

(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.

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) NJ FamilyCare beneficiaries whose gross income, as adjusted for the size of the family unit, exceeds 150 percent 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.

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.

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).

(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 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.

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.



1. If the application for premium support is denied due to lack of cooperation by the employer, the applicant (and family, if applicable) shall continue to participate in a State-contracted managed care plan through the NJ FamilyCare program.

2. If the application for premium support is denied due to lack of cooperation by the applicant and after multiple attempts by the Premium Support Program to enlist cooperation, the NJ FamilyCare participation of the applicant and any other adult eligible members of the household shall be discontinued immediately. The eligible children in the household will continue to remain eligible until the next annual redetermination at which time failure to cooperate and provide necessary information shall result in termination of NJ FamilyCare eligibility for all members of the household.

10:78–9.7 Premium Support Program data collection

(a) Upon receipt of a completed application, the Premium Support Program (PSP) will:

1. Issue a notification letter to the applicant(s) stating that the application has been referred to the Premium Support Program for determination of eligibility for PSP participation; and

2. Send a letter and a Request for Information Form to the applicant's employer, seeking information on the type of employer-sponsored health plan(s) available to the employee.

10:78–9.8 Employer participation criteria

(a) The employer should complete the Request for Information Form and return the form to the Premium Support Program (PSP) with a copy of the employer's Statement of Insurance Coverage.

(b) An application to participate in the Premium Support Program shall be supported by the indication by the applicant's employer that the employer contributes, at a minimum, 50 percent of the annual cost of the insurance premium for the employee (and family, as applicable). If the employer does not contribute 50 percent of the premium cost, the PSP application shall be denied and the applicant shall continue to participate in a State-contracted managed care program through the NJ FamilyCare program.

(c) If the employer does attest to contributing, at a minimum, 50 percent of the annual cost of premium on behalf of the employee (and family, as applicable), the Division will evaluate the application for cost-effectiveness, in accordance with N.J.A.C. 10:78–9.10.

10:78–9.9 Employer plan review

(a) Upon return of the employer's completed "Request for Information Form" and "Statement of Insurance Coverage," the Premium Support Program will initiate a two step

review of the employer plan to determine if the plan meets the Division's plan participation requirements, as follows:

1. Step I: The employer-sponsored plan shall be compared, benefit-by-benefit, to the NJ FamilyCare Plan 'D' service package, to determine whether the employer-sponsored plan's services are the same services the employee would be eligible for under NJ FamilyCare.

i. If the employer is a large employer, both the specific services and the extent of coverage of the services shall be at least equal to the services in the NJ FamilyCare Plan D service package.

ii. If the employer is a small employer, the specific services shall be identical 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 small employer health plan information, refer to N.J.A.C. 11:21.

2. Step II: The employer plan will be evaluated for cost effectiveness, in accordance with N.J.A.C. 10:78–9.10.

10:78–9.10 Cost-effectiveness test

(a) Cost-effectiveness shall be determined by comparing the cost of the beneficiary/employee and all eligible family members' participation in the NJ FamilyCare program against the total cost to the State of reimbursing the beneficiary/employee for the employee share of the cost of family coverage less a monthly premium contribution amount for the family purchasing the employer plan. The amounts used for the calculations in this section shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.

(b) For the State to provide benefits under NJ FamilyCare, an actuarially valid total cost per family per month will be determined, using current data from NJ FamilyCare (NJFC), Managed Care participant rates.

(c) The cost of the employer-sponsored plan shall be determined by totaling the costs to the State to participate in the employer-sponsored plan.

1. The monthly amount of the employee premium plus the actuarial value of all excess cost-sharing expenditures (co-payments, deductible and coinsurance), less the NJ FamilyCare/Premium Support Program monthly premium amount, plus the cost of "wraparound" services, if applicable, will constitute the total cost to the State to purchase the employer plan.

(d) As a condition of PSP approval, the result of the cost-effectiveness test shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the employee's participation in the employer-spon-

sored health plan and what the State would pay for the employee's participation in the NJ FamilyCare program.

(e) If the employer-sponsored plan is determined by the Division to be cost-effective in accordance with (d) above, the applicant shall participate in the Premium Support Program. If the employer-sponsored plan is determined not cost-effective, in accordance with (d) above, the beneficiary will continue to participate in the NJ FamilyCare program.

10:78-9.11 Plan approval notification and premium support payments

(a) If the beneficiary/employee is found eligible to participate in the Premium Support Program (PSP), a letter of notification will be sent to the employee. The notification letter will advise the employee of PSP approval and request that the beneficiary/employee and all eligible family members be enrolled in the employer-sponsored plan at the earliest possible date.

(b) The letter of notification will provide a suggested future date of plan enrollment, and a date on which the first PSP payment should be made.

1. The first PSP payment will be made to the employee in advance of the first payroll deduction by the employer.

(c) All PSP participants' payments to their employers shall be subject to verification by the Division.

(d) The PSP beneficiary/employee shall submit proof of employer plan participation prior to the payment by the Division of any premium support payments after the initial payment. Proof of employer plan participation shall include, but need not be limited to: payroll stubs indicating the amount of the employee's contribution to employer plan coverage, a copy of the insurance carrier identification card indicating all covered family members, or a letter of coverage from the employer or insurance carrier. All documents submitted shall be subject to verification by the Division.

10:78-9.12 Payment of premium support to beneficiaries

(a) All Premium Support Program (PSP) payments will be made directly to the beneficiaries, for a portion of the amount payable to the employer by the beneficiary for the employer-sponsored health plan.

(b) The periodic payments to the beneficiary will coincide with the schedule of payroll deductions as established by the employer.

(c) The amount of the periodic payments to the employee shall be the amount of the employee's contribution to the employer's plan, less the monthly NJFC/PSP premium amounts for which the employee is responsible, in accordance with N.J.A.C. 10:78-9.13.

10:78-9.13 NJ FamilyCare/Premium Support Program payment formula

(a) A monthly premium charge shall be assessed and collected for all participants in the NJ FamilyCare Premium Support Program (PSP), as provided in this section.

(b) NJ FamilyCare PSP participants whose gross income, as adjusted for the size of the family unit, exceeds 150 percent, but is not in excess of 200 percent, 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 \$10.00 per month for one or more children. For example:

1. A family of two adults and one child would pay \$45.00 per month;
2. A family of two adults and three children would pay \$45.00 per month;
3. A family of one adult and one child would pay \$35.00 per month; and
4. A family of one adult and three children would pay \$35.00 per month.

(c) NJ FamilyCare PSP participants whose gross income, as adjusted for the size of the family unit, exceeds 200 percent, but does not exceed 250 percent, of the Federal poverty level shall be responsible for a monthly premium of \$20.00 for one or more children.

(d) NJ FamilyCare PSP participants whose gross income, as adjusted for the size of the family unit, exceeds 250 percent, but does not exceed 300 percent, of the Federal poverty level shall be responsible for a monthly premium of \$50.00 for one or more children.

(e) NJ FamilyCare PSP participants whose gross income, as adjusted for the size of the family unit, exceeds 300 percent, but does not exceed 350 percent, of the Federal poverty level shall be responsible for a monthly premium of \$90.00 for one or more children.

10:78-9.14 Payment of cost sharing expenditures

(a) The Premium Support Program (PSP) will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is \$5.00 and the employer-sponsored plan co-pay charge is \$15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount (\$10.00).

(b) Copayment amounts for services available through the HMO shall be consistent with those of the NJ FamilyCare program (see N.J.A.C. 10:78).