i. If the CBOSS determines that the individual had good cause for not applying within three months, an extension may be granted for an additional three months.

ii. Newborns of eligible women are deemed to have applied and shall be added to the Medicaid case, effective the date of birth, upon receipt of a valid Form PA–1C (see N.J.A.C. 10:69–8.10(e) for coverage limits).

(g) Those cases which are in Medicaid extension only shall also be transferred to the new county of residence when the family moves from the county of origin in the same manner as active AFDC-related Medicaid cases. The procedures established at N.J.A.C. 10:69–3.27(b) are to be followed when transferring a case in Medicaid extension.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).
See: 32 N.J.R. 3598(a).
In (a)1, deleted a former ii, and recodified a former iii and iv as ii and iii; and in (a)3 deleted a reference to resources.

10:69–5.14 Change in eligible unit

(a) A newborn child shall be added to the AFDC-related Medicaid case effective with the date of birth, provided that the CBOSS is notified within one year of that date.

(b) The date of change for adding other members added to an eligible unit shall be the first day of the month the eligible unit reports to the CBOSS the addition of the member.

SUBCHAPTER 6. COMPLAINTS, HEARINGS AND ADMINISTRATIVE REVIEWS

10:69–6.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Adequate notice" means a written notice that meets the requirements of N.J.A.C. 10:69–6.3

"Administrative hearings" are hearings concerning either contested cases or non-contested cases, which have been determined by the Director of the Division of Medical Assistance and Health Services (DMAHS) in accordance with N.J.A.C. 1:1–1, to be appropriately heard in the Office of Administrative Law (see N.J.A.C. 10:6).

"Administrative law judge" (ALJ) means the person from the Office of Administrative Law (OAL) who conducts the hearing and who writes an initial decision which may be reviewed by the Director of the Division of Medical Assistance and Health Services.

"Administrative review" means a review of a disputed matter which has been determined by the Director of the Division of Medical Assistance and Health Services not to constitute a contested case and therefore remains in the Division for review. At the discretion of the Director, an administrative review may be conducted as a procedure at which parties appear and are heard or it may be a paper review. (See N.J.A.C. 10:69–1.2.)

"Administrative review official" is a representative of the State, Department of Human Services assigned to conduct an administrative review.

"Adverse action" means any action by a CBOSS resulting in denial of application for AFDC-related Medicaid. An adverse action is an action to deny an application for Medicaid, or to terminate Medicaid (including service, vendor payments or Medicaid entitlement) or to deny payment to a vendor for medical services required to be reimbursed by the county board of social services.

"CFR" is the acronym for Code of Federal Regulations.

"Contested case" means a dispute that is heard by an Administrative Law Judge.

"Fair hearing" means a formal or informal procedure through which a AFDC-related Medicaid client may protest an adverse action or decision of the county board of social services (CBOSS) regarding eligibility or manner of granting AFDC-related Medicaid. Fair hearing is a general term which includes administrative hearing and administrative review.

"Initial decision" means the decision of an administrative law judge that is sent to the Director of the Division of Medical Assistance and Health Services, who may accept, reject or modify it within 45 days.

"Timely notice" means that the notice is mailed at least 10 days before the effective date of agency action.

10:69–6.2 Right to fair hearing and administrative review

(a) It is the right of every applicant or beneficiary adversely affected by an action by a county board of social services (CBOSS) to be afforded a fair hearing in a manner established by the rules in this subchapter and by the Uniform Administrative Procedure Rules (N.J.A.C. 1:1). These rules have been established pursuant to Federal regulations (45 CFR 205.10) and the New Jersey Administrative Procedure Act (N.J.S.A. 52:14B–1 et seq.).

(b) The county board of social services shall promptly notify the beneficiary in writing of any agency decision affecting that client. The term "agency decision" refers to a decision made by the county board of social services and includes any decision made by the county board of social services. In the case of a client who cannot be located, notice shall be sent to his or her last known address.

(c) Agency action which adversely affects an applicant or beneficiary includes:

1. Any action, inaction, refusal of action, or unduly delayed action with respect to program eligibility, including, but not limited to, denial or termination of benefits; and

2. When the complete processing of an application is delayed beyond 30 days, the applicant is to be notified of this fact and the reason(s) for the delay on or before the expiration of such period (see N.J.A.C. 10:69–2.14 and 2.15).

(d) The written notice of adverse action shall, at a minimum, include the following:

1. The action the agency intends to take;

2. The reasons for the intended agency action;

3. The specific regulations supporting such action;

4. An explanation of the individual's right to request a fair hearing;

5. An explanation of how to request a fair hearing;

6. The time limits on requesting a hearing;

7. An explanation of the right to examine evidence;

8. An explanation of the circumstances under which continued Medicaid coverage is continued if a hearing is requested;

9. An explanation of the requirement to repay Medicaid coverage received during the period pending the hearing, if the agency action is upheld;

10. A sentence in Spanish cautioning the client that the notice relates to a change in Medicaid coverage and if he or she does not understand the notice, he or she should contact the CBOSS; and

11. The name, address and phone number of the nearest legal services office where available.

(e) Where an agency decision results in an adverse action, there will be no termination of the AFDC-Medicaid related coverage until at least 10 days after the mailing date of the notice, except in situations described in (f) below.

(f) Timely notice may be dispensed with but adequate notice shall be sent not later than the effective date of action when:

1. The agency has factual information confirming the death of a beneficiary;

2. The agency receives a clear written statement signed by a beneficiary that he or she no longer wishes continued Medicaid coverage, or that gives information which requires termination, and the beneficiary has indicated, in writing, that he or she understands that this must be the consequence of supplying such information;

3. The beneficiary has been admitted or committed to an institution, that does not qualify for Federal financial participation under the State plan;

4. The beneficiary has been placed in a nursing facility, intermediate care facility or long-term hospital;

5. The claimant's whereabouts are unknown and agency mail has been returned by the post office indicating no known forwarding address. The Medicaid Card must, however, be made available to the beneficiary if his or her whereabouts become known during the medical coverage period, unless (e)5i below applies.

i. The claimant moves out-of-State, with apparent intent to remain permanently absent from New Jersey;

6. A beneficiary has been accepted for medical assistance in another state and that fact has been established by the CBOSS previously providing Medicaid coverage;

7. An AFDC child is removed from the home as a result of a judicial determination, or voluntarily placed in foster care by his or her legal guardian; or

8. The application for Medicaid coverage is being denied.

10:69–6.3 Responsibilities of the CBOSS in processing hearing requests

(a) Upon receipt of a timely request for a fair hearing, Medicaid coverage shall be continued until a written decision is rendered, unless:

1. A determination is made at the hearing by the ALJ that the sole issue is one of State or Federal law or policy, or change in State or Federal law, and not one of disputed facts; or

2. A change occurs which further affects beneficiary's eligibility while the first hearing decision is pending and the beneficiary fails to request an additional hearing after notice of this change within the time allowed.

(b) In the event of either (a)1 or 2 above, the beneficiary shall be promptly notified in writing that the proposed action will be implemented after the hearing while the decision is pending.

(c) Any incorrectly paid benefit resulting from continued Medicaid coverage is subject to recovery. In the event that agency action is sustained and a beneficiary has received incorrectly paid Medicaid benefit, solely due to continued eligibility, recovery shall be effected in accordance with procedures in N.J.A.C. 10:69–9.23.

(d) A beneficiary may waive his or her claim to Medicaid by submitting a written statement at the time the fair hearing is requested.

(e) To assure orderly and expeditious processing of complaints and hearing requests, each CBOSS shall designate a liaison between the county and State Division whose duties shall include, but not be limited to:

1. Informing the Bureau of Legal and Regulatory Liaison (BLRL) by telephone on the same day an oral or written request for a hearing is received, providing the following information:

i. The case number and the applicant/beneficiary's name and address;

ii. The date the request received;

iii. The nature of contested action;

iv. The date of action; and

v. The reason for action;

2. Establishing a system to assure that every written request for a hearing received in the CBOSS office is stamped with the date of receipt and forwarded to BLRL within one work day of the date;

3. Reviewing incoming requests for possible corrective action prior to hearing;

4. Identifying and arranging for participation of staff individuals who are essential to a hearing, and assembling all records relevant to a hearing and arranging for an interpreter when the client is non-English speaking;

5. Contacting the applicant/beneficiary or his or her legal or authorized representative not less than two days prior to a hearing to confirm attendance and arranging for transportation by agency staff and vehicles or otherwise at agency expense when no other reasonable means of transportation is available;

6. Submitting special reports on hearing requests prior to the hearing date, when requested by OEP or BLRL;

7. Submitting reports on implementation of fair hearing decisions as soon as such action is taken when requested; and

8. Serving as the single individual in the CBOSS to be contacted regarding matters relating to hearings and the monitoring system.

(f) The CBOSS is responsible to inform the applicant/beneficiary who is requesting a hearing and elects to receive continued Medicaid that the ALJ may find him or her not entitled to all or a portion of the Medicaid coverage received during the pendency of the hearing and that, in such event, repayment may be required of the amount of benefits received from the effective date of the proposed adverse action to the date of the scheduled hearing.

1. The beneficiary shall also be advised that if he or she elects not to receive continued Medicaid coverage and the hearing decision is favorable to the client, Medicaid coverage shall be reinstated retroactive to when it was terminated.

10:69–6.4 Responsibilities of the Division of Medical Assistance and Health Services

(a) Each request for a fair hearing shall be registered by BLRL on the date the request is received.

(b) Requests initially received in BLRL shall be transmitted by telephone to the CBOSS on the date received.

(c) BLRL shall transmit each contested case to OAL within five work days of the receipt of the request.

(d) Written determination on entitlement to receive continuing Medicaid coverage shall be included in the OAL transmittal and sent to the applicant/beneficiary and the CBOSS.

10:69–6.5 Responsibilities of the Office of Administrative Law upon transmittal of a contested case from the DMAHS (45 CFR 205.10 and N.J.A.C. 1:1–1 et seq.)

(a) The Office of Administrative Law shall schedule the hearing and shall send any necessary notices to the parties.

(b) The hearing shall be conducted by an administrative law judge who shall issue an initial decision.

10:69–6.6 Administrative hearings and administrative reviews

(a) Requests on matters which constitute a contested case (as defined by N.J.A.C. 1:1–1 and consistent with case law) shall be handled in accordance with the Department of Human Services (DHS) rules on "Administrative Hearings and Administrative Reviews" at N.J.A.C. 10:6.

(b) Requests on matters which do not constitute a contested case (as defined by N.J.A.C. 1:1–1 and consistent with case law) shall be handled in accordance with the DHS rules on "Administrative Hearings and Administrative Reviews" at N.J.A.C. 10:6.

10:69–6.7 Complaints and adjustment procedures

(a) Prompt and courteous attention shall be given to all complaints, whether or not such complaints constitute requests for fair hearing and whether or not they are directed to the CBOSS or the Division of Medical Assistance and Health Services. All complaints received shall be acknowledged promptly and, if it is not apparent from the complaint that a fair hearing request has been made, the acknowledgment shall inform the beneficiary of his or her right to a fair hearing.

(b) Informal efforts to effect a resolution may be made through field contacts, office interviews with supervisory personnel, or consultation with Division staff as needed. In no event, however, are such informal efforts to be considered as prerequisite to a fair hearing, and in no event do they delay, interfere with or otherwise impede the processing of a fair hearing whenever a request for such is made. Agency emphasis shall be on helping the client to prepare and submit his or her request for a fair hearing.

(c) Any clear expression (oral or written) by a beneficiary (or person acting for him or her, such as his or her legal representative or relative) to the effect that the beneficiary wants the opportunity to present his or her case to a higher authority constitutes a request for a fair hearing.

(d) A request for a fair hearing may be either oral or in writing and addressed to the CBOSS or to the State Division. Oral requests for fair hearing shall be immediately reduced to a written record by the staff person to whom the request is made. No special form of statement or manner of expression is required so long as the request identifies the nature of the complaint and the relief sought. Requests made to the CBOSS shall be immediately transmitted to the BLRL, and in no event later than one work day after receipt of the request.

(e) Upon receipt of any request for a fair hearing, a determination shall be made by the Division on the appropriateness of an administrative hearing or administrative review (N.J.A.C. 10:6–1.2). If the matter is deemed contested, BLRL will send an acknowledgment of the request to the client. All contested cases shall be promptly forwarded to the OAL for a hearing before an ALJ.

10:69–6.8 Time limitations on entitlement to fair hearings

(a) An applicant or beneficiary has a right to request a fair hearing which relates to an agency action or lack of action within 20 days of such action or lack of action.

(b) If the request for a fair hearing relates to an agency action or lack of action that occurred more than 20 days prior to the date of the request, there shall be no entitlement to a hearing on such action or lack of action, unless extraordinary and extenuating circumstances exist as determined by the Division of Medical Assistance and Health Services. Extraordinary or extenuating circumstances are defined as conditions beyond the applicant or beneficiary's control. This could include, but is not limited to, the beneficiary's receipt of notice after due date or personal illness or incapacity.

10:69–6.9 Eligibility for continued Medicaid coverage

(a) When a request is made for a fair hearing within 15 days from the date of mailing of a notice of termination, Medicaid coverage shall be continued until the scheduled date of the administrative hearing or the date of the administrative review unless the beneficiary waives such entitlement or requests postponement of the scheduled hearing or review date. In the event the beneficiary elects to receive continued benefits, they will be continued pending a final decision if the ALJ or the administrative review official determines that the issue is one of fact rather than law or policy. (45 CFR 205.10(a)(7))

(b) An adjournment of a hearing at the request of an beneficiary shall not prolong continuation of Medicaid coverage, unless the adjournment is due to delay caused by the State Division, OAL or the CBOSS; unavoidable causes, such as an illness on the part of the applicant/beneficiary; or the failure of the CBOSS to provide assistance for transportation when such assistance is required by regulations. Adjournment at the request of the CBOSS or by the ALJ shall not affect continued benefits.