

(c) A person denied presumptive eligibility by an approved presumptive eligibility determination entity shall not be entitled to adequate notice of that determination and shall not be entitled to a grievance review on that action. The denial of presumptive eligibility shall not affect the applicant's right to apply for NJ FamilyCare in order to receive a formal eligibility determination.

#### **10:78-5.8 Limitation on number of presumptive eligibility periods**

All beneficiaries of presumptive eligibility who apply for presumptive eligibility benefits for NJ FamilyCare shall be limited to one continuous presumptive eligibility period. The provisions of this section shall expire on September 1, 2002.

#### **10:78-5.9 Hospital-specific payment caps for presumptive eligibility**

(a) Throughout the two year period in which presumptive eligibility shall be determined by hospitals, the Director shall establish hospital-specific caps in the amount of direct fee-for-service payments by DMAHS to hospitals for serving presumptively eligibles. The hospital-specific caps for each State fiscal year are subject to revision by the Director, based on availability of funds and the success in enrollment into managed care plans.

(b) Payments to hospitals for uninsured cases determined presumptively eligible for NJ FamilyCare by a hospital that ultimately are determined ineligible shall be recovered by DMAHS. That case shall be converted to charity care, provided all requirements for charity care participation are met.

#### **10:78-5.10 Subchapter effective period**

(a) This subchapter shall be in effect until April 2, 2001.

(b) Presumptive eligibility as a means of accessing benefits through the NJ FamilyCare program for all adults and for immigrant children whose date of entry was after August 22, 1996 is hereby terminated, effective April 2, 2001.

(c) The action described in (b) above shall not affect presumptive eligibility for other children and for pregnant women who meet the program requirements.

(d) For certifications subject to the action described in (b) above that are signed prior to April 2, 2001 and are received by the Division within two business days, presumptive eligibility shall be processed. All certifications that do not meet those requirements shall be returned to the provider. These returned cases may be considered for the Charity Care program.

## **SUBCHAPTER 6. ELIGIBILITY DETERMINATION AGENCY ADMINISTRATIVE REQUIREMENTS**

### **10:78-6.1 Notice of the eligibility determination agency decision**

(a) The eligibility determination agency shall promptly notify any applicant for, or beneficiary of, the NJ FamilyCare program in writing of any agency decision affecting the applicant or beneficiary. When a decision relates to any adverse action which may entitle a beneficiary to a grievance review, the action shall not be implemented until at least 10 days after the mailing of the notice (see (e) below for exceptions to the 10-day notice requirement).

1. For notices of action adverse to a beneficiary, the date of mailing of the notice shall appear on the notice.

2. Notices of any eligibility determination agency action shall contain the name, address, and telephone number of the legal services agency serving that county.

3. In the case of an applicant or beneficiary who cannot be located, the notice shall be mailed to his or her last known address.

(b) All notices of agency decision shall state, in clear and simple language, the nature of the agency decision and an accurate and factual legal basis for the decision.

1. All notices of the agency decision shall include an explanation of the right to a grievance review.

2. All notices of agency decisions adverse to the applicant or recipient shall include the complete citation and title of the rule(s) upon which the agency decision is based.

(c) All notices of denial or termination shall include an explicit statement of the reason for program ineligibility and (except in the case of the death of an applicant or beneficiary) shall advise of the right to reapply whenever the applicant or beneficiary believes that circumstances have changed such that the reason for program ineligibility no longer exist.

(d) When the processing of an application shall be delayed beyond the standards for disposition of an application as set forth in N.J.A.C. 10:78-2.1(d), notice shall be mailed prior to the expiration of the disposition period notifying the applicant of the delay and the reasons for the delay.

(e) The 10-day notice requirement for actions adverse to a program beneficiary need not be adhered to when:

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

2. The eligibility determination agency receives a clear written statement, signed by the beneficiary, that he or she no longer wishes to receive program benefits, or which gives information indicating a change in circumstances which requires a termination or reduction in

benefits, and the beneficiary has indicated in writing that he or she understands that termination or reduction in benefits shall be the consequence of supplying such information;

3. The beneficiary's whereabouts are unknown and agency mail directed to him or her has been returned by the postal service indicating no forwarding address;

4. The beneficiary has been accepted for public or medical assistance in another state and that fact has been confirmed by the eligibility determination agency; or

5. A beneficiary child has been removed from the home as a result of a judicial determination or voluntarily placed in foster care by his or her legal guardian.

### 10:78-6.2 Case records

(a) The purpose of the case record is to provide a complete documentary record of eligibility determination agency actions and the reasons therefor.

(b) The case record shall include:

1. A record of all eligibility determination agency actions and decisions relating to the case, as well as documentary evidence relating to such actions and decisions, including application forms;

2. All forms relating to financial eligibility; and

3. All case-related correspondence, memorandum, and documents except those required by law or regulation to be maintained elsewhere.

(c) No case record, or part thereof, shall be removed from its file location without a record identifying the person who has custody of it.

(d) No case record, or part thereof, shall be removed from the eligibility determination agency offices except upon the specific authorization of the agency director, deputy director, or other person specifically designated by the agency director to authorize such removal.

(e) All case records shall be filed in a secure and fire-resistant location.

## SUBCHAPTER 7. SERVICES UNDER NJ FAMILYCARE

### 10:78-7.1 Scope of services

(a) The NJ FamilyCare "Plan A" service package shall contain those services described at N.J.A.C. 10:49-5.2.

(b) The NJ FamilyCare "Plan D" benefit package shall contain those services described at N.J.A.C. 10:49-5.7. Those FamilyCare Plan D beneficiaries whose income is above 150 percent of the Federal poverty level shall be responsible for copayments for services received, in accordance with the provisions of this chapter.

1. No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

(c) Individuals who would be eligible for AFDC-related Medicaid or NJ KidCare and who are subject to the Federal immigration residency restriction shall receive services and shall be subject to any applicable premium contribution based on income eligibility, under the provisions of N.J.A.C. 10:69 or 10:79.

(d) Except as noted in (c) above, NJ FamilyCare beneficiaries shall receive services through managed care organizations operating under a contract with the Department of Human Services. Single adults and couples without dependent children whose gross income is not more than 100 percent, of the Federal poverty level will be enrolled in a conventional managed care program. Effective July 1, 2002, childless adults who are not eligible for WFNJ/GA and whose income is below 100 percent of the Federal poverty level shall receive the NJ FamilyCare Plan H service package described at N.J.A.C. 10:49-5.8.

(e) Copayments required of NJ FamilyCare beneficiaries shall be as described at N.J.A.C. 10:49-9.1. Premium payments required of NJ FamilyCare beneficiaries shall be as described at N.J.A.C. 10:49-9.2. Enrollment for these beneficiaries shall commence after their first premium payment has been received by the Statewide eligibility determination agency. No other NJ FamilyCare beneficiary will be responsible for a premium payment or a copayment.

1. No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

(f) Drugs used exclusively to treat AIDS and HIV shall not be included in the FamilyCare services packages, but shall be made available to FamilyCare beneficiaries through the ADDP program in accordance with N.J.A.C. 8:61-2.

(g) Effective July 1, 2002, for WFNJ/GA-eligible individuals, no managed care services will be provided. WFNJ/GA-eligible individuals will receive medical services in accordance with N.J.A.C. 10:49-24.3. Effective July 1, 2002, all substance abuse services for WFNJ/GA-eligible individuals will be provided through the Substance Abuse Initiative (SAI).

1. Effective June 15, 2002, hospital services for WFNJ/GA-eligible individuals must be submitted for reimbursement through charity care.

(h) Childless adults with incomes below 100 percent of the Federal poverty level who are not eligible for WFNJ/GA and who are enrolled in NJ FamilyCare on June 30, 2002 shall receive the Plan H service package described at N.J.A.C. 10:49-5.8.

1. Effective June 15, 2002, hospital-based behavioral health services for childless adults with incomes below 100 percent of the Federal poverty level who are not eligible for WFNJ/GA must be submitted for reimbursement through charity care.

(i) Effective upon approval by the Centers for Medicare and Medicaid Services of New Jersey's pending Health Insurance Flexibility and Accountability Act (HIFA) waiver, certain parents/ caretakers of children enrolled in NJ FamilyCare who have earned incomes below 134 percent of the Federal poverty level shall receive the Plan D benefit package described at N.J.A.C. 10:49-5.7. Those parents/caretakers who are awaiting enrollment in a managed care organization or who meet the standards for exemption from the requirement for enrollment in managed care will receive the Plan D benefit package on a fee-for-service basis, which shall be called Plan I. Services available under Plan I are described at N.J.A.C. 10:49-5.10.

1. Parents who are eligible for NJ FamilyCare Plan A in accordance with N.J.A.C. 10:69, AFDC-Related Medicaid, shall continue to receive the Plan A benefit package.

Special amendment, R.2001 d.304, effective July 31, 2001 (operative September 1, 2001).

See: 33 N.J.R. 2912(a).

In (d), substituted "shall not" for "may" preceding "be eligible"; added (g) and (h).

Special amendment, R.2002 d.214, effective June 10, 2002.

See: 34 N.J.R. 2338(a).

Rewrote (a), (d), (g) and (h).

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added b(1); added e(1).

Special amendment, R.2003 d.98, effective January 31, 2003 (to expire March 3, 2006).

See: 35 N.J.R. 1303(a).

In (b), rewrote the first sentence in the introductory paragraph; in (e), rewrote the introductory paragraph; added (i).

1. Those agency actions which adversely affect an applicant or beneficiary and may be grieved shall include, but shall not be limited to:

- i. Determination of household composition;
- ii. Earned and unearned income calculations; and
- iii. Interpretation of residency, citizenship and age requirements.

(b) A grievance shall not be considered for those circumstances in which eligibility is precluded by Federal or State statute. These circumstances include, but are not limited to: income standard, age requirement, and citizenship requirements. A grievance shall not be considered for non-payment of premiums.

(c) An applicant shall submit a description of the grievance to the agency in writing within 20 days of the date of the adverse action notice. The agency shall notify the applicant or beneficiary of its decision on the matter, specifying the reasons for the decision, within 60 days of the receipt of the complete documentation of the grievance.

(d) The grievance shall be heard by a panel comprised of State staff, who will make recommendations to the DMAHS Director. Within 60 days of receipt of the appeal, the DMAHS Director shall issue a disposition. The final agency decision is subject to judicial review in the Appellate Division.

(e) As a first step in the grievance process, the Division shall initiate an informal dispute resolution process upon receipt of the grievance request and prior to the grievance board hearing the case. The informal dispute resolution process shall include reviewing the grievance, researching the issue involved, and may include contact with the individual filing the grievance. The intent of the informal dispute resolution process is to try and resolve the grievance prior to the grievance board hearing.

(f) The agency shall retain all correspondence and documentation relating to the grievance in the applicant's or beneficiary's file.

### 10:78-8.2 Fair hearing

No applicant or beneficiary of the NJ FamilyCare program shall be entitled to a fair hearing as a result of adverse agency action; however, nothing in this chapter shall prevent an applicant or beneficiary from requesting a fair hearing to which they may otherwise be entitled under the provisions of any other law, rule, or regulation.

### 10:78-8.3 Post-application responsibilities

Once determined eligible for NJ FamilyCare, the applicant shall have the on-going responsibility for reporting to the eligibility determination agency any changes in family circumstances and for providing information as delineated at N.J.A.C. 10:78-2.7. The applicant shall provide additional

## SUBCHAPTER 8. BENEFICIARY RIGHTS AND RESPONSIBILITIES

### 10:78-8.1 Grievance reviews

(a) All NJ FamilyCare applicants and beneficiaries shall be afforded the opportunity for a grievance review.

information as requested by the eligibility determination agency. At any time that the eligibility determination agency lacks sufficient information to confirm continuing program eligibility because of the unwillingness of the applicant or beneficiary to provide necessary information, the agency shall commence action to terminate the case and pursue recovery when warranted.

## SUBCHAPTER 9. PREMIUM SUPPORT PROGRAM (PSP)

### Authority

N.J.S.A. 30:4D-1 et seq., as amended by P.L. 2000, c.71, specifically N.J.S.A. 30:4J-4.

### Source and Effective Date

R.2002 d.199, effective July 1, 2002.  
See: 33 N.J.R. 2913(a), 34 N.J.R. 2331(b).

### Subchapter Historical Note

Subchapter 9, Premium Support Program (PSP), was adopted as special new rules by R.2001 d.286, effective July 20, 2001. See: 33 N.J.R. 2913(a). Subchapter 9, Premium Support Program (PSP), expired on January 20, 2002.

Subchapter 9, Premium Support Program (PSP), was adopted as new rules by R.2002 d.199, effective July 1, 2002. See: Source and Effective Date.

### 10:78-9.1 Purpose and scope

(a) The purpose of the Premium Support Program (PSP) is to provide financial support to adults and children to help defray the cost of employer-sponsored health insurance.

(b) The Premium Support Program is designed to cover individuals eligible for NJ FamilyCare who have access to employer-sponsored health plans. Assistance will be provided in the form of a direct subsidy payment to the beneficiary for a portion of the payroll deduction required for participation in the employer-sponsored health plan. Beneficiaries will be reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary.

### 10:78-9.2 Definitions

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

“Large employer” means any person, firm, corporation, partnership or political subdivision that is actively engaged in business that employed an average of more than 50 employees on business days during the preceding calendar year.

“Small employer” means any person, firm, corporation, partnership or political subdivision that is actively engaged in business that employed an average of at least two, but no more than 50, employees on business days during the preceding calendar year.

“Wraparound service” means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility.

### 10:78-9.3 Who is eligible to participate in NJ FamilyCare/Premium Support Program

(a) Single individuals, childless couples and families, as defined in N.J.A.C. 10:69, who have been determined eligible for NJ FamilyCare in accordance with this chapter shall be eligible to apply for participation in the Premium Support Program (PSP).

(b) An applicant shall have access to an employer-sponsored health plan prior to applying to participate in the PSP.

(c) In order to participate in the PSP, a PSP applicant employed by a large employer shall first have access to an employer-sponsored plan which provides coverage at least equal to the services provided in the NJ FamilyCare Plan D service package.

(d) If an applicant is employed by a small employer, the specific services available to the applicant shall be at least equal to the services in the NJ FamilyCare Plan D service package; however, the extent of coverage of the services need not be the same as the extent of coverage in the NJ FamilyCare Plan D service package. For a comprehensive listing of small employers health plans, refer to N.J.A.C. 11:21.

### 10:78-9.4 Premium Support Program enrollment process

(a) All applicants to the Premium Support Program shall first be found eligible for the NJ FamilyCare program. Applicants to the Premium Support Program shall provide information concerning employment and employer-sponsored health insurance benefits. If an otherwise eligible applicant has access to employer-sponsored health benefits, the applicant must enroll in the Premium Support Program, in accordance with the provisions of this subchapter.

(b) If the applicant meets the criteria in (a) above, the State Eligibility Vendor for the NJ FamilyCare program or the County Board of Social Services that made the determination of eligibility will refer the case record for review to:

DMAHS/PSP  
PO Box 712  
Mail Code 46  
Trenton, NJ 08625-0712