

10:78-9.15 Five percent of gross family income annual limit on cost-sharing (out-of-pocket) expenditures

(a) If, during the course of a regular plan year (January 1 to December 31), the beneficiary and/or any other eligible family members incur cost sharing expenditures (copayments, co-insurance and deductibles) that are not directly reimbursable by the Premium Support Program (PSP), and that exceed five percent of the individual's or family's gross annual income, they may submit proof of such expenditures to the PSP for review and possible reimbursement, in accordance with the provisions of this section. If the beneficiary chooses an employer-sponsored plan which costs more than the basic plan approved by the Premium Support Program for that employee and/or any other eligible family members, the difference between the approved premium and the actual premium:

1. Will not be reimbursed by the Premium Support Program; and
2. Will not be included in the five percent cost sharing calculation (see N.J.A.C. 10:49-9.3).

(b) The annual limit on cost sharing expenditures shall be five percent of the individual's or family's gross annual income.

(c) The PSP will review all submitted medical expenditures made during the course of a plan year, and will determine those expenses that are allowable. If the allowable expenditures are equal to or greater than five percent of the individual's or family's gross annual income, all future cost sharing expenditures for the remainder of the plan year will be payable by the PSP.

1. Allowable expenses, for the purpose of the annual limit on cost-sharing (out-of-pocket) expenditures, shall be those expenses for services covered under the beneficiary's service package.

(d) The PSP will authorize such expenses by indicating a message on the NJ FamilyCare monthly ID Card waiving payment of such expenses for the remainder of the plan year. The provider will then bill the PSP for the amount of the cost share or the beneficiary may submit a bill to the PSP for reimbursement.

10:78-9.16 Covered services

(a) Participants in the NJ FamilyCare/Premium Support Program shall be eligible for all covered services based on their NJ FamilyCare category of eligibility (Plan A, B, C or D). Premium Support Program (PSP) participants shall utilize their employer-sponsored plan as primary coverage.

(b) Any services not covered by the employer plan, but covered under the enrollees' NJ FamilyCare category of eligibility, will be available to PSP participants as a "wraparound" service. Any such wraparound service (for example, optical appliances or hearing aids) shall be provided by a

New Jersey Medicaid/NJ FamilyCare participating approved provider. The failure of a beneficiary to use a New Jersey Medicaid/FamilyCare provider for "wraparound services" will result in a denial of payment by the NJ FamilyCare Program. The services received would then be the full responsibility and liability of the beneficiary.

(c) To access any "wraparound" service, a Premium Support Program beneficiary/employee or eligible family member will be issued a NJ FamilyCare monthly identification card and shall present such proof of eligibility to the provider prior to receipt of services. Failure to present proof will not obligate the PSP to pay for such services or require the provider to bill NJ FamilyCare for such services. In case of failure to present proof of eligibility, the beneficiary/employee or eligible family member shall be liable for all incurred expenses. Any wraparound services shall be received from a NJ Medicaid/FamilyCare participating provider. Reimbursement will be made to the provider on a fee-for-service basis according to the Division's rules for those services.

10:78-9.17 Certain Medicaid provisions applicable to the Premium Support Program

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 the Premium Support Program: 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 through 9.12, 11.1, 12.1 through 12.7, 13.1, 13.4, 14.2 through 14.6 and 16.5.

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.

10:78-9.18 Applicability of rules of the Department of Banking and Insurance; small employer health plans

Notwithstanding the provisions of this subchapter, in the case of a conflict between the rules in this subchapter and the rules of the Department of Banking and Insurance, the rules of the Department of Banking and Insurance regarding small employer health plans shall apply.

10:78-9.19 Interpretations of rules

Circumstances which are neither specifically nor generally addressed in these rules shall be referred to the DMAHS/PSP unit for resolution.

SUBCHAPTER 10. FRAUD AND ABUSE UNDER NJ FAMILYCARE

10:78-10.1 Termination of eligibility for good cause for fraud and abuse

(a) Subject to the limitations contained in 42 U.S.C. § 1320a-7b(a), "Criminal Penalties for Acts Involving Fed-

eral Health Care Programs," any violation of (b) below shall result in the issuance of a Notice of Proposed Termination of the processing of the applicant's application, or of the beneficiary's eligibility for NJ FamilyCare. An individual receiving a Notice of Proposed Termination may request a grievance review.

(b) Subject to the limitations contained in 42 U.S.C. § 1320a-7b(a), cause for termination exists when a NJ FamilyCare applicant or beneficiary:

1. Knowingly or intentionally makes or causes to be made false statements or misrepresentations of material fact in any application or reapplication for benefits under NJ FamilyCare;
2. Knowingly or intentionally makes or causes to be made false statements, misrepresentations of material fact, or alterations on any NJ FamilyCare claim, eligibility card, or other document issued by or on behalf of the Division;
3. Intentionally misuses or abuses NJ FamilyCare benefits;
4. Knowingly or intentionally converts all or part of NJ FamilyCare benefits to a use other than the individual's own legitimate use and benefit;
5. Gives, loans, or sells an eligibility card to anyone for use by an individual or individuals other than the eligible person or persons for whom the card was issued;
6. Engages in forgery or attempted forgery involving eligible services and/or claims for such services;
7. Engages in a course of conduct or performs an act deemed improper or abusive of the NJ FamilyCare program following notification that this conduct should cease; or
8. Fails to cooperate in a NJ FamilyCare investigation.

(c) Subject to the limitations contained in 42 U.S.C. § 1320a-7b(a), the existence of a cause for termination described in (b) above may be established by:

1. A judgment of conviction for a crime, disorderly persons offense, or petty disorderly persons offense;
2. A judgment or order of either a court of competent jurisdiction or an administrative agency; or
3. A preponderance of the evidence.

10:78-10.2 Applications for readmission subsequent to termination of eligibility, or of applications for determination of eligibility

(a) The terminated individual, or anyone with authority to act on his or her behalf, may apply to the Director for readmission to the NJ FamilyCare program no earlier than one year from the date of the final agency decision terminating the applicant's application process or the beneficiary's eligibility.

(b) The Director shall approve or deny such an application in accordance with the provisions of this chapter.

(c) An individual whose application for readmission has been denied may request a grievance review on the denial, and/or may submit another application to the Director no earlier than two years from the date of the final agency decision denying readmission.

10:78-10.3 Applicability

N.J.A.C. 10:78-10.1(a) and 10.2 shall apply only to NJ FamilyCare applicants and beneficiaries whose eligibility has been terminated for the reasons set forth in N.J.A.C. 10:78-10.1(b) and shall not apply to termination due to ineligibility initiated under N.J.A.C. 10:78-2 through 4.

SUBCHAPTER 11. PROVISIONS GOVERNING FORMER NEW JERSEY HEALTH ACCESS ENROLLEES

Authority

N.J.S.A. 30:4D-6(b)(17) and 30:4D-7 and 30:4D-12, as amended by P.L. 2000, c.71; and P.L. 2001, c.130, pages 121, 122 and 123.

Source and Effective Date

R.2002 d.29, effective December 21, 2001 (to expire July 24, 2003). See: 34 N.J.R. 602(a).

Subchapter Historical Note

Subchapter 11, Provisions Governing Former New Jersey Health Access Enrollees, was adopted as special new rules by R.2002 d.29, effective December 21, 2001 (to expire July 24, 2003). See: Source and Effective Date.

10:78-11.1 Purpose, scope and definitions

(a) The purpose of this subchapter is to set forth the general provisions of the New Jersey FamilyCare program as it applies to those who were enrolled in the New Jersey Health Access program on October 31, 2001.

(b) This subchapter applies to all individuals who:

1. Were enrolled in the New Jersey Health Access program on October 31, 2001; and
2. Are enrolled in the NJ FamilyCare program.

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

"Health Maintenance Organization (HMO) plan" means that managed care contract which is in force between the Department of Human Services and the managed care organizations and which is administered by the Division of Medical Assistance and Health Services.

10:78-11.2 Eligibility and redetermination of eligibility

(a) Individuals who were enrolled in the New Jersey Health Access program on October 31, 2001, and who returned a plan selection form by November 13, 2001, shall be eligible to enroll in the NJ FamilyCare program.

1. An enrollee who is denied the opportunity to enroll in the New Jersey FamilyCare program because he or she did not return a plan selection form by November 13, 2001 shall have the right to file a grievance with the Health Access New Jersey Grievance Board in accordance with (a)2 below, if the grievance is filed with the Access program within 10 days of receipt of notice of discontinuation of the Access program mailed November 14, 2001. If the enrollee has not filed a grievance within 10 days of receipt of the notice mailed on November 14, 2001, no further opportunity to file a grievance shall be available.

2. If an enrollee has a grievance pertaining to the subsidy level calculated or involuntary disenrollment in the Access Program, the enrollee shall submit a description of the grievance to the Access Program in writing within 10 days of the adverse notification. The Access Program shall notify the enrollee of its decision on the matter in writing, specifying the reasons for the decision, within 30 days of receipt of the complete documentation of the grievance. The Access Program shall retain all correspondence and documentation relating to the grievance in the enrollee's file. The Access Program's decision shall be considered the final agency determination.

(b) An enrollee shall remain eligible for the NJ FamilyCare program for former Health Access enrollees if:

1. The enrollee meets the eligibility limits established by the Division at (b)2 through 5 below, and the applicant's family gross income meets the income limits established by the Division, which shall not exceed 250 percent of the Federal poverty income guidelines revised annually by the United States Department of Health and Human Services, pursuant to the provisions of 42 U.S.C. § 9902(2), incorporated herein by reference. (For further information on the poverty income guidelines, contact the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, DC 20201; telephone: 202-690-6141);

2. The enrollee continues to reside in New Jersey;

i. All enrollees shall be required to submit a signed affidavit stating their intent to remain in New Jersey; and

ii. Documentation of residency may be required, if determined necessary by program audit staff;

3. The enrollee is not eligible for employer-based insurance;

4. The enrollee is not currently enrolled in any other government program providing health care benefits; and

5. The enrollee is not currently covered under an individual standard health benefits plan or other individual health coverage.

(c) An enrollee's eligibility shall be redetermined on at least an annual basis, and in each subsequent 12-month period an enrollee shall submit an attestation of assets in addition to submitting to a redetermination of eligibility based on gross income, in accordance with (d) and (e) below.

(d) Determination of income for former Health Access enrollees shall be as follows:

1. Gross income for the person to be insured shall include the gross income of all legally responsible adults in a family, unearned income of minor children, and with respect to dependents of persons residing in a household separate from the dependent, that portion of the legally responsible adult's income required to be available for the care and support of that dependent.

i. A family includes legally married spouses and their dependent child(ren), and a single person and his or her dependent child(ren), as child and dependent are defined by the Board in the standard health benefits plan HMO policy form in Exhibit F of the Appendix to N.J.A.C. 11:20.

ii. A family shall not include persons residing within the same residence who do not have a legal relationship or legal dependency obligation for support.

2. Income for purposes of redetermining eligibility of former Health Access enrollees for NJ FamilyCare shall be determined as follows:

i. For farm and non-farm self-employed persons, income shall be calculated using adjusted gross income reported on the family's Federal income tax form(s) from the prior year as the baseline and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged. Enrollees shall report the most recent financial situation of the family if it has changed from the period of time covered by the Federal income tax form. The report may be in the form of a percentage increase or decrease.

ii. For wage earners, income shall be calculated based on gross income reported in the four months immediately preceding, multiplied by three to reflect a 12-month period.

iii. For unemployed persons eligible for a governmental income program, income shall be determined by the amount of expected payments from the government agency plus any other gross income.

iv. For other individual circumstances, income shall be calculated based on a combination and/or variation of (d)2i, ii and/or iii above, as appropriate.

(e) Proof of income requirements for former New Jersey Health Access enrollees shall be as follows:

1. The enrollee shall provide acceptable proof of income that may include any of the following: paycheck stub, W-2 form, a letter from an employer on company letterhead stating an individual's income, or a statement of the gross benefit amount from any governmental agency providing benefit to the individual. These should be submitted in the combination appropriate for the individual or family. Enrollees shall submit a signed copy of their most recent Federal income tax form filed, if any.

2. Additional documentation may be requested of an individual, on a case-by-case basis, for verifying eligibility.

3. Changes that could impact an individual's or family's eligibility shall be reported immediately. As soon as identified, enrollees shall report, at a minimum, changes in the following:

- i. Income;
- ii. Employment status;
- iii. Family composition (birth, death, marriage, divorce);
- iv. Address; and
- v. Availability of other health coverage.

4. Failure to provide factual information may result in immediate disenrollment and may result in the imposition of payback provisions available under the law.

(f) A beneficiary who was transferred to NJ FamilyCare from the NJ Health Access program shall be eligible to receive the service package appropriate for that beneficiary, based on all relevant eligibility factors other than financial eligibility factors.

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

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

Added (f).

10:78-11.3 Subsidy, contribution and copayments

(a) The total subsidy the State shall submit on behalf of a former New Jersey Health Access program enrollee shall be based upon the contract in force between the State and the managed care organization in which the individual is enrolled. The subsidy shall be recalculated in accordance with the contract between the Division and the managed care organization.

(b) The contribution that a former New Jersey Health Access Program enrollee shall be required to pay to the State shall be as provided for in N.J.A.C. 10:78-7.1(e).

10:78-11.4 Disenrollment

(a) Any individual who does not submit timely payment for his or her share of the premium, as determined by the State, in accordance with N.J.A.C. 10:78-7.1, shall be disenrolled.

(b) The Division may disenroll any former Access program enrollee from the NJ FamilyCare program for good cause, which shall include: failure to meet the eligibility requirements set forth in this subchapter; loss of eligibility; nonpayment of premium contribution; and fraud or abuse. The Division shall provide the enrollee with advance written notice of its intent to disenroll the enrollee specifying the reasons for the disenrollment action. Such notice shall specify an effective date of the notice, and shall describe procedures for disenrollment, including the enrollee's right to appeal the disenrollment decision pursuant to N.J.A.C. 10:78-8.

10:78-11.5 Applicability

(a) Except as otherwise specified in this subchapter, all provisions of N.J.A.C. 10:78, NJ FamilyCare, shall apply to the administration of the NJ FamilyCare program services provided to former New Jersey Health Access program enrollees.

(b) Notwithstanding the provisions of this subchapter, in the case of a conflict between these rules and the rules of the Department of Banking and Insurance, the rules of the Department of Banking and Insurance shall apply.