

CHAPTER 78

NJ FAMILYCARE

Authority

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

Source and Effective Date

R.2001 d.113, effective March 5, 2001.
See: 32 N.J.R. 3603(a), 33 N.J.R. 1126(a).

Executive Order No. 66(1978) Expiration Date

Chapter 78, NJ FamilyCare, expires on March 5, 2006, except for Subchapter 9, Premium Support Program (PSP), which expires on January 20, 2002.

Chapter Historical Note

Chapter 78, NJ FamilyCare, was adopted as special new rules by R.2000 d.393, effective September 6, 2000, to expire March 5, 2001. See: 32 N.J.R. 3603(a). The provisions of R.2000 d.393 were readopted as R.2001 d.113, effective March 5, 2001. See: Source and Effective Date.

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SUBCHAPTER 1. INTRODUCTION

10:78-1.1 Program outline

(a) NJ FamilyCare is a broad term used to describe a State subsidized health insurance program. This chapter contains the criteria for NJ FamilyCare eligibility for certain uninsured parents, caretakers and children not eligible under the provisions of N.J.A.C. 10:69 and 10:79, as well as certain uninsured single individuals and couples without dependent children not eligible under the provisions of N.J.A.C. 10:90. FamilyCare also provides subsidized health insurance to those legal immigrants who are lawfully admitted for permanent residence who meet all other qualifications under the provisions of N.J.A.C. 10:69, 10:72 and 10:79, but for the Federal immigrant residency restrictions.

(b) Because the eligibility criteria established by the rules in this chapter are more liberal than those applicable under AFDC-related Medicaid and SSI-related Medicaid, parents, caretakers, children, single adults and couples without dependent children who are losing Medicaid eligibility because of financial reasons should be evaluated for FamilyCare eligibility under the provisions of this chapter.

1. Individuals financially ineligible for Medicaid under the provisions of N.J.A.C. 10:71, 10:72 or 10:69 and who are income ineligible for FamilyCare under the provisions of this chapter shall be evaluated for eligibility as Medically Needy under the provisions of N.J.A.C. 10:70.

2. Immigrant infants and children not eligible under the provisions of N.J.A.C. 10:49, 10:71, 10:72, 10:69 or 10:79 should be evaluated for NJ FamilyCare eligibility under the provisions of this chapter.

(c) Eligibility under the provisions of this chapter shall be limited to those individuals not otherwise eligible for Medicaid or NJ KidCare, including:

1. Parents and caretakers of children under the age of 19;
2. Pregnant women whose income is over 185 percent of the Federal poverty line;

3. Immigrant pregnant women lawfully admitted for permanent residence who would be eligible for Medicaid but for Federal immigrant residency restrictions;

4. Single individuals and couples without dependent children; and

5. Children under the age of 21.

(d) Persons found eligible for NJ FamilyCare will receive services as set forth in N.J.A.C. 10:78-7.1, Scope of services.

10:78-1.2 Purpose

(a) The purpose of the rules contained within this chapter is to:

1. Set forth eligibility criteria for the NJ FamilyCare program; and

2. Specify the rights and responsibilities of program applicants and beneficiaries.

(b) Circumstances which are neither specifically nor generally addressed in these rules shall be referred to designated staff of the Division of Medical Assistance and Health Services for resolution.

(c) The director of the eligibility determination agency shall assign copies of this chapter to administrative staff, all staff responsible for the determination of NJ FamilyCare eligibility, social services staff as appropriate and shall ensure that each staff member is thoroughly familiar with its requirements in order to apply the policies and procedures consistently.

(d) The Division of Medical Assistance and Health Services shall issue amendments to this chapter as they are promulgated in accordance with New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(e) At least one administrative copy of all obsolete pages of this chapter shall be maintained by the eligibility determination agency.

(f) This chapter is a public document. All copies in use shall be updated accurately as amendments are issued. The chapter is available as follows:

1. Copies are available in the State offices of the Division of Medical Assistance and Health Services and in each eligibility determination agency for examination and review during regular office hours.

2. Specific requirements necessary for an applicant or beneficiary or his or her representative to determine whether a grievance review is to be requested or to prepare for a grievance review shall be provided to such persons without charge.

3. All public and university libraries which have agreed to maintain the chapter up-to-date will have a copy available under their regulations.

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 investigations and administrative actions, third party liability, and recoveries

All of the relevant provisions pertaining to fraud and abuse investigations and administrative actions, third party liability, and recoveries which are contained in N.J.S.A. 30:4D-1 et seq. and in N.J.A.C. 10:49 shall be fully applicable to NJ FamilyCare including, but not limited to, 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.

New Rule, R.2002 d.155, effective May 20, 2002.
See: 33 N.J.R. 3893(a), 34 N.J.R. 1852(a).

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:

1. Complete, with the assistance of the eligibility determination agency, as needed, any forms required as part of the application process;
 2. Assist the eligibility determination agency in securing evidence that verifies his or her statements regarding eligibility; and
 3. Provide medical confirmation of pregnancy when NJ FamilyCare benefits are sought on that basis.
- (d) For any application for NJ FamilyCare benefits under the provisions of this chapter, the eligibility determination

agency shall accomplish disposition of the application as soon as all factors of eligibility are met and verified but not later than 30 days from the date of application. Exceptions to the timeliness standard appear in (d)2 below.

1. "Disposition of the application" means the official determination by the eligibility determination agency of eligibility or ineligibility of the applicant(s) for NJ FamilyCare.

2. Disposition of the application may exceed the applicable processing standard when substantially reliable evidence of eligibility or entitlement for benefits is lacking at the end of the processing period. In such circumstances, the application may be continued in pending status. The eligibility determination agency shall fully document in the case record the circumstances of the delayed application processing. The processing standard may be exceeded for any of the following:

- i. Circumstances wholly within the control of the applicant;
- ii. A determination by the eligibility determination agency, when evidence of eligibility or entitlement is incomplete or inconclusive, to afford the applicant additional time to provide evidence of eligibility before final action on the application;
- iii. An administrative or other emergency that could not reasonably have been avoided; or
- iv. Circumstances wholly beyond the control of both the applicant and the eligibility determination agency.

3. When disposition of the application is delayed beyond the processing standard, the eligibility determination agency shall provide the applicant written notification prior to the expiration of the processing period, setting forth the specific reasons for the delay.

4. Each eligibility determination agency director shall establish appropriate operational controls to expedite the processing of applications and to assure maximum compliance with the processing standard.

- i. The eligibility determination agency shall maintain control records identifying all pending applications which have exceeded the processing standard and the reason therefor. The record shall be adequate to make possible the preparation of reports of such information as may be requested by the Division of Medical Assistance and Health Services.

(e) The following actions on an application qualify as disposition of an application for purposes of the processing standard:

1. Approved: The applicant has been determined eligible for NJ FamilyCare;
2. Denied: The applicant has been determined ineligible for NJ FamilyCare;
3. Dismissed: A decision by the eligibility determination agency that the application process need not be completed because:
 - i. The applicant has died;
 - ii. The applicant cannot be located;
 - iii. The application was registered in error; or

iv. The applicant has moved out of the State during the application process; and

4. Withdrawn: The applicant requests that eligibility for the NJ FamilyCare program no longer be considered.

(f) The New Jersey FamilyCare Health Coverage Program will not process applications postmarked on or after September 1, 2001 for single adults and couples without dependent children who are not eligible for General Assistance.

Special amendment, R.2001 d.304, effective July 31, 2001 (operative September 1, 2001).
See: 33 N.J.R. 2912(a).
Added (f).

10:78-2.2 Interview

The eligibility determination agency may conduct, but is not required to conduct, a personal face-to-face interview with the program applicant or the authorized agents as part of the process of determining program eligibility.

10:78-2.3 Verification requirements

(a) The eligibility determination agency shall verify all factors related to eligibility for the NJ FamilyCare program. Factors subject to verification include:

1. Pregnancy: For women seeking benefits under the provisions of this chapter, pregnancy shall be medically verified. The medical verification shall include the estimated date of delivery;
2. Birth date: The birth date of any person for whom benefits are sought shall be verified;
3. Citizenship/Immigration status: The immigration status of any individual seeking benefits who is not a citizen of the United States shall be verified to establish entitlement for NJ FamilyCare benefits;
4. Household composition: The eligibility determination agency shall verify the household composition in order to ascertain which persons will be included in the determination of eligibility for NJ FamilyCare benefits;
5. Social Security number: The Social Security number of any person seeking NJ FamilyCare benefits shall be verified; and
6. The eligibility determination agency shall verify all sources of income of any person whose income shall be counted in the determination of program eligibility. While resources are not a factor of eligibility, resources shall be identified and verified to determine if income is derived from the resources.

(b) The eligibility determination agency shall use documentary evidence as the primary source of verification. Documentary evidence is written confirmation of the family's circumstances. It is the responsibility of the applicant to

obtain or to assist the eligibility determination agency in obtaining any required documentation.

(c) In circumstances in which the documentary evidence is questionable or is not available, the eligibility determination agency may use collateral contact to confirm the family's circumstances. A collateral contact is a verbal confirmation of a family's circumstances by a person outside the family. In order to be acceptable as verification, a collateral contact shall be in a position to provide accurate information about the family and the circumstance in question.

(d) Subsequent to the initial application, verification is required for only those factors of eligibility which are subject to change or for those factors for which the original verification has become questionable.

(e) In the absence of credible verification of all eligibility factors, eligibility for the NJ FamilyCare program shall not be established.

10:78-2.4 Case transfer from one county to another

(a) When individuals move permanently to another county within the State, responsibility for the case shall be transferred in accordance with the provisions of this section. The case transfer shall be accomplished in a manner so as not to adversely affect the rights of any individual to program entitlement.

1. A temporary visit out-of-county shall not be considered to be a change of county residence until the visit has continued for longer than three calendar months.

(b) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (c) and (d) below.

(c) For persons who move from the county in which application for NJ FamilyCare is made prior to the determination of eligibility or ineligibility:

1. The county in which the application was made has the responsibility to:

i. Complete the eligibility determination process;

ii. If determined eligible for the NJ FamilyCare program, add the eligible person(s) to the Eligibility File with the correct effective date of NJ FamilyCare eligibility and the new address in the receiving county; and

iii. If the case is determined eligible, within five working days of that determination, transfer the case record material to the receiving county in accordance with (d)1i through iv below.

2. The receiving county shall:

i. Communicate promptly with the beneficiary upon the receipt of the case material to advise of continued program entitlement; and

ii. Immediately notify the county of origin, in writing, of the date the case material was received.

(d) For cases which have already been determined eligible for the NJ FamilyCare program:

1. The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent application form (including all verification), Social Security number(s), and the new address in the receiving county;

ii. Send with the case material in (d)1i above, a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;

iii. Forward promptly to the receiving county, copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any of the case material.

2. The receiving county shall:

i. Communicate promptly with the beneficiary upon receipt of the case material;

ii. Immediately notify the county of origin, in writing, of the date the initial case material was received;

iii. Review eligibility for the case. If questions regarding case eligibility exist because of information provided by the county of origin, that county shall be consulted for resolution of the issues;

iv. Accept responsibility for the case (provided application to transfer has been made) effective with the next month if the initial case material has been received before the 10th of the month;

v. Accept responsibility for the case (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such material is received on or after the 10th of the month;

vi. Update the Eligibility File as necessary including entry of a new case number. If the case is determined eligible for NJ FamilyCare in the receiving county, there shall be no interruption of entitlement. If the case is determined ineligible for NJ FamilyCare in the receiving county, eligibility shall be terminated, subject to timely and adequate notice, and the previously eligible person terminated on the Eligibility File; and

vii. Notify the county of origin of the date eligibility for NJ FamilyCare will begin or will be terminated in the receiving county.

10:78-2.5 Case transfer from one eligibility determination agency to another

(a) When an individual's eligibility transfers from one eligibility determination agency to another, responsibility for the case shall be transferred in a manner so as not to adversely affect the rights of any individual to program entitlement.

1. For individuals for whom, because of an initial screening, it is determined that the eligibility determination agency shall transfer the application to the appropriate agency, the agency of origin has the responsibility to:

i. Transfer, within five working days from the date of the initial screening, a copy of the application form including all verification; and

ii. Send the materials in (a)1i above, with a cover letter specifying that the application is being transferred and requesting written or verbal acknowledgment of receipt.

2. For individuals for whom a determination has been made, it is determined that because of a change in circumstances the eligibility determination agency shall transfer the case, the agency of origin has the responsibility to:

i. Transfer, within five working days from the date of the report of a change in circumstances, a copy of pertinent material to the appropriate agency. Such material shall include, at a minimum, a copy of the first application and most recent application form including all verification;

ii. Send the case material in (a)2i above, with a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;



vi. Conditional Entry under Law in Effect before April 1, 1980—INS Form I-94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Forms I-688B annotated “274a. 12(a)(3)” or I-766 annotated “A3.”

vii. Cuban Haitian Entrant—INS Form I-94 stamped “Cuban/Haitian Entrant under section 212(d)(5) of the INA.”

viii. An American Indian born in Canada—INS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes—a membership card or other tribal document showing membership in tribe is acceptable documentation.

x. Amerasian Immigrant—INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7, or AM8.

3. For aliens who entered the United States on or after August 22, 1996, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the eligibility determination agency should contact the INS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the eligibility determination agency shall ask the alien to present Form I-94. If that form is not available, the eligibility determination agency shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the eligibility determination agency shall contact the INS by submitting a Form G-845, attaching a copy of the document presented.

4. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following shall serve as documentation:

i. For discharge status, an original, or notarized copy of the veteran’s discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original, or notarized copy, of the applicant’s current orders showing the individual is on full-time duty with the U.S.

Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self-declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

(d) As a condition of eligibility, all applicants for NJ FamilyCare shall sign a declaration under penalty of perjury that they are citizens of the United States or aliens in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant’s behalf shall complete the same written declaration under penalty of perjury.

10:78-3.3 State residency

(a) In order to be eligible for the NJ FamilyCare program, an individual shall be a resident of the State of New Jersey. The term “resident” shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

1. If an individual leaves New Jersey with the intent to establish permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, he or she ceases to be eligible to receive NJ FamilyCare from this State.

2. When an individual enters this State in order to receive medical care and applies for NJ FamilyCare to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making the person ineligible for the NJ FamilyCare program. It is the responsibility of the eligibility determination agency to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

i. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;

ii. Whether there is clear expression of intent on the part of the individual to remain permanently in this State;

iii. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he or she came; and

iv. Whether the state in which the individual previously resided recognizes him or her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

3. If, after full consideration of the above factors, the eligibility determination agency is satisfied that the indi-

vidual has become a resident of this State, NJ FamilyCare eligibility may be established.

10:78-3.4 Beneficiaries

(a) The following persons who meet all eligibility criteria of this chapter and are not eligible to receive Medicaid or NJ KidCare under current provisions are eligible for NJ FamilyCare benefits:

1. Parents and caretakers of dependent children under the age of 19 whose gross family income does not exceed 200 percent of the Federal Poverty level (see N.J.A.C. 10:78-4);

2. Single adults or couples without dependent children whose gross family income does not exceed 100 percent of the Federal Poverty level (see N.J.A.C. 10:78-4).

i. A couple shall be defined as a man and a woman who are legally married, or who have been determined to be a couple by the Social Security Administration, or who are living together in the same household and presenting themselves to the community in which they live as husband and wife;

3. Pregnant women of any age during the term of a medically verified pregnancy whose gross family income does not exceed 200 percent of the Federal Poverty level.

i. A pregnant woman who is determined eligible under the criteria of this chapter shall, for purposes of eligibility, be considered to be a pregnant woman until the end of the 60-day period beginning with the last day of her pregnancy. Her eligibility as a pregnant woman shall end on the last day of the month in which the 60-day period ends;

4. Individuals under the age of 21 lawfully admitted for permanent residence and who qualify under the provisions in N.J.A.C. 10:69 or 10:79 but for Federal immigration residency restrictions;

5. Any child born to a woman eligible under the provisions of this chapter (except to a presumptively eligible pregnant woman who has subsequently been found ineligible for the month the child was born) shall remain eligible for a period of not less than 60 days from his or her birth and up to one year, so long as the mother remains eligible for NJ FamilyCare, or would remain eligible if pregnant, whether or not application has been made, if the child lives with his or her mother.

i. Notwithstanding (a)5 above, any child resulting from the pregnancy shall be eligible for NJ FamilyCare, if not otherwise eligible for Medicaid or NJ KidCare, without regard to changes in the household unit's income for a period of not less than 60 days and up to a period of one year, so long as the mother remains eligible for NJ FamilyCare, or would remain eligible if pregnant, and the child remains in the mother's custody; and

6. Any individual receiving NJ FamilyCare under the provisions of this chapter who is receiving inpatient services covered by NJ FamilyCare shall continue to be eligible for FamilyCare until the end of the stay for which the inpatient services are furnished, notwithstanding any other provision of this chapter.

10:78-3.5 Household unit

(a) The term "household unit" means those persons whose income is counted in the determination of eligibility under the provisions of this chapter. The following persons, if they reside with the program applicant or beneficiary, shall be considered members of the household unit:

1. In the case of a parent or caretaker:

i. The parent or caretaker;

ii. The spouse of the parent or caretaker;

iii. The parent or caretaker's natural or adoptive children under the age of 21;

iv. The blood-related siblings (including those of half-blood) of the parent or caretaker's children who are under the age of 21; and

v. The natural or adoptive father of any children in the household unit;

2. In the case of a single adult who does not meet the definition of dependent child under N.J.A.C. 10:69, the single adult only;

3. In the case of the couple without dependent children, the couple only;

4. In the case of a child who does not qualify for NJ KidCare Plan A because of Federal immigrant residency restriction or health insurance (see N.J.A.C. 10:79):

i. The child;

ii. The child's natural or adoptive parents;

iii. The child's blood-related (including half-blood) and adoptive siblings under the age of 21; and

iv. At the option of the household, the child's stepparent;

5. In the case of a child who does not qualify for NJ KidCare Plans B, C, or D because of alien residency restrictions (see N.J.A.C. 10:79):

i. The child;

ii. The child's natural or adoptive parents;

iii. The child's blood-related (including half-blood) and adoptive siblings under the age of 21;

iv. The natural or adoptive father of any child(ren) in the household unit; or

v. The stepparent if the stepparent is married to the natural parent; and

(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, except that long term care services shall be restricted to individuals who would qualify for programs for the aged, blind and disabled under N.J.A.C. 10:71 or 10:72, but for Federal immigration residency restrictions and/or categorical requirements.

(b) The NJ FamilyCare "Plan D" service package shall contain those services described at N.J.A.C. 10:49-5.7, ex-

cept 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. Certain single adults and couples without dependent children whose gross income is less than or equal to 50 percent of the Federal poverty level shall not be eligible to receive NJ FamilyCare services on a fee-for-service basis until such time as they become active enrollees of a managed care organization. Certain single adults and couples without dependent children whose gross income is more than 50 percent, but not more than 100 percent, of the Federal poverty level will be enrolled in a conventional managed care program.

(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 September 1, 2001, for NJ FamilyCare WorkFirstNew Jersey/GA-eligible individuals, the program will not cover hospital or hospital-based services (including hospital-based ambulatory clinic services) until the individual is enrolled in a managed care organization. Coverage of non-hospital-based ambulatory services will continue.

(h) Effective September 1, 2001, adults who have incomes below 50 percent of the Federal poverty level shall receive all services through a managed care organization, and shall not receive NJ FamilyCare coverage for any services until they are enrolled in a managed care organization. Upon enrollment in a managed care organization, such individuals shall receive the NJ FamilyCare Plan A package.

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

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

In (d), substituted "shall not" for "may" preceding "be eligible"; added (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.2001 d.286, effective July 20, 2001.
Sec: 33 N.J.R. 2913(a).

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.

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 eligi-

ble 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 expendi-

tures (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-sponsored 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.

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).

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.

(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 eligible 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.

10:78-9.17 Fraud and abuse provisions applicable to the Premium Support Program

All of the relevant provisions pertaining to fraud and abuse investigations and administrative actions, third party liability, and recoveries which are contained in N.J.S.A. 30:4D-1 et seq. and in N.J.A.C. 10:49 shall be fully applicable to the NJ FamilyCare/ Premium Support Program, including, but not limited to, 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, and 14.2 through 14.6 and 16.5.

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 Federal 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.

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.