

4. Welfare, social service, and other nonprofit organizations shall be furnished with a copy of this chapter at no cost upon an official written request on agency letterhead to the Division of Medical Assistance and Health Services.

5. A current up-to-date copy of this chapter is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing.

10:78-1.3 Administrative organization

The NJ FamilyCare program is under the supervision of the Division of Medical Assistance and Health Services.

10:78-1.4 Principles of administration

(a) The following principles of administration apply in the NJ FamilyCare program.

1. Opportunity to make application shall be as follows:

i. Any individual who believes he or she is eligible shall be afforded an opportunity to make application (or reapplication) for the NJ FamilyCare program without delay.

2. The primary source of information requirements shall be as follows:

i. Program applicants or beneficiaries shall be the primary source of information concerning program eligibility; and

ii. The eligibility determination agency shall, when necessary, in the process of determining eligibility, use secondary sources of information with the knowledge and consent of the applicant or eligible person.

3. Adherence to law and administrative policy shall be as follows:

i. There shall be strict adherence to law and complete conformity with rules; and

ii. Requirements other than those established by law or rule shall not be imposed as a condition of receiving assistance under the NJ FamilyCare program.

10:78-1.5 Confidentiality of information

(a) No member, officer, or employee of the eligibility determination agency shall produce or disclose any confidential information to any person except as authorized below.

1. Information considered confidential shall include, but shall not be limited to, the following:

i. Names and addresses;

ii. Medical services provided;

iii. Social and economic conditions and circumstances;

iv. Eligibility determination agency evaluation of personal information; and

v. Medical data, including diagnosis and past history of disease or disability.

2. The eligibility determination agency may disclose information concerning an applicant or eligible person to persons and agencies directly related to the administration of the NJ FamilyCare program. Persons and agencies directly related to program administration shall include, but shall not be limited to, those who are properly authorized to be involved in the following:

i. The establishment of eligibility;

ii. The determination of the amount and scope of medical assistance;

iii. The provision of services for beneficiaries; and

iv. The conduct or assisting in the conduct of an investigation, prosecution, or civil or criminal proceeding related to the NJ FamilyCare program.

3. The eligibility determination agency may release information whenever the applicant or eligible person waives confidentiality, but only to the extent authorized by the waiver.

4. If a court issues a subpoena for a case record or any other confidential information or for any agency representative to testify concerning an applicant or eligible person, the eligibility determination agency shall make a statement substantially as follows:

i. Information concerning applicants and beneficiaries of NJ FamilyCare shall be restricted to persons directly connected to the administration of such assistance. This includes a requirement of nondisclosure of such information in response to a subpoena, except in those instances where refusal to follow orders of the court will result in an individual or agency being held in contempt of court.

ii. In any instance of a subpoena for case record information or for agency testimony, a complete report of the disposition of the court's request shall be entered into the case record.

5. Pertinent information and records may be released in conjunction with an administrative hearing conducted by the Office of Administrative Law regarding action or inaction of the eligibility determination agency affecting an applicant's or beneficiary's eligibility under the NJ FamilyCare program.

10:78-1.6 Materials distributed to NJ FamilyCare applicants or beneficiaries

(a) All materials distributed to program applicants or beneficiaries shall:

1. Directly relate to the administration of the NJ FamilyCare program;
2. Have no political implications;
3. Contain names only of individuals directly connected with the administration of the NJ FamilyCare program; and
4. Identify those individuals only in their capacity with the State or the eligibility determination agency.

(b) The eligibility determination agency shall not distribute materials such as "holiday" greetings, general public announcements, or alien registration notices.

(c) The eligibility determination agency may distribute materials directly related to the health and welfare of program applicants and beneficiaries, such as announcements of free medical examinations, availability of surplus food, voter registration and consumer protection information.

10:78-1.7 Nondiscrimination

(a) Discrimination on the basis of race, color, national origin, age, or disability shall be prohibited.

(b) All persons seeking or receiving FamilyCare benefits shall be afforded an opportunity to file a complaint alleging discrimination. Such complaints may be filed directly with the Director, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712.

(c) In any instance in which a complaint of alleged discrimination is filed with a State or county agency, the complaint shall be forwarded immediately to the Director, Division of Medical Assistance and Health Services. The Director, upon receipt of any such complaint, shall take any such action he or she deems appropriate to the situation. This action may include, but shall not be limited to, the securing of reports from whatever sources have knowledge pertinent to the situation and referral to the Division on Civil Rights of the New Jersey Department of Law and Public Safety for investigation, evaluation, and recommendation by that agency.

(d) The eligibility determination agency shall afford full cooperation in the investigation of complaints of discrimination as may be requested by the State Division of Medical Assistance and Health Services, or the State Division on Civil Rights.

10:78-1.8 Assignment of medical support rights

(a) Any person who applies for NJ FamilyCare, by virtue of the application for benefits, shall be deemed to have assigned to the Commissioner of the Department of Human Services any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for care from any third party. Program applicants and beneficiaries shall cooperate in the identification of and the obtainment of any such rights. Failure to cooperate shall result in denial of eligibility for any adult. Children shall not be subject to this sanction.

1. The eligibility determination agency shall advise program applicants and beneficiaries of the terms of the assignment and the consequences thereto.

10:78-1.9 Applicability to this chapter of Medicaid provisions relating to fraud and abuse, third party liability and administrative and judicial remedies

All of the relevant provisions pertaining to fraud and abuse, third party liability, and administrative and judicial remedies which are contained in the following sections of N.J.S.A. 30:4D-1 et seq. and N.J.A.C. 10:49 shall be fully applicable to NJ FamilyCare: N.J.S.A. 30:4D-6c, 6f, 7h, 7i, 7k, 7l, 7.1, 12, 17(e), 17(f), 17(g), 17(i), 17.1 and 17.2, as well as N.J.A.C. 10:49-3.2, 4.1 through 4.5, 5.5, 6.1(a)3, 7.3, 7.4, 7.5, 9.6 though 9.12, 11.1, 12.1 though 12.7, 13.1, 13.4, 14.2 through 14.6 and 16.5.

New Rule, R.2002 d.155, effective May 20, 2002.

See: 33 N.J.R. 3893(a), 34 N.J.R. 1852(a).

Amended by R.2002 d.318, effective September 16, 2002.

See: 34 N.J.R. 1787(a), 34 N.J.R. 3273(a).

Rewrote the section.

SUBCHAPTER 2. CASE PROCESSING

10:78-2.1 Application

(a) Application for NJ FamilyCare benefits shall be accomplished by completing and signing the application form as well as any addenda to that form as prescribed by the Division of Medical Assistance and Health Services. Applicants may obtain NJ FamilyCare applications from various social service locations or by calling the Division. The eligibility determination agency shall process all applications mailed or forwarded or presented to them.

(b) The eligibility determination agency shall:

1. Inform applicants of the purpose of and the eligibility requirements for the NJ FamilyCare program, including their rights to a grievance review;
2. Receive applications and review them for completeness, consistency, and reasonableness;
3. Assist program applicants in exploring their eligibility for program benefits;
4. Make known to program applicants the appropriate resources and services both within the agency and in the community; and
5. Assure the prompt and accurate submission of eligibility data to the Eligibility File for beneficiaries and prompt notification to beneficiaries of the reason for their eligibility or ineligibility.

(c) As part of the application process, an applicant for NJ FamilyCare has the responsibility to:

(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" service package shall contain those services described at N.J.A.C. 10:49-5.7, except that long term care services shall not be provided. Those FamilyCare Plan D beneficiaries whose income is above 150 percent of the Federal poverty line shall be responsible for copayments for services received, in accordance with the provisions of this chapter.

(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) NJ FamilyCare beneficiaries whose gross income, as adjusted for the size of the family unit, exceeds 150 per cent of the Federal poverty level shall be responsible for a monthly premium of \$25.00 for the first adult, \$10.00 for the second eligible adult in the household unit, and a copayment established under contract between the Department of Human Services and managed care organizations administering services to this population. 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.

(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.

Special amendment, R.2001 d.304, effective July 31, 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).

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.

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 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

10:78-9.5 Application review

(a) The NJ FamilyCare Program eligibility vendor or County Board of Social Services will refer all applications to the Premium Support Program. The referral will consist of a copy of the original application for NJ FamilyCare and shall include copies of any pertinent documentation, including, but not limited to, any information provided by the applicant regarding his or her employer's health benefit plan.

(b) The application will be reviewed for completeness and NJ FamilyCare eligibility will be verified by the Division.

10:78-9.6 Applicant's responsibilities during the application process

(a) The Premium Support Program applicant shall provide employer health benefit plan information regarding all family members for whom coverage is sought.

(b) The applicant shall assist the Division as needed in obtaining employer health benefits plan information.

(c) If the employee fails to provide the Division with the information needed to complete the application review, the application for premium support shall be denied.