and experiential requirements set forth [in] **at** N.J.A.C. 10:31-3.2(a)**,** and fulfills the duties set forth [in] **at** N.J.A.C. 10:31-3.2(b).

. . .

SUBCHAPTER 5. SYSTEMS REVIEW IN THE ACUTE CARE SYSTEM

10:31-5.3 Role of the systems review committee

(a) The systems review committee shall perform the following functions:

1.-5. (No change.)

6. Investigate and make recommendations to [DMH & H] **the Division** and county mental health boards regarding impediments and obstacles in the acute care system;

7. Discuss additional systems issues within the geographic area, and make recommendations to [DMH & H] **the Division** and county mental health boards;

8.-10. (No change.)

SUBCHAPTER 11. WAIVER

10:31-11.2 Procedures for all but personnel-related waivers

(a)-(b) (No change.)

(c) The screening service's waiver request will be reviewed according to the following procedure:

1.-3. (No change.)

4. The screening service may appeal denial by the regional assistant director of its waiver request by submitting an appeal to the **Division's** Assistant Commissioner [for Mental Health Services]. The screening service that originally requested the waiver, and other interested parties, may communicate their opinions about the appeal of the waiver denial to the **Division's** Assistant Commissioner [for Mental Health Services] prior to [his or her] **their** final decision. The **Division's** Assistant Commissioner [for Mental Health Services] shall uphold or reverse the original waiver denial by the regional assistant director and communicate the decision to the screening service in a written final agency decision; and

5. (No change.)

(a)

DIVISION OF DISABILITY SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Notice of Readoption

Personal Preference Program

Readoption and Recodification with Technical Changes: N.J.A.C. 10:142 as 10:60C

Authority: N.J.S.A. 30:4D-1 et seq., 30:6E-1 et seq., and 30:4J-8 et seq.

Authorized By: Sarah Adelman, Commissioner, Department of Human Services.

Effective Dates: November 1, 2024, Readoption; December 2, 2024, Technical Changes and Recodification.

New Expiration Date: November 1, 2031.

Take notice that pursuant to N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 10:142 were scheduled to expire December 18, 2024. This chapter sets forth the rules of the Department of Human Services (Department) regarding the Personal Preference Program (PPP). The Department is transferring the chapter interdepartmentally from the Division of Disability Services (DDS) to the Division of Medical Assistance and Health Services ("DMAHS" or "Division") and recodifying the chapter as N.J.A.C. 10:60C.

Individuals participating in the PPP receive a monthly budget to arrange for personal care assistant (PCA) services instead of receiving traditional PCA services. Traditional PCA services provided by an agency often have specific, sometimes restrictive, scheduling and staffing availability that adversely influence the individual's quality of life. The PPP allows the participant to manage their own PCA services and decide the best way to meet their individual needs. The PPP gives the participant the opportunity to customize their PCA services by deciding by whom, when, and how the services are provided, including the opportunity to hire people they know, such as family members and/or friends.

The chapter is comprised of 10 subchapters as summarized below.

Subchapter 1, General Provisions, provides the purpose, scope, and nature of the chapter; details the participant's rights; defines terms used throughout the chapter; and describes the administration of the program.

Subchapter 2, Eligibility and Participant Responsibilities, provides the eligibility requirements of the program, the responsibilities of the program participants, and the requirements of the employees providing the services.

Subchapter 3, Screening and Application, provides the screening and application process for Medicaid/NJ FamilyCare beneficiaries who are interested in participant-directed services whether they are enrolled in managed care or receive services on a fee-for-service basis; describes the participant's opportunity to designate an authorized representative to assist them and explains the requirements related to the standards, roles, and responsibilities of the authorized representative; defines the role and responsibilities of the consultant who assists the participant in developing a budget for services; and sets forth the requirements related to confidentiality and disclosure of information.

Subchapter 4, Cash Grant and Cash Management Plan, provides the requirements related to budget determination, how the budget allocation impacts other government benefits the participant may be receiving, the standards for the use of the budget, items not permissible as part of the budget, the cash management plan standards, penalties for overspending the budget, and how the cash management plan is monitored and modified.

Subchapter 5, Application Disposition, Enrollment, and Services, provides the requirements related to processing an individual's application for participation in the PPP, the enrollment of the participant, and the standards required for the types of services paid for using the PPP funds.

Subchapter 6, Participant Self-Direction and Reassessment, provides the requirements related to participant self-direction; reassessment by managed care organization (MCO) or DMAHS staff of the needs of the participant; and any change in the scope, duration, and/or amount of services based on the results of the reassessment.

Subchapter 7, Vendor Fiscal Employer Agent (VF/EA), specifies the financial administrative functions required to be performed by the VF/EA. The VF/EA shall be an agency under contract with DMAHS that shall serve as a business agent for the participants.

Subchapter 8, Disenrollment and Reinstatement, provides the procedure for voluntary disenrollment from PPP, the factors that will result in involuntary disenrollment from PPP, and the procedures for being reinstated into PPP following either type of disenrollment.

Subchapter 9, Administrative Reviews, Adverse Agency Actions, and Fair Hearings, provides the procedures that enable a PPP applicant or participant to submit complaints related to any aspect of the PPP by requesting an administrative review of their complaint, to appeal adverse agency actions resulting in elimination or reduction of services, to file a request for a fair hearing to be heard by an administrative law judge, and the procedures related to the outcome of the fair hearing.

Subchapter 10, Medicaid Fraud and Abuse, requires that any suspected fraud or abuse shall be reported to the Division immediately and provides the procedures and contact information needed to submit such information.

While the Department is readopting these rules with technical changes, including the recodification, it recognizes that further rulemaking may be necessary to update these rules to reflect current practices. Thus, the Department will continue to review the rules and may consider making substantive amendments prior to the next scheduled expiration.

The Department has reviewed the rules and has determined them to be necessary, reasonable, and proper for the purpose for which they were originally promulgated. Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1),

these rules are readopted and shall continue in effect for a seven-year period, with the technical changes as summarized below.

Throughout the chapter, changes update references from N.J.A.C. 10:142 to 10:60C to reflect the recodification of the rules due to the interdepartmental transfer described above, replace references to "Division of Disability Services (DDS)" with "Division of Medical Assistance and Health Services (DMAHS)," and replace references to "Medicaid" with "Medicaid/NJ FamilyCare" to be consistent with the current program terminology.

At recodified N.J.A.C. 10:60C-1.1(a), changes made are grammatical changes that do not change the purpose or intent of the subsection.

At recodified N.J.A.C. 10:60C-1.4, the definition of "Division," which defines the Division of Disability Services, is deleted because the rules are being transferred to the Division of Medical Assistance and Health Services (DMAHS), which is already defined in the section, however the definition is revised to state that the Division is responsible for the administration of the PPP and may be referred to in the chapter as "Division" or "State program office." The definition of "State program office" is updated to replace the reference to "Division of Disability Services" with "Division of Medical Assistance and Health Services."

At recodified N.J.A.C. 10:60C-9.1, the changes update the Division reference and address to reflect the Division of Medical Assistance and Health Services.

Full text of the technical changes follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

CHAPTER [142] **60C**
PERSONAL PREFERENCE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

[10:142]**10:60C**-1.1 Purpose

(a) In [accord] **accordance** with the mission of the Department of Human Services**,** and pursuant to provisions [under] **pursuant to** the Centers for Medicare and Medicaid Services (CMS) 1915(j) Waiver**,** [authority participants] **individuals** are offered a monthly allowance in place of traditional agency Personal Care Assistant (PCA) services [under] **provided pursuant to** N.J.A.C. 10:60-3.1**. These funds shall be used** to direct and manage their own PCA services. The Personal Preference Program is designed to:

1. Provide eligible [Medicaid] **Medicaid/NJ FamilyCare** beneficiaries an option to self-direct their own personal care services;

2.-4. (No change.)

[10:142]**10:60C**-1.2 Scope and nature

(a) The Personal Preference Program shall serve as an alternative delivery mechanism for eligible [Medicaid] **Medicaid/NJ FamilyCare** PCA services.

(b) (No change.)

(c) Participants in the program may utilize a portion of the benefit to purchase goods and services that are clearly related to meeting personal care needs. Approved purchase of goods and services are described at N.J.A.C. [10:142]**10:60C**-4.3(a), and items that are prohibited [under] **pursuant to** the program are described at N.J.A.C. [10:142]**10:60C**-4.4(a).

(d)-(e) (No change.)

[10:142]**10:60C**-1.3 Participant rights

(a) Participants are afforded the following rights [under] **pursuant to** the Personal Preference Program:

1.-4. (No change.)

5. To exercise choice of individuals for hiring as employees, including family members, to provide needed services, subject to limitations set forth at N.J.A.C. [10:142]**10:60C**-2.3;

6. To disenroll from the program, at any time, and return to the traditional [Medicaid] **Medicaid/NJ FamilyCare** PCA program [under] **pursuant to** N.J.A.C. 10:60-3 without penalty or loss of benefits currently received;

7.-9. (No change.)

[10:142]**10:60C**-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context indicates otherwise:

. . .

"Centers for Medicare and Medicaid Services" (CMS) means the Federal agency within the U.S. Department of Health and Human Services that works with the State to administer [Medicaid] **the Medicaid/NJ FamilyCare program**.

. . .

["Division" means the Division of Disability Services (DDS) within the New Jersey Department of Human Services, which is responsible for the administration of the Personal Preference Program (PPP). The DDS may alternately be referred to as the "State Program Office."]

"Division of Medical Assistance and Health Services (DMAHS)" **or "Division"** means the agency within the New Jersey Department of Human Services, that administers the New Jersey managed care organization (MCO) contract on behalf of the Department. DHS is the single State Medicaid agency in New Jersey, and DMAHS is designated as the [Medicaid] **Medicaid/NJ FamilyCare** administrative authority. **DMAHS is also responsible for the administration of the Personal Preference Program (PPP). The DMAHS may alternately be referred to as the "State program office."**

. . .

"Fee for service (FFS)" means the method used for [Medicaid] **Medicaid/NJ FamilyCare** reimbursement based on its payment for specific services covered by the DMAHS, but not covered by the MCO, which are rendered to an eligible participant, in accordance with N.J.A.C. 10:49.

. . .

"Managed care organization (MCO)" refers to a health maintenance organization (HMO) that is under contract with the State of New Jersey, Division of Medical Assistance and Health Services (DMAHS), for the provision of health care services for consumers that are eligible for [Medicaid] **Medicaid/NJ FamilyCare** benefits, as defined by Article 1, page 15**,** of the MCO contract.

"[Medicaid] **Medicaid/NJ FamilyCare** fiscal agent" means an entity under contract with the State of New Jersey that processes and adjudicates provider claims on behalf of the New Jersey [Medicaid] **Medicaid/NJ FamilyCare** Program.

"[Medicaid] **Medicaid/NJ FamilyCare** provider" means any agency meeting applicable requirements and standards for participation in the New Jersey [Medicaid] **Medicaid/NJ FamilyCare** Program, meeting the requirements at N.J.A.C. 10:49-3.1.

. . .

"Participant directed goods and services" means equipment or supplies in lieu of [hands on] **hands-on** personal care provided by an assistant employed by the participant not otherwise afforded through [Medicaid] **Medicaid/NJ FamilyCare** or the Medicaid State Plan.

. . .

"Personal care assistance services," also known as PCA services, means a [Medicaid] **Medicaid/NJ FamilyCare** service pursuant to N.J.A.C. 10:60-3.1, which provides for assistance with personal care, household duties, and health-related tasks performed by a qualified individual in a beneficiary's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. PCA services are alternatively known as traditional agency services[,] or traditional model.

"Personal care assistant" means a person who is employed by a [Medicaid] **Medicaid/NJ FamilyCare** provider agency to provide personal care assistance services, and who meets the qualifications set forth at N.J.A.C. 10:60-1.2.

. . .

"State program office" is also known as the Division of [Disability] **Medical Assistance and Health** Services, [under] **in** the New Jersey Department of Human Services, and is the agency responsible for the administration of the Personal Preference Program.

. . .

[10:142]**10:60C**-1.5 Administration of the Personal Preference Program

The Personal Preference Program (PPP) shall be administered by the Department of Human Services, Division of [Disability] **Medical Assistance and Health** Services. The Division shall perform all contracting responsibilities related to the administration of the program and employ staff to oversee the [day to day] **day-to-day** operations of the program.

SUBCHAPTER 2. ELIGIBILITY AND PARTICIPANT RESPONSIBILITIES

[10:142]**10:60C**-2.1 Eligibility requirements for the Personal Preference Program

(a) For the purposes of enrollment and continued participation in the Personal Preference Program, an eligible individual must meet the following standards:

1. An eligible applicant or participant shall be a resident of the State of New Jersey and must reside within the geographic boundaries thereof**,** in order to qualify for services. Residency shall be determined by physical domicile in the State of New Jersey. Exceptions to this rule include participants who are enrolled in a college/university on a full-time basis in- or out-of-State subject to the following:

i. Participant students must be present at their New Jersey address to participate in home visits and nursing reassessments, in accordance with N.J.A.C. [10:142]**10:60C**-2.2(a)13.

ii. (No change.)

2. An eligible applicant or participant must be eligible for a [Medicaid] **Medicaid/NJ FamilyCare** program pursuant to N.J.A.C. 10:49.

3. An eligible applicant or participant must have and maintain [Medicaid] **Medicaid/NJ FamilyCare** eligibility as categorically needy as defined [in] **at** N.J.A.C. 10:49.

4. An eligible applicant or participant must be capable of self-directing services and/or be willing to use an authorized representative to manage services pursuant to N.J.A.C. [10:142]**10:60C**-2.2(c) and 3.3.

5. (No change.)

(b)-(d) (No change.)

(e) It is the responsibility of the participant[,] and/or representative, where appropriate, to maintain program eligibility in good standing by complying with all requirements**,** as specified [in] **at** N.J.A.C. [10:142]**10:60C**-2.2.

[10:142]**10:60C**-2.2 Participant responsibilities

(a) Participants must agree to be the employer of record as defined by the Internal Revenue Service (IRS) at Section 3504 of the IRS Code and Revenue Procedure 70-6f, the Fair Labor Standards Act of 1938 at 29 CFR Part 201, and shall be expected to make decisions regarding their services and carry out required program activities, which include**,** but are not limited to:

1.-14. (No change.)

15. Informing the Division, or other agent thereof, for program purposes, of any change in the participant's contact information (such as address/phone number) or [Medicaid] **Medicaid/NJ FamilyCare** eligibility;

16.-21. (No change.)

(b)-(c) (No change.)

(d) Prospective applicants who withdraw from the program enrollment process following prepayment of workers' compensation insurance by the **vendor fiscal/employment agent (**VF/EA**)** [under] **pursuant to** N.J.A.C. [10:142]**10:60C**-7.1(b), shall be responsible for reimbursement of above expenses by the program.

1. (No change.)

2. In the event an applicant withdraws prior to enrollment in the program, the VF/EA shall be responsible for billing the applicant and collecting worker compensation fee expenses incurred. With consent from the State program office, the VF/EA may take action to refer the matter to a collection agency, as necessary, pursuant to N.J.A.C. [10:142]**10:60C**-7.1(b), to obtain reimbursement for fees previously paid.

[10:142]**10:60C**-2.3 (No change in text.)

SUBCHAPTER 3. SCREENING AND APPLICATION

[10:142]**10:60C**-3.1 Screening and application process for PCA participants enrolled in [NJ FamilyCare/Medicaid] **Medicaid/NJ FamilyCare** managed care

(a) Individuals who are enrolled in [NJ FamilyCare/Medicaid] **Medicaid/NJ FamilyCare** MCO and are interested in participant-directed services shall make application directly to their respective MCO.

(b)-(e) (No change.)

[10:142]**10:60C**-3.2 Screening and application process for PCA participants enrolled in **Medicaid/NJ FamilyCare** fee-for-services

(a) For both [Medicaid] **Medicaid/NJ FamilyCare** eligible fee-for-service participants receiving PCA services through a traditional provider agency, and for new applicants who are interested in applying for the Personal Preference Program, an application must be made directly to the Division of [Disability] **Medical Assistance and Health** Services.

1. (No change.)

2. For new applicants opting for participant-directed services, the Division will arrange for a PCA assessment [by a DDS staff nurse] in accordance with N.J.A.C. 10:60-3.1.

3. If the PCA assessment process [under] **at** (a)1 and 2 above determines that a new applicant does not meet the eligibility criteria for PCA services, the Division shall issue a letter denying PCA (and, therefore, PPP) services. In the event an applicant disagrees with the decision, he or she will be afforded appeal rights [under] **pursuant to** N.J.A.C. [10:142]**10:60C**-9.1 and 9.3.

(b) The Division shall make a referral to the counseling agency to assign a consultant to outreach the participant, pursuant to N.J.A.C. [10:142]**10:60C**-3.1(d), and complete a self-direction enrollment package, pursuant to N.J.A.C. [10:142]**10:60C**-3.1.

(c) Upon completion of the self-direction enrollment package described [in] **at** N.J.A.C. [10:142]**10:60C**-3.1(b), the consultant shall notify the Division that the applicant is prepared to begin self-directing PCA services, and submit the package to the Division.

[10:142]**10:60C**-3.3 Authorized representative standards, roles, and responsibilities

(a) (No change.)

(b) The approved authorized representative shall assume full responsibilities of the participant as described [in] **at** N.J.A.C. [10:142]**10:60C**-2.2(a).

(c) (No change.)

(d) If a participant no longer needs a representative and is requesting the ability to manage his or her services independently, the consultant shall perform a home visit with the participant and current representative to assess the participant's capacity to perform responsibilities, as identified [in] **at** N.J.A.C. [10:142]**10:60C**-2.2(a), without need of assistance.

1.-2. (No change.)

(e)-(g) (No change.)

[10:142]**10:60C**-3.4 Consultant role and responsibilities

(a)-(b) (No change.)

(c) The consultant shall monitor for abuse or neglect of participants, and immediately report to the Division**,** in writing**,** of any situation of suspected abuse and neglect[,] and submit a written report on the incident within two business days. Consultants shall simultaneously report abuse and neglect to the designated State protective agency in accordance with legislative and regulatory requirements [under] **at** N.J.A.C. [10:142]**10:60C**-10.1.

[10:142]**10:60C**-3.5 (No change in text.)

SUBCHAPTER 4. CASH GRANT AND CASH MANAGEMENT PLAN

[10:142]**10:60C**-4.1 Budget determination

(a) (No change.)

(b) The budget shall be determined by cashing out the participant's PCA benefit based on the current authorization of hours [per] **pursuant to** the current PCA assessment and present rate of reimbursement for PCA services performed on a monthly basis. An identified percentage of the total cashed out benefit is deducted for the cost of administrative services performed by the VF/EA as described [in] **at** N.J.A.C. [10:142]**10:60C**-7.1 to be determined by the State program office.

(c) The funds derived from the calculation [in] **at** (b) above shall be maintained in a designated account by the VF/EA, to be used towards issuing payroll checks to employees hired by the participant, and payment for purchase of necessary equipment, supplies, and services upon receipt of timesheets and invoices/bills, in accordance with N.J.A.C. [10:142]**10:60C**-4.3.

(d) The monthly budget shall form the initial basis for completion of the cash management plan (CMP) described [in] **at** N.J.A.C. [10:142]**10:60C**-4.5.

[10:142]**10:60C**-4.2 Impact of budget allocation on governmental benefits

(a) The budget allocation obtained by the participant, as described [in] **at** N.J.A.C. [10:142]**10:60C**-4.1(a) and (b), shall not be counted as income or as a resource for determining his or her benefits for Supplemental Security Income (SSI) or Supplemental Nutritional Assistance Program (SNAP) (formerly known as food stamps), housing eligibility for individuals receiving rental assistance, or who reside in subsidized housing.

(b) The budget allocation as described [in] **at** N.J.A.C. [10:142]**10:60C**-4.1(a) and (b) may be counted as income or as an asset for participants applying for a post-secondary education loan program eligibility during enrollment [under] **pursuant to** the program.

(c)-(d) (No change.)

(e) The budget amount shall count as income in accordance with N.J.A.C. [10:142]**10:60C**-2.3(c).

[10:142]**10:60C**-4.3 Standards for use of the budget

(a) The budget may be used for participant-directed goods and services, to eliminate or diminish the need for personal care, and promote independence related to ensuring completion of activities of daily living with respect to each participant's individual needs including, but not limited to:

1.-4. (No change.)

5. Technology for safety and independence not otherwise covered by [Medicaid] **Medicaid/NJ FamilyCare**;

6.-13. (No change.)

(b)-(c) (No change.)

(d) Participants shall be allowed to use up to 10 percent of the total monthly cash allocation, in the form of cash, for expenses related to activities of daily living not otherwise covered by [Medicaid] **Medicaid/NJ FamilyCare** benefits. The cash amount(s) must be itemized in the CMP and reviewed and approved at the discretion of the Division. The Division reserves the right to deny any item(s) and may request receipts/invoices as proof of payment for those items indicated.

(e)-(g) (No change.)

[10:142]**10:60C**-4.4 Non-permissible expense items

(a) The budget may not be used for goods and services that are not related to the activities of daily living including, but not limited to:

1. Goods and services covered by [Medicaid] **Medicaid/NJ FamilyCare** or other public entitlement programs;

2.-20. (No change.)

[10:142]**10:60C**-4.5 Cash management plan standards

(a) The cash management plan (CMP) shall indicate a pre-determined monthly cash allowance, which represents the amount available for use for hiring employees and purchasing services and/or goods as described [in] **at** N.J.A.C. [10:142]**10:60C**-4.3.

(b)-(g) (No change.)

(h) In the event of a disagreement with the decision to not approve the CMP by the State program office, the participant may submit a written request for an administrative review pursuant to N.J.A.C. [10:142]**10:60C**-9.1.

[10:142]**10:60C**-4.6 Penalties for overspending the cash management plan

(a) Participants/authorized representatives are responsible for ensuring that cash grant expenses are not in excess of the total allocation as determined [under] **pursuant to** N.J.A.C. [10:142]**10:60C**-4.1(a).

(b) (No change.)

(c) Any continued pattern of overspending of the cash management plan may result in the participant being disenrolled from the program due to failure to manage services appropriately in accordance with N.J.A.C. [10:142]**10:60C**-8.2 and 8.3.

[10:142]**10:60C**-4.7 Cash management plan monitoring and modification

(a) (No change.)

(b) The CMP may be revised as often as needed, at the request of the participant/authorized representative, if a participant decides to change the way he or she is using his or her funds to ensure that needs are being met, or based upon a reassessment determination pursuant to N.J.A.C. [10:142]**10:60C**-6.2.

1.-2. (No change.)

(c) (No change.)

(d) All approved revisions to CMPs shall be made effective in accordance with standards and procedures [under] **pursuant to** N.J.A.C. [10:142]**10:60C**-4.5(g), once approval for the modification is granted by the State program office.

SUBCHAPTER 5. APPLICATION DISPOSITION, ENROLLMENT, AND SERVICES

[10:142]**10:60C**-5.1 Application disposition

(a) (No change.)

(b) Division staff shall verify [Medicaid] **Medicaid/NJ FamilyCare** eligibility as defined [in] **at** N.J.A.C. [10:142]**10:60C**-2.1.

(c) If the participant is determined as appropriate for participant directed services following review of the application described [in] **at** (a) above, the Division shall:

1. Inform the respective MCO liaison (for participants enrolled in managed care) and VF/EA of the start date for program services; **and**

2. Issue written or electronic correspondence informing the applicant of the start date and monthly budget amount pursuant to N.J.A.C. [10:142]**10:60C**-4.1[; and]**.**

(d) Upon notice of approval, the participant must refuse acceptance of traditional PCA services from a provider agency as of the planned start date in the Personal Preference Program to obtain participant-directed services, in order to avoid commission of fraud and possible disenrollment [under] **pursuant to** N.J.A.C. [10:142]**10:60C**-10.1(d).

[10:142]**10:60C**-5.2 Enrollment

(a) The start date for initiating services and using the CMP for new applicants shall be determined by the Division in accordance with N.J.A.C. [10:142]**10:60C**-4.5(g).

(b) If the enrollment package as described [in] **at** N.J.A.C. [10:142]**10:60C**-5.1(a) is determined to be incomplete and/or contains errors, the Division will return the forms to the VF/EA for correction and resubmission. Participants may not be enrolled into the program until the application package is determined as completed in full by the Division.

[10:142]**10:60C**-5.3 Service standards

(a) (No change.)

(b) Participants may be afforded program services while on a vacation, [or] at an out-of-State stay**, or** at an alternate residence in- or out-of-State, up to 30 days, subject to the following conditions and procedures:

1. Participants must inform their consultant, a minimum of 15 days prior to leaving New Jersey, and must indicate dates of departure and return, and emergency contact information. Participants must also ensure that the vacation or stay will not conflict with required reassessments or consultant visits pursuant to N.J.A.C. [10:142]**10:60C**-2.1(a)13 and 6.2.

2.-3. (No change.)

SUBCHAPTER 6. PARTICIPANT SELF-DIRECTION AND REASSESSMENT

[10:142]**10:60C**-6.1 (No change in text.)

[10:142]**10:60C**-6.2 Reassessment requirements

(a) A personal care assistant nursing reassessment visit shall be conducted on a schedule determined by the Division of Medical Assistance and Health Services or at the discretion of the MCO or Division, as appropriate. A reassessment may be required in the event of a change in the participant's health condition or needs, support system, or the duration of a period of disenrollment from the program**,** if those circumstances affect the need for personal care assistance. The following documents must be submitted in support of a request for reassessment:

1.-2. (No change.)

3. Participant request for reinstatement for program eligibility as described [in] **at** N.J.A.C. [10:142] **10:60C**-8.3, where the reassessment approval period has expired.

(b) The nursing reassessment shall be performed by a registered nurse employed or under contract with the MCO, for participants enrolled in managed care, or employed by the Division for participants enrolled in [Medicaid] **Medicaid/NJ FamilyCare** fee-for-service benefits.

(c) (No change.)

[10:142]**10:60C**-6.3 Change in scope, duration, and/or amount of services

(a) The outcome of the reassessment pursuant to N.J.A.C. [10:142]**10:60C**-6.2 shall determine the number of PCA hours needed to be used as the basis for determining the budget allocation [under] **pursuant to** the program as described [in] **at** N.J.A.C. [10:142]**10:60C**-4.1.

(b) The reassessment package documents**,** as described [in] **at** N.J.A.C. [10:142]**10:60C**-3.1(c)**,** shall be reviewed by the Division, following completion of the reassessment by the MCOs for participants enrolled in managed care, or by Division staff for individuals enrolled in fee-for-services. The Division shall communicate the results of the reassessment to the participant[,] pursuant to contract provisions between the Department and MCOs.

(c) A change in the monthly cash allocation may not be initiated without an approved modified cash management plan (CMP). The Division shall inform the participant**,** in writing**,** of any need to modify the CMP pursuant to N.J.A.C. [10:142]**10:60C**-4.7, resulting from the reassessment outcome and the subsequent change in the monthly cash allocation [under] **pursuant to** (b) above.

(d) (No change.)

SUBCHAPTER 7. VENDOR FISCAL EMPLOYER AGENT (VF/EA)

[10:142]**10:60C**-7.1 Responsibilities of the VF/EA

(a)-(b) (No change.)

(c) In the event an applicant withdraws from enrollment in the program, following the payment of workers' compensation insurance pursuant to (b)11 above, the VF/EA may take action, to obtain reimbursement for expenses incurred**,** in accordance with N.J.A.C. [10:142]**10:60C**-2.2(d)1 and 2.

SUBCHAPTER 8. DISENROLLMENT AND REINSTATEMENT

[10:142]**10:60C**-8.1 Voluntary disenrollment

(a) (No change.)

(b) Participants that voluntarily discontinue services and request disenrollment from the program may return to traditional PCA services through an approved [Medicaid] **Medicaid/NJ FamilyCare** home care provider agency at any time**,** in accordance with N.J.A.C. [10:142]**10:60C**-1.3(a)6.

(c) In the event of a request for a voluntary disenrollment of service by the participant, the following procedures shall be followed:

1.-2. (No change.)

3. The Division shall provide assistance for individuals enrolled in [Medicaid] **Medicaid/NJ FamilyCare** fee-for-service with the transition to traditional services through an approved home care provider, at the request of the participant.

[10:142]**10:60C**-8.2 Involuntary disenrollment

(a) Involuntary disenrollment shall be a result of non-compliance with program rules and procedures, or an inability to self-direct and manage program services, which may include, but are not limited to, the following circumstances:

1.-5. (No change.)

6. Participant is no longer eligible for [Medicaid] **Medicaid/NJ FamilyCare** benefits;

7.-8. (No change.)

9. Failure to participate in mandated required home visits pursuant to N.J.A.C. [10:142]**10:60C**-2.2(a)13;

10.-11. (No change.)

12. Documented unwillingness to accept assignment of a mandated representative**,** in accordance with requirements [under] **at** N.J.A.C. [10:142]**10:60C**-2.2(c) and 3.3(e);

13. Documented inability to comply with participant responsibilities**,** as identified [under] **at** N.J.A.C. [10:142]**10:60C**-2.2; or

14. Failure to report changes in program contact information to the Division, or agents thereof, pursuant to N.J.A.C. [10:142]**10:60C**-2.2(a)16.

(b) (No change.)

(c) Individuals who are involuntarily disenrolled shall have participant directed services terminated immediately. Participants shall receive subsequent written notice from the Division following any determination pursuant to (b) above. The notice must include the reason/justification for the action taken, and include information to enable access to the Division's administrative review process pursuant to N.J.A.C. [10:142]**10:60C**-9.1.

1.-2. (No change.)

(d) (No change.)

[10:142]**10:60C**-8.3 Reinstatement standards and procedures

(a) An individual who has been disenrolled pursuant to N.J.A.C. [10:142]**10:60C**-8.1 or 8.2 may request a reinstatement to receive participant-directed services by contacting the State program office**,** in writing, and completing the application process pursuant to N.J.A.C. [10:142]**10:60C**-3.1 and 3.2 with the assistance of the State [Program Office] **program office**.

(b) A reinstatement of program services may be granted, with permission from an MCO, where appropriate, if a valid PCA nursing reassessment is current and establishes a need for assistance with personal care, and the Division affirms the individual's continued ability to manage services independently or with the assistance of a representative, in accordance with requirements [under] **at** N.J.A.C. [10:142]**10:60C**-6.3.

(c) (No change.)

(d) Individuals may obtain traditional agency PCA services, in the event of any delay in reactivation of a participant-directed services account by the VF/EA, in accordance with requirements [under] **at** N.J.A.C. [10:142]**10:60C**-8.2(c)1 and 2.

(e)-(f) (No change.)

SUBCHAPTER 9. ADMINISTRATIVE REVIEWS, ADVERSE AGENCY ACTIONS, AND FAIR HEARINGS

[10:142]**10:60C**-9.1 Request for administrative review

(a)-(b) (No change.)

(c) Requests for an administrative review must state the question/issue to be resolved by a review made by letter and mailed to:

State Program [Manager] **Office**
Personal Preference Program
Division of [Disability] **Medical Assistance and Health Services**
PO Box [705] **712**
Trenton, New Jersey [08625-0705] **08625-0712**

(d) (No change.)

(e) Applicants or participants who disagree with the decision of the administrative review, wherein the outcome results in an adverse agency action as described [in] **at** N.J.A.C. [10:142]**10:60C**-9.2, may request a

fair hearing before an [Administrative Law Judge] **administrative law judge** pursuant to N.J.A.C. [10:142]**10:60C**-9.3. Instructions for such requests shall be incorporated into the written response noted [in] **at** (d) above.

(f) An exception to (e) above shall apply in situations in which a participant is involuntarily disenrolled due to non-compliance with program requirements as described [in] **at** N.J.A.C. [10:142]**10:60C**-8.2(a)1 through 14. The determination on the administrative review described [in] **at** (d) and (e) above shall be deemed as the final agency decision, in which a participant will not be entitled to a fair hearing [under] **pursuant to** N.J.A.C. [10:142]**10:60C**-9.3, or any additional appeals regarding the matter in dispute.

[10:142]**10:60C**-9.2 Adverse agency actions and appeal rights

(a) Determinations on denial of participant-directed services and/or involuntary disenrollment from the program shall be the responsibility of the Division, pursuant to N.J.A.C. [10:142]**10:60C**-8.2, for all participants whether enrolled in managed care or in [Medicaid] **Medicaid/NJ FamilyCare** fee-for-service[s].

1. (No change.)

(b) An applicant or participant may request a fair hearing pursuant to N.J.A.C. [10:142]**10:60C**-9.3, on any adverse action, whether initiated by the managed care organization (MCO) or the Division pursuant to (a)1 above.

(c) Written notice (or other acceptable electronic communication in lieu of a written notice) shall be issued to the applicant or participant at least 20 days prior to initiation of an adverse action, by the agency rendering the decision, except in situations of involuntary disenrollment due to non-compliance**, as** stated [in] **at** N.J.A.C. [10:142]**10:60C**-8.2(c).

(d) The written notice pursuant to (c) above, shall indicate the reason(s) for the action to be taken, citing the basis for the decision, and language that affords the applicant or participant a right to appeal, through a fair hearing, pursuant to N.J.A.C. [10:142]**10:60C**-9.3. The notice may also provide participants the ability to pursue the matter in dispute through a Division administrative review process as described [in] **at** N.J.A.C. [10:142]**10:60C**-9.1, as an alternative to a fair hearing.

(e) (No change.)

(f) A participant request for a fair hearing as described [in] **at** (b) above, to dispute an involuntary disenrollment due to non-compliance with program requirements as described [in] **at** N.J.A.C. [10:142]**10:60C**-8.2(a) and (c) shall be denied.

[10:142]**10:60C**-9.3 (No change in text.)

[10:142]**10:60C**-9.4 Outcome of fair hearings

(a) If the outcome of a fair hearing proceeding results in upholding the adverse action initiated by the MCO or State program agency, the following will take place:

1. (No change.)

2. Modifications to the budget allocation and cash management plan shall be made effective in accordance with procedures [under] **at** N.J.A.C. [10:142]**10:60C**-4.7.

(b)-(c) (No change.)

SUBCHAPTER 10. MEDICAID FRAUD AND ABUSE

[10:142]**10:60C**-10.1 (No change in text.)

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Notice of Administrative Changes
Notice of Terminology Changes Throughout Division of Medical Assistance and Health Services Regulatory Chapters
N.J.A.C. 10:49, 10:52, 10:53A, 10:54, 10:58A, 10:66, 10:69, 10:70, 10:71, 10:72, 10:74, and 10:79

Effective Date: November 4, 2024.

Take notice that, the Division of Medical Assistance and Health Services (DMAHS) is changing all references of county welfare agencies (CWA) to county social service agencies (CSSA) throughout N.J.A.C. 10:49, 10:52, 10:53A, 10:54, 10:58A, 10:66, 10:69, 10:70, 10:71, 10:72, 10:74, and 10:79. When referencing the county offices that work in partnership with DMAHS, this updated terminology will better reflect the various programs and services provided to the public by the county offices.

DMAHS has requested, and the Office of Administrative Law has agreed to permit, the administrative changes of the Department of Human Services's rules. These technical changes are effective November 4, 2024, and shall be manifested in the New Jersey Administrative Code beginning with the 12-02-24 Code Update and continuing until all chapters are so updated. It is anticipated that approximately two to four chapters will be updated with each Code Update produced.

CORRECTIONS

(b)

THE COMMISSIONER

Inmate Groups

Adopted New Rules: N.J.A.C. 10A:12

Proposed: April 15, 2024, at 56 N.J.R. 543(a).
Adopted: October 24, 2024, by Victoria L. Kuhn, Commissioner, Department of Corrections.
Filed: October 25, 2024, as R.2024 d.113, **without change**.

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Effective Date: December 2, 2024.
Expiration Date: December 2, 2031.

Summary of Public Comment and Agency Response:
No comments were received.

Federal Standards Statement

The expired rules adopted herein as new rules are promulgated pursuant to the authority of the rulemaking requirements of the Department of Corrections, as established at N.J.S.A. 30:1B-6 and 30:1B-10. The expired rules adopted herein as new rules are not subject to any Federal statutes, requirements, or standards; therefore, a Federal standards analysis is not required.

Full text of the expired rules adopted herein as new rules can be found in the New Jersey Administrative Code at N.J.A.C. 10A:12.

Full text of the adopted amendments to the expired rules adopted herein as new rules follows:

SUBCHAPTER 1. GENERAL PROVISIONS

10A:12-1.1 Purpose

(a) The purpose of this chapter is to set forth provisions regarding:

1.-2. (No change.)