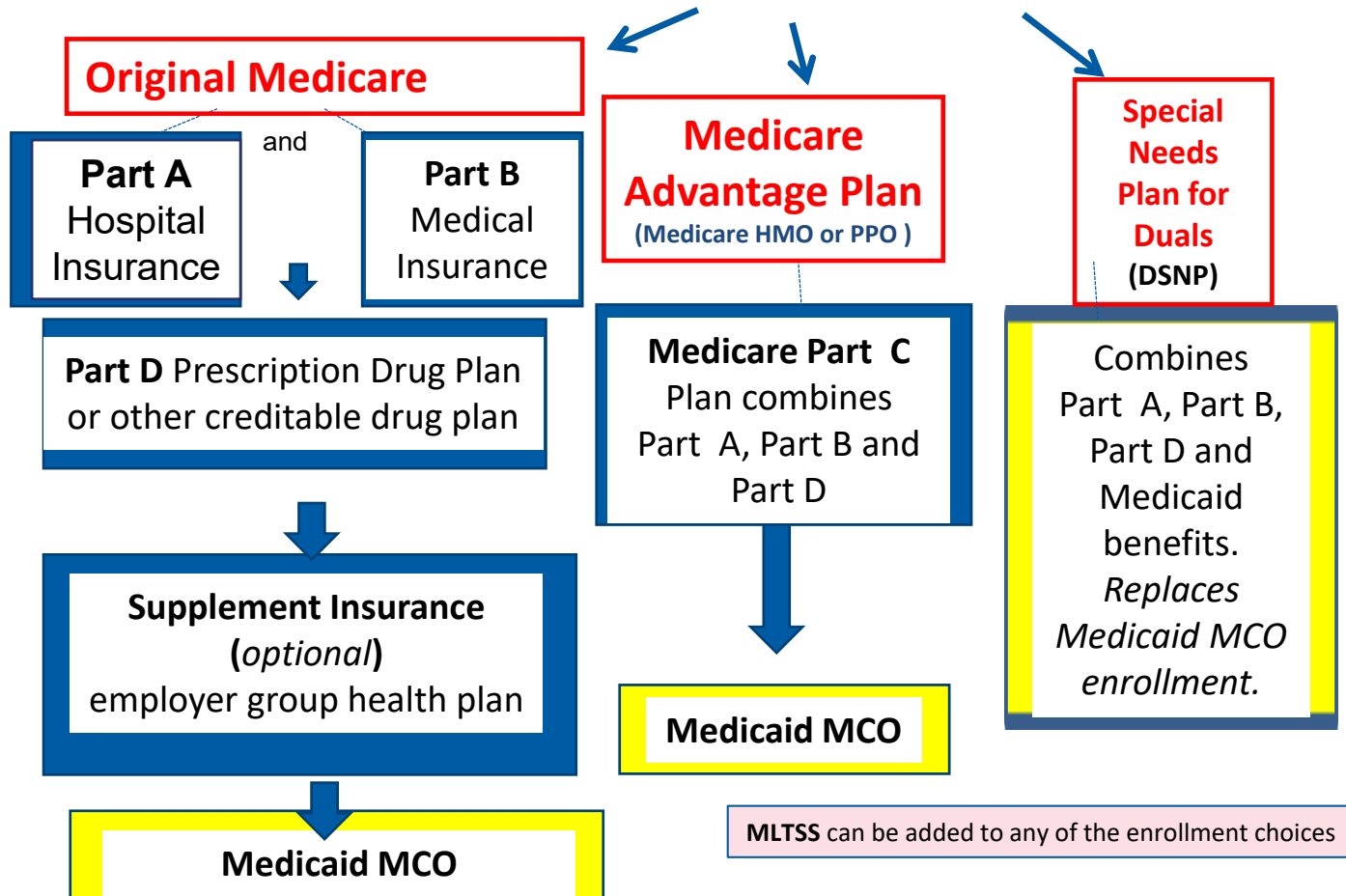
Duals Require Prescription Drug Coverage

- Dually eligible beneficiaries need to explore options in receiving their Prescription Drug Coverage
- Once Dually Eligible, Medicaid no longer provides Prescription Drug Coverage (Need Medicare Part D plan)
- There are programs that are available to Duals to cover costs related to their prescription drug coverage

How To Get Medications if No Medicare Drug Plan Enrollment

- Ask the pharmacist to enroll the dual eligible in **LINET**: Limited Income Newly Eligible Transition Program, with Humana.
- This process allows pharmacist to enroll dual eligible (or other Low Income Subsidy person) into a temporary Part D plan (LINET Humana) in order to get medications immediately.
- This process is also for dual eligibles NEW to Medicare Part D who are not yet auto-enrolled.
- If pharmacists need help with LINET enrollment, they can call **1-800-783-1307, ext. 1.**

Dual Eligible's Enrollment Choices



Aspects of Medicare Part D That Do Not Apply to the Dual Eligibles

- Monthly premium fees
 - As long as consumer is enrolled in a benchmark plan, there is no premium fee
 - Non-bench mark plans will have the premium subsidized
- No deductibles.
- Drug tiers
 - As long as a drug is on the formulary, it does not matter which tier it is on
- Preferred Pharmacies —
 - You do not need to use the drug plan's "preferred pharmacy" but must use a pharmacy in the plan's network.

Low Income Subsidy Level	2026 Copays for Drugs on Part D Plan Formulary
<u>LIS Level 3</u> Duals (people with Medicare and full Medicaid) who also • live in nursing home or Assisted Living, or • have MLTSS, or • on other Medicaid Waiver (CCP) or Supports Program • Enrolled in a DSNP plan	\$0
<u>LIS Level 2</u> Duals with full Medicaid Benefits	\$1.60 generics \$4.90 brand names
<u>LIS Level 1</u> ▪ Help paying Part B premium (SLMB, QI or QMB); ▪ Duals on Workability NJ Family Care ▪ Those who approved for LIS via SSA	\$5.10 generics \$12.65 brand names <i>(\$5 for generics/\$7 brand if they have PAAD)</i>

What is a “Benchmark” Drug Plan?

- The Medicare drug plans **do** require a monthly fee. However, for the dual eligibles, that fee is subsidized by Medicare up to a specific amount (which is known as the benchmark).

Benchmark premium for **2026** in NJ is **\$54.17**

- **When a dual eligible enrolls in a benchmark drug plan, there is no monthly premium fee.**
- There are two types of drug plans: Basic and Enhanced, but only the Basic plans can qualify as benchmark plans.

Why Would Dual Eligibles Select a Non-Benchmark Drug Plan?

- If a dual eligible needs a medication not available on the formulary of benchmark drug plans, but it is available in non-benchmark plan – it may be more cost-effective to pay a relatively low monthly premium to get the needed medications.
- This decision must be made on an individual basis.
- NJ Division of Aging Services has all Part D drug plans on its website.
 - The chart shows the monthly premium fees for NJ's non-benchmark drug plans in 2026 in the column with the heading "Premium with Medicaid."

MEDICARE PART D STAND-ALONE PRESCRIPTION DRUG PLANS IN NEW JERSEY

Company Name	Plan Name	Benefit Type	Premium with Medicaid or LIS/Extra Help	2026 Premium	Annual Drug Deductible	Contract ID	Plan ID	Plan's Performance Rating*	\$0 premium with NJ PAAD	Preferred Pharmacy Chains**
United Healthcare 1-888-867-5564(Saver) 1-800-753-8004 (Preferred) aarpmedicareplans.com <i>National Plan</i>	AARP Medicare RX Saver from UHC	Basic	\$23.20	\$77.40	\$615	S5921	349	2.5 stars	PAAD pays full premium	Walgreens, Walmart, Costco
	AARP Medicare Rx Preferred from UHC	Enhanced	\$64.70	\$118.90	\$0 Tier 1 & 2 \$130 Tier 3, 4 & 5	S5821	386	2.5 stars		Walgreens, Walmart, Costco, Mail Order
Health Care Service Corp 1-877-665-1842 HealthSpringMedicare.com <i>National Plan</i>	HealthSpring Extra Rx <i>(previously Cigna Healthcare Saver Rx)</i>	Enhanced	\$18.50	\$59.90	\$0 Tier 1 & 2 \$615 Tier 3, 4 & 5	S5617	354	Too new to rate	PAAD pays full premium	Walgreens, Walmart, Mail Order
	HealthSpring Assurance Rx <i>(previously Cigna Healthcare Assurance Rx)</i>	Basic	\$55.10	\$109.30	\$615	S5617	018	Too new to rate		Walgreens, Walmart, Mail Order
Horizon Blue Cross Blue Shield of NJ 1-888-765-7134 horizonblue.com	Horizon Medicare Blue Rx Standard	Basic	\$18.10	\$72.30	\$615	S5993	001	3 stars	PAAD pays full premium	Many network pharmacies locally, Mail Order has preferred pricing
	Horizon Medicare Blue Rx Enhanced	Enhanced	\$84.90	\$139.10	\$0 Tier 1 & 2 \$200 Tier 3, 4 & 5	S5993	003	3 stars		
Humana 1-877-529-9871 humana.com/medicare <i>National Plan</i>	Humana Basic Rx Plan	Basic	\$0.00	\$4.40	\$615	S5884	131	3.5 stars	PAAD pays premium but does not enroll	Many network pharmacies locally, Mail Order has preferred pricing
	Humana Value Rx Plan	Enhanced	\$18.90	\$35.60	\$0 Tier 1 & 2 \$601 Tier 3, 4 & 5	S5884	183	3.5 stars	PAAD pays premium but does not enroll	Walmart, Costco
	Humana Premier Rx Plan	Enhanced	\$57.70	\$111.90	\$0	S5884	150	3.5 stars		Walmart, Costco

Company Name	Plan Name	Benefit Type	Premium with Medicaid or LIS/Extra Help	2026 Premium	Annual Drug Deductible	Contract ID	Plan ID	Plan's Performance Rating*	\$0 premium with NJ PAAD	Preferred Pharmacy Chains**
Aetna 1-833-526-2445 aetnamedicare.com <i>National Plan</i>	SilverScript Choice	Basic	\$43.20	\$97.40	\$615	S5601	008	2.5 stars		No preferred pharmacies. Same copays at all network pharmacies.
Wellcare 1-866-859-9084 go.wellcare.com/PDP <i>National Plan</i>	WellCare Value Script	Enhanced	\$21.80	\$22.80	\$0 Tier 1 & 2 \$615 Tier 3, 4, 5 & 6	S4802	139	3.5 stars	PAAD pays full premium	CVS, Walgreens and most grocers
	WellCare Classic	Basic	\$0.00	\$28.20	\$615	S4802	078	3.5 stars	PAAD pays full premium	CVS, Walgreens and most grocers

2026 Medicare Benchmark Drug Plans for NJ's Dual Eligibles

Humana Basic RX

WellCare Classic

MEDICARE PART D STANDARD BENEFIT

Benefit	2025	2026
Maximum Deductible	\$590	\$615
Initial Coverage Period	Member Cost Sharing	Member Cost Sharing
Coverage Gap	Eliminated	Eliminated
Out-of-Pocket Maximum	\$2,000*	\$2,100*
Catastrophic Phase Cost Sharing	\$0	\$0
Late Enrollment Penalty <i>(1% of this amount for every month client did not have drug coverage)</i>	\$36.78	\$38.99
Low-Income Benchmark Premium for NJ	\$56.86	\$54.17
LIS Copays for Full Benefit Duals (QMB+)	\$1.60/ \$4.80	\$1.60/\$4.90
LIS Copays for SLMB and QMB-only	\$4.90/ \$12.15 If on PAAD, Brand copay reduced to \$7	\$5.10/\$12.65 If on PAAD, Brand copay reduced to \$7
LIS Copay for MLTSS or D-SNP members	\$0	\$0

Medicare Part D Co-Pays for Dual Eligibles

- Dual eligibles receiving DDD services have either Supports or the Community Care Program (CCP). **They have a \$0 co-pay for Medicare Part D drugs.**
- A dual eligible receiving Managed Long-Term Services and Supports (MLTSS) will have \$0 copay for Part drugs.
- If a dual eligible does not receive DDD services: Drug co-pays for 2026 will be **\$1.60** for each generic and **\$4.90** for each brand name drug.
- Dual Eligibles or those on PAAD should **NOT** enroll in the new Medicare Part D Prescription Plan

No “lock-in” For Dual Eligibles!

- Dual eligibles are not “locked in” to a Medicare drug plan.
- If dual eligibles want to switch drug plans and they don’t do it before 1/1/ 2026, they can switch next year.
- **Continuing for 2026:** Drug plans or DSNP plans can be switched **every month**, but enrollment into Medicare Advantage Plan is limited to Fall Open Enrollment.
- Drug plan changes are always effective the first day of the next month.

New Jersey Dual Eligible Special Needs Plans: D-SNPs

**Also called FIDE-SNPs:
*Fully Integrated Dual Eligible
Special Needs Plans***

ENROLLMENT IS VOLUNTARY

Voluntary enrollment in Medicare HMO D-SNP

- Dual eligibles may enroll **voluntarily** in a Medicare managed care D-SNP at any time. **Enrollees do not receive any bills when using in-network providers.**
- If thinking about joining a D-SNP:
 - Network of doctors, hospitals & prescription drugs are through the D-SNP. **Must** use that provider network.
 - **If enrolled in D-SNP and go to out-of-network provider – dual eligible will be charged the full cost of the medical care provided.**
 - Cannot be in a stand-alone drug plan if enrolled in a D-SNP. Check the D-SNP formulary before enrolling to be sure needed drugs are on the formulary.
 - Enrollees in D-SNP have a \$0 co-pay for prescription drugs.
 - Plans offer Extra benefits such as spending card for over-the –counter health items, or groceries.

If enrolled in a Medicare D-SNP and want to disenroll...

- To disenroll from D-SNP call **1-800-Medicare**
- Will be in “Original” Medicare, and a Medicaid HMO
- Will need to select a Part D drug plan

Why enroll in Medicare Advantage Plan instead of stay with Original Medicare?

- Maybe you cannot find providers/specialists willing to treat the Medicare consumer because they also have Medicaid AND
 - You are not satisfied with the Medicaid provider options.
- Maybe you want some of the “extra” benefits offered by some of the plans such as debit card for buying things like aspirin or cold medicine.
- Maybe you cannot afford the drug copays of \$1.60/\$4.80 and need to lower it to \$0 that the D-SNP plans offer.

Caution Regarding Copays in Medicare Advantage Plans

- Although dual eligibles enrolled in Medicare Advantage plans are not required to pay in-network doctor or other medical service co-pays, in practice, co-pays are often charged.
- It is difficult to convince some medical providers that co-pays should be waived for dual eligibles,
- Call the plan or Medicare to complain about any providers charging copays to a dual eligible who has QMB status (Qualified Medicare Beneficiary).

Which is better- Medicare Advantage Plan or Special Needs Plan?

- Depends on the NETWORK of providers you want to use
- For a dual, start by looking at the D-SNP plans.
 - Easier to use the providers because all agree to treat duals
 - ONE network to navigate
 - ID card shows \$0 copays for medical services
 - All covered drugs have \$0 copay
 - CAUTION- if have MLTSS with your Medicaid MCO, will be assigned a different care manager if switch to the MCO's DSNP plan.
- If not happy with DSNP network of providers or formulary of drugs, then look at Medicare Advantage Plan options.
 - Some MA plans have bigger network of providers than DSNP plans.

Tips for using Medicare Plan Finder for Dual Eligibles

Question on “Extra Help”

Do you get help with your Medicare health or drug costs?

If you get help with your Medicare health or drug costs from one of the programs below, it's important for us to know so we can show you accurate cost information when you search for and compare plans.

Have an account? [Log in](#) so we can give you the most accurate cost information based on any help you get.

☐ **Medicaid**
If you have both Medicare and Medicaid, you might qualify for a type of plan that helps coordinate your Medicare and Medicaid benefits. These are called "Dual Eligible Special Needs Plans" (D-SNPs). If these plans are available in your area, we'll list them in your search results.

☐ **Supplemental Security Income**

☐ **Medicare Savings Program**

☐ **Extra Help (with drug costs)**

Not sure? [Learn more about these programs.](#) ⓘ

☐ **I don't get help from any of these programs**

Programs that can help with your Medicare health and drug costs ×

If you're eligible, these programs can help with your costs:

- **Medicaid:** A joint federal and state program for certain people with limited income and resources. Your state might call this something different, like Medi-Cal or BadgerCare.
- **Supplemental Security Income (SSI):** A monthly Social Security benefit for people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits are different from Social Security retirement or disability benefits.
- **Medicare Savings Program (MSP):** State-run programs that help people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.
- **Extra Help:** A program that helps people with limited income and resources pay Medicare drug costs (Part D).

Not sure if you get help? [Log in or create an account](#) so we can give you accurate cost information based on any help you get.

Feedback

Medicare Resources

- <http://www.Medicare.gov>
- Medicare Plan Finder at [Medicare.gov/plan-compare](http://www.Medicare.gov/plan-compare)
- 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048
 - *Customer service assistance for choosing a plan & enrolling*
 - *Available 24 hours a day, 7 days a week (closed Thanksgiving Day)*
 - *Language line interpreters for more than 200 languages*
- State Health Insurance Assistance Programs (SHIPs)

Medicaid never pays before Medicare.

Medicaid only pays after Medicare, an employer group health plan, and/or Medicare Supplement Insurance (Medigap).

Tell Medicare if your other health or drug coverage changes. Let the Benefits Coordination & Recovery Center know by calling 1-855-798-2627

- Name
- Health or drug plan's name and address
- Health or drug plan's policy number
- The date coverage was added, changed, or stopped, and why

Remember to tell your doctor and other health care providers about your health or drug coverage changes the next time you get care

Know who pays first:

If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees ...	Medicare pays first.
If you have group health plan coverage based on your or a family member's employment or former employment, and you're eligible for Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)...	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare pays first after this 30-month period.

If you would like to become a [SHIP volunteer](#) and help people in your community better understand their Medicare-related insurance options or to schedule an appointment for counseling, please call [1-800-792-8820](tel:1-800-792-8820), contact your local SHIP [counseling agency](#) in your area or text SHIP@NJDOAS.



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Thank you!

- Slides and the recording will be available on The Arc of New Jersey website:
<https://www.arcnj.org/programs/health-care-advocacy/beverly-roberts-health-care-symposium.html>
- Certificates of attendance will be sent in 24 hours.
- If you have questions, please email:
healthcareadvocacy@arcnj.org