HEALTH

(a)

PUBLIC HEALTH SERVICES BRANCH
DIVISION OF EPIDEMIOLOGY, ENVIRONMENTAL, AND OCCUPATIONAL HEALTH SERVICES
COMMUNICABLE DISEASE SERVICE
ZOONOTIC DISEASE EPIDEMIOLOGY SURVEILLANCE UNIT

Notice of Readoption
Importation of Dogs, Reporting of Rabies in Animals, Control of Avian Chlamydiosis in Pet Birds, Sales and Distribution of Turtles and Turtle Eggs and Transportation by Animal Control Officers
Readoption: N.J.A.C. 8:23

Authority: N.J.S.A. 4:19-15.16, 26:1A-7 and 15, and 26:4-78 et seq.

Authorized By: Shereef Elnahal, Commissioner, Department of Health (in consultation with the Public Health Council).

Effective Date: August 13, 2018.

New Expiration Date: August 13, 2025.

Take notice that pursuant to N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 8:23, Importation of Dogs, Reporting of Rabies in Animals, Control of Avian Chlamydiosis in Pet Birds, Sales and Distribution of Turtles and Turtle Eggs, and Transportation by Animal Control Officers, were to expire on September 12, 2018.

N.J.A.C. 8:23 regulates the importation of dogs, rabies reporting, transportation of confined animals, the quarantine of pet birds, and the sales of live turtles and turtle eggs. Subchapter 1 provides specifics regarding the certification requirements for imported dogs; reporting requirements of rabies in animals; the transportation of confined animals; the quarantine, testing, and transportation of quarantined pet birds; and the record maintenance of pet bird dealers. Subchapter 2 establishes the requirements for the sale or distribution of viable turtle eggs and live turtles. Subchapter 3 establishes the responsibilities of animal control officers in the transportation of animals.

The Department is developing rulemaking to revise and update existing N.J.A.C. 8:23 and anticipates filing this rulemaking with the Office of Administrative Law for processing in the ordinary course. However, this rulemaking could not be proposed prior to the expiration of existing N.J.A.C. 8:23. The Commissioner has reviewed N.J.A.C. 8:23 and determined that, pending the finalization of the anticipated rulemaking described above, the existing chapter remains necessary, proper, reasonable, efficient, understandable, and responsive for the purposes for which it was originally promulgated, as amended and supplemented over time, and should be readopted. Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1), N.J.A.C. 8:23 is readopted and shall continue in effect for a seven-year period.

HUMAN SERVICES

(b)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
Home Care Services
Adopted Amendments: N.J.A.C. 10:60-1.1, 1.2, 1.3, 1.6, 1.7, 1.8, 1.9, 2.2, 2.3, 2.5, 3.1 through 3.9, 5.1 through 5.11, and 11.2 and 10:60 Appendix A
Adopted Repeals and New Rules: N.J.A.C. 10:60-6
Adopted New Rules: N.J.A.C. 10:60-3.10
Adopted Repeals: N.J.A.C. 10:60-4, 7, 8, 9, and 10

Proposed: August 21, 2017, at 49 N.J.R. 2698(a).

Adopted: August 20, 2018, by Carole Johnson, Commissioner, Department of Human Services.

Filed: August 21, 2018, as R.2018 d.172, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Agency Control Number: 17-A-02.

Effective Date: September 17, 2018.

Expiration Date: April 4, 2020.

Summary of Public Comments and Agency Responses:

Comments were received from: The Arc of New Jersey, Thomas Buffuto, Executive Director; Community Health Law Project, Stuart H. Weiner, Government Affairs Agent; Disability Rights New Jersey, Susan Saidel, Legal Director; Health Force, Mindy Rosenblum, President; Home Care and Hospice Association of NJ, Chrissy Buteas, President and CEO; and New Jersey Association of Community Providers, Valerie Sellers, CEO.

1. COMMENT: General. Health Force. The commenter asks: "Are [managed care organizations (MCO)] members who refuse the hands-on assistance, as described above, required to be discharged from services or can the MCO transfer the member to another home care agency?"

RESPONSE: Beneficiaries have the right to refuse personal care assistant (PCA) services and there is a large array of reasons why. If the reason is related to an individual provider or an individual home care agency, the MCO can transfer the authorization to provide services to another agency. For those beneficiaries who continue to refuse, PCA services should be discontinued.

2. COMMENT: General. Home Care and Hospice Association of NJ. The commenter submits that since many of the home and community-based services regulated by N.J.A.C. 10:60 are administered under managed care, each subchapter of the chapter should be clearly delineated into separate categories as they apply to a fee-for-service versus managed care environment.

RESPONSE: The Department of Human Services ("Department" or "DHS") disagrees with the need to restructure N.J.A.C. 10:60. Home care providers in an MCO's network are required to comply with the terms of the contract with their MCO, and with any applicable provisions in the MCO's contract with DHS/Division of Medical Assistance and Health Services (DMAHS). They are required to comply with N.J.A.C. 10:60 only if mandated by the terms of those contracts, or if mandated by specific language in N.J.A.C. 10:60 or other applicable rules.

3. COMMENT: General. Home Care and Hospice Association of NJ. The commenter notes that there are several terms used in the proposed rulemaking to indicate the Medicaid/NJ FamilyCare beneficiary, including the terms beneficiary, client, recipient, individual, and patient and the suggestion was made to use one consistent term to alleviate confusion.

RESPONSE: The Department agrees with the commenter and the various terms have been changed to "beneficiary" throughout the chapter upon adoption.

4. COMMENT: General. New Jersey Association of Community Providers (NJACP). The commenter seeks clarification of the situations where the medical necessity component is applied, especially in instances where the circumstances would appear to be habilitative, such as PCA services.

RESPONSE: The Department does not view PCA services as habilitative services. Medical necessity is always required and is specifically identified at the time the physician or advanced practice nurse (APN) certifies the treatment plan and determines that the services being proposed are medically necessary to keep the client in a home setting. The physician or APN certifies that, in the absence of alternative support, the health-related tasks identified are required to be rendered by a qualified individual under the supervision of a registered professional nurse. Medical necessity should be certified with the initial plan of care, and annually thereafter.

5. COMMENT: N.J.A.C. 10:60-1.1(c). Home Care and Hospice Association of NJ. The commenter suggests that the term "homemaker agencies" be deleted to be consistent with the deletion of the term at N.J.A.C. 10:60-1.2.

RESPONSE: The Department agrees with the commenter; and the rule and the regulation will be changed upon adoption.

6. COMMENT: N.J.A.C. 10:60-1.2. Disability Rights New Jersey (DRNJ) and Home Care and Hospice Association of NJ. Regarding the definition of activities of daily living (ADL), the commenters suggest that this term should include activities related to self-care, including dressing, bathing, eating, toileting, grooming, ambulation, and mobility, but not be limited to those categories. They suggest that the term "including but not limited to" be added to the definition, so that the term "activities related to self-care" is not interpreted too narrowly. DRNJ suggests using the term "toileting" as opposed to "going to the bathroom" because that term more accurately describes the ADL as it includes a more complete range of assistance, that is, providing the beneficiary with assistance with complete incontinence to simple assistance with using the bathroom. Home Care and Hospice Association of NJ suggested noting that the activities are either done independently or with supervision or assistance and should include transferring and undressing, consistent with the definition of this term used by the Department of Health (DOH) and the Board of Nursing.

RESPONSE: The Department agrees with the commenters' suggestions and the definition of activities of daily living will be changed upon adoption to incorporate these suggestions.

7. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "annual cost threshold (ACT)," the commenter objects to the language allowing ACT to be determined in accordance with any "relative resource intensity allocation employed by the State" because N.J.A.C. 8:85 defines ACT and does not allow the State to reference or adopt extraneous methods of determining the ACT.

RESPONSE: As the commenter correctly states, the Department of Health (DOH) is responsible for the determination of the cost threshold each year under N.J.A.C. 8:85, which is referred to as the annual cost threshold (ACT). Therefore, the setting of the ACT is not under the purview of the Department; however, the definition is included for the sake of information. For the purposes of this chapter, the Department of Human Services will revise the definition to clearly indicate that the ACT is determined by DOH in accordance with N.J.A.C. 8:85, which is promulgated by the Department of Health.

8. COMMENT: N.J.A.C. 10:60-1.2 and 5.8. DRNJ. Regarding the definition of "continuous ongoing," the commenter maintains that defining the term as needing skilled nursing intervention 24 hours per day/seven days per week is overly narrow because beneficiaries may require multiple nursing visits throughout the day but would not require one-to-one nursing all the time. DRNJ requests that the definition be modified to allow people who need nursing interventions, but not 24-hour care, be eligible to receive private duty nursing (PDN) services and maintains that not modifying the definition would eclipse the 16-hour limitation at N.J.A.C. 10:60-5.9(b) and (c). DRNJ also requests that corresponding changes be made to the rule text using that term.

RESPONSE: The Department agrees with the commenter that the definition should be expanded to clarify that PDN services are appropriate when there is a skilled nursing need on an ongoing basis, not necessarily only one visit, and will change the definition at N.J.A.C. 10:60-1.2 and the text at N.J.A.C. 10:60-5.8(b)1i upon adoption.

9. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "hands-on personal care," the commenter objects to the definition limiting this term to only the provision of assistance with the activities listed and suggests that the term be revised to be consistent with N.J.A.C. 10:60-3.1(b).

RESPONSE: The Department believes that the definition is adequate as it includes assistance related to the ADLs of bathing, dressing, grooming, toileting, mobility/ambulation, feeding, and transfers; therefore, no changes will be made in response to the comment.

10. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. Regarding the definition of "home health agency," the commenter suggests that the definition be more consistent with the Department of Health's definition to ensure clarity among all parties.

RESPONSE: The Department maintains that the definition is adequate as proposed. Regarding consistency between the Department and DOH, the definition requires that the agency be approved and licensed by DOH and that process should ensure that the agency meets the definition and requirements of the DOH. The additional requirements included in the definition are intended to ensure that the home health agencies meet the needs of the New Jersey Medicaid/NJ FamilyCare program. Therefore, the suggested changes to the definition will not be made in response to the comment. However, it is noted that a correction needs to be made to correct the name of the Department of Health. This reference was inadvertently not made during the original preparation of the proposed rulemaking and will be made upon adoption.

11. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. The commenter notes that the term "hospice service" was deleted from the rule and submits, that since hospice services are rendered to Medicaid/NJ FamilyCare beneficiaries, this definition should remain in the rule.

RESPONSE: The term "hospice service" was deleted from this chapter because hospice services are regulated under N.J.A.C. 10:53A. Hospice agencies are included in this rule to the extent that they are legally permitted to provide home health services that are not hospice services.

12. COMMENT: N.J.A.C. 10:60-1.2 and 3.3. Home Care and Hospice Association of NJ. The commenter submits that the term "independent activities of daily living (IADL)" is an incorrect term and that the correct term is "instrumental activities of daily living." The commenter notes that the term "instrumental activities of daily living" is used on the DHS website and suggests that the rules and the website be consistent. In a related comment, Disability Rights New Jersey (DRNJ) notes that the definition of IADLs at N.J.A.C. 10:60-3.3(b) varies from the definition at N.J.A.C. 10:60-1.2 and suggests that the definitions be consistent.

RESPONSE: The Department agrees with the commenters and the suggested changes will be made upon adoption. As part of making the definitions consistent, the phrase "assisting with finances" has been removed from the definition because assuming the responsibility for handling a beneficiary's financial matters is beyond the scope of personal care assistance services and should be addressed using legal documents such as power of attorney.

13. COMMENT: N.J.A.C. 10:60-1.2. The Arc of New Jersey and Home Care and Hospice Association of NJ. Regarding the definition of "legally responsible relative," the commenters submitted that several other types of individuals be added to the list of legally responsible relatives, including the legal guardian of an adult with a cognitive disability, a beneficiary's adult child or grandchild, the beneficiary's adult sibling, or others who are not necessarily legally related, such as a significant other or life partner, since some beneficiaries may not have any living blood relatives. In addition, the commenter states: "Clarification to further define the meaning of legally responsible. Legalities could include health care decision making, financial responsibility for the beneficiary's debt or simply due to a legal bond such as marriage (whether or not the spouse is engaged in the beneficiary's life or care needs). We recommend removing the term legally responsible relative as it could mean different things to different people depending on their family or social structure."

RESPONSE: The scope of this rule, as it relates to individuals defined as "legally responsible relatives" is to indicate two requirements: (1) which individuals are expected to help with IADLs when residing with the beneficiary; and (2) when personal care assistant services provided by a family member shall not be considered a covered Medicaid/NJ FamilyCare service. Legal considerations, such as health care decision making and the responsibility for handling a beneficiary's financial matters, are beyond the scope of this rulemaking and should be addressed using legal documents, such as advanced directives and power of attorney. The Department's position is that the definition is adequate for the scope of the rules and, therefore, will not be making any changes upon adoption.

14. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "minimal assistance," the commenter suggests replacing the use of the term "client" with the term "beneficiary" to be consistent with other sections. Additionally, DRNJ requests that DMAHS clarify that the tasks listed are examples and not an exhaustive list.

RESPONSE: The tasks listed are examples and not an exhaustive list as indicated with the phrase "such as" before the listed examples. The definition will be changed upon adoption, as described in the Response to Comment 3, to replace "client" with "beneficiary."

15. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "moderate assistance," the commenter suggests replacing the use of the term "client" with the term "beneficiary" to be consistent with other sections. Additionally, DRNJ seeks clarification for the term "hand-over-hand assistance" as it is used in this definition.

RESPONSE: Hand-over-hand assistance involves placing ones hands over the individual's hands to help them complete a movement. When using hand-over-hand assistance, the assistant is helping to control the movements of the beneficiary's hands. The definition will be changed upon adoption as described in the Response to Comment 3, to replace "client" with "beneficiary."

16. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "nurse delegation," the commenter appreciates the fact that DMAHS permits the delegation of certain nursing tasks in appropriate situations, but requests clarification that it is the "treating" registered nurse who may delegate the tasks. Additionally, DRNJ feels that the term "selected nursing tasks" is too broad and suggests replacing the term with "may delegate selected nursing tasks pursuant to N.J.A.C. 13:37-6.2," the New Jersey Board of Nursing's regulation regarding the delegation of nursing tasks.

RESPONSE: The Department agrees with the commenter's suggestions and the definition will be so changed upon adoption.

17. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. Regarding the definition of "on-site monitoring," the commenter suggests replacing the reference to "personal care agency, private duty nursing agency, provider of waiver services," with a reference to "home health agency, accredited health care services firm."

RESPONSE: The Department agrees with the commenter that the terminology should be changed to be consistent with the nomenclature used when these organizations are licensed and to be consistent with the changes made throughout this rulemaking and the definition will be changed upon adoption.

18. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. Regarding the definition of "personal care assistant," the commenter submits that the term is not a recognized name of a caregiver in home care and suggests that it be replaced with the term "certified home health aide" and that the term be replaced throughout the chapter.

RESPONSE: The term "personal care assistant (PCA) services" is a term used by the Department to describe specific services as detailed in the chapter. The definition of the term "personal care assistant" includes the requirement that the individual must successfully complete a training program in personal care services and be certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a home health aide. The Department maintains that the definition is adequate; therefore, no changes will be made upon adoption.

19. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "personal care assistant (PCA) services," the commenter notes that at N.J.A.C. 10:60-1.3(b), PCA services specifically include independent activities of daily living, but that this term is not defined at N.J.A.C. 10:60-1.2.

RESPONSE: The term "independent activities of daily living" is defined at N.J.A.C. 10:60-1.2; and as noted in the Response to Comment 12, the term is being changed to "instrumental activities of daily living" upon adoption. The Department will also change the definition of "personal care assistant services" upon adoption to include a reference to IADLs to emphasize that both ADLs and IADLs are included in the service.

20. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. Regarding the definition of "personal care assistant (PCA) services," the commenter notes that the word "physician" was deleted from the definition, implying that a non-physician practitioner is permitted to certify the service as medically necessary. The commenter requests that confirmation be added to the rule that a non-physician can certify medical necessity of PCA services. In addition, the commenter suggests adding a definition for "non-physician practitioner" to the rule.

RESPONSE: Pursuant to N.J.A.C. 10:60-3.4, PCA services can be certified as medically necessary by a physician or an advanced practice nurse (APN); that is why the word "physician" was removed from the definition. Since it is standard practice that an APN can determine medical necessity and prescribe treatment, the Department does not feel that the term "non-physician practitioner" needs to be defined. No changes will be made to the rule in response to the comment.

21. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "primary caregiver," the commenter objects to the requirements that a recipient of private duty nursing (PDN) services must have a live-in primary caregiver as it represents a significant restriction on community living opportunities for those individuals who do not have a family member or friend willing to take on that responsibility or those individuals who do not want to live with another person.

RESPONSE: The amendments to the definition reflect the existing requirement at N.J.A.C. 10:60-5.9(c) that a recipient of PDN services must have a live-in primary caregiver and the requirement was not changed by this rulemaking. The Department understands the commenter's desire to allow a PDN beneficiary the highest level of independence possible; however, for a person to simply agree to meet the needs of the PDN beneficiary, a minimum of eight hours a day without being present poses an undue risk to the health and safety of the beneficiary. Therefore, in order to ensure the safety of the Medicaid/NJ FamilyCare beneficiary receiving PDN services, the Department is retaining the existing requirement that the beneficiary must have a live-in primary caregiver.

22. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. Regarding the definition of "private duty nursing agency," the commenter submits that "private duty nursing" does not exist as a licensed health care entity in New Jersey and that PDN services must be provided by a licensed home health agency, hospice, or an accredited health care service firm only and that the term "accredited home health care services firm" in this definition is incorrect and should read "accredited health care service firm" because home health and home care services are not the same service.

RESPONSE: The Department recognizes that the term "private duty nursing agency" is not used by the licensing agencies; however, it is a term that is used by the Department to describe a type of provider agency that provides services to NJ Medicaid/NJ FamilyCare beneficiaries. The definition includes the terms used by the licensure agencies indicating which types of provider agencies are recognized as private duty nursing agencies under this chapter. There will be no changes made in response to this comment.

23. COMMENT: N.J.A.C. 10:60-1.2, 1.3, and 1.8. Home Care and Hospice Association of NJ. The commenter suggests adding a definition of the term "provider agency" to the chapter and to include licensed home health agencies, hospice providers, and healthcare service firms who are in good standing and enrolled as Medicaid providers and that the term "provider agency" be used throughout the chapter.

RESPONSE: N.J.A.C. 10:60-1.3 clearly defines the providers eligible to provide services under this chapter and includes the three specific agencies the commenter suggests. N.J.A.C. 10:49 is the Administration Manual for the Medicaid/NJ FamilyCare program and applies to all

provider types. N.J.A.C. 10:49-1.2 defines the term "provider" and N.J.A.C. 10:49-3 regulates provider participation for all Medicaid/NJ FamilyCare-enrolled providers, including, but not limited to, requiring that all providers be appropriately licensed for the services they provide. The Department maintains that these existing rules adequately define the term "provider agency" and, therefore, no changes will be made in response to this comment.

24. COMMENT: N.J.A.C. 10:60-1.2. Home Care and Hospice Association of NJ. Regarding the definition of "quality assurance," the commenter submits that the emphasis on post-payment reviews is primarily for financial and utilization compliance and does not include or collect information on beneficiary satisfaction. The commenter recommends removing the reference to "beneficiary satisfaction" until a suitable tool or survey is established for measuring any feedback regarding beneficiary satisfaction with services rendered.

RESPONSE: The Department acknowledges the commenter's concerns and is committed to providing quality services to the beneficiaries. The Department maintains that the quality assurance tools utilized allows managed long-term services and support (MLTSS) clients to provide feedback on services received, including PCA and home care services. No changes will be made in response to the comment.

25. COMMENT: N.J.A.C. 10:60-1.2. The Arc of New Jersey and DRNJ. Regarding the definition of "skilled nursing interventions," DRNJ submits that "the term 'so inherently complex' is a highly restrictive but undefined term that will lead to a reduction of services." The Arc and DRNJ submit that the multiple references to the complexity of tasks, and the requirement that they be performed by the nurse, is contradictory to language at N.J.A.C. 10:60-5.8(b) that requires the primary caregiver to be trained by the registered nurse in the complex task and provide a minimum of eight hours of care per day to the patient.

RESPONSE: The Department disagrees with the commenter. Skilled nursing intervention is adequately defined and the inclusion of complexity to define skilled nursing is reasonable. Additionally, it is noted that to be eligible to receive PDN services there must be "a capable adult primary caregiver residing with the individual who accepts ongoing 24-hour responsibility for the health and welfare of the beneficiary" (see N.J.A.C. 10:60-5.8(b)2), and it is stated in the definition of "skilled nursing intervention" that the procedure be provided by "someone with the knowledge and experience of licensed nursing personnel or a trained primary caregiver." The adult primary caregiver must agree to be trained to provide services to the beneficiary (see N.J.A.C. 10:60-5.8(b)3). No changes will be made upon adoption in response to the comment.

26. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "skilled nursing intervention," the commenter submits that the term "professional or technical personnel" should be defined.

RESPONSE: The term "professional or technical personnel" refers to the registered nurse, or the licensed practical nurse under the supervision of the registered nurse, responsible for the provision of the skilled nursing intervention. The definition will be changed upon adoption to add that clarifying language.

27. COMMENT: N.J.A.C. 10:60-1.2. DRNJ. Regarding the definition of "skilled nursing intervention," the commenter expressed concern that the RN is directed to delegate specified tasks by the use of the term "shall" and suggests that DMAHS change it to read "may," consistent with N.J.A.C. 13:37-6.2, which permits, but does not require, the delegation of such tasks.

RESPONSE: The definition of "skilled nursing intervention" does not direct the registered nurse to delegate specified tasks, but rather to determine if there are tasks that "could be or should be taught to and delegated to a caregiver who could safely perform it so as not to endanger or risk the beneficiary's health and safety." This allows the registered nurse to use his or her knowledge and experience to assess the situation and the caregiver's ability and willingness to perform certain tasks and then make a professional decision as to the appropriateness of delegating those specific tasks. The delegation of tasks shall be done in accordance with the definition of "nurse delegation" discussed above, which states that the registered professional nurse may delegate selected tasks in accordance with N.J.A.C. 13:37-6.2. Therefore, the commenter's suggested change will not be made.

28. COMMENT: N.J.A.C. 10:60-1.2. DRNJ and Home Care and Hospice Association of NJ. Regarding the definition of "skilled nursing intervention," the commenters submit that it is excessively restrictive, in that the definition should allow both registered nurses (RNs) and licensed practical nurses (LPNs) to be designated as able to provide skilled nursing interventions because, according to the Centers for Medicare and Medicaid Services' (CMS) definition, and pursuant to 42 CFR 409.32, an LPN can provide skilled nursing services if he or she is doing so under the supervision of an RN.

RESPONSE: The Department agrees with the commenter and will change the definition to be consistent with the definition used by CMS as discussed in Response to Comment 26. This change is not considered to be a substantial change because the change reflects the Federal regulations regarding nursing services and does not change the intention of the rule as originally proposed.

29. COMMENT: N.J.A.C. 10:60-1.3. NJACP. The commenter submits that "Qualified Providers for the Division of Developmental Disabilities (DDD) Supports Program" are, at a minimum, also qualified to be PCA providers and those providers should also be allowed to provide PCA services, thus increasing the availability of critical services for those people with intellectual/developmental disabilities (I/DD).

RESPONSE: As stated at N.J.A.C. 10:60-3.1(a), personal care assistant services are to be provided by a certified licensed home health agency, a certified hospice agency, or a health care service firm that is accredited, initially, and on an ongoing basis, by an accrediting body approved by DMAHS. If providers who are "Qualified Providers for the Division of Developmental Disabilities (DDD)" meet this criteria, then those providers are welcome to enroll as Medicaid/NJ FamilyCare PCA providers and provide services under this chapter.

30. COMMENT: N.J.A.C. 10:60-1.8 and 3.9. DRNJ. The commenter submits that the proposed rule is imprecise because it requires the use of a "State-approved PCA tool" but does not identify what the tool is and, therefore, Medicaid beneficiaries do not have knowledge regarding the standard to which they are being held to qualify for PCA services.

RESPONSE: The Department maintains that it is a common and acceptable practice for medical professionals to perform assessments to determine the need for a specific medical service and to document those assessments using written guidelines or tools. N.J.A.C. 10:60-3.1(c) clearly states the requirements to qualify for PCA services; that is, that a beneficiary "must be in need of moderate, or greater, hands-on assistance in at least one activity of daily living (ADL), or, minimal assistance or greater in three different ADLs, one of which must require hands-on assistance." The terms "minimal assistance" and "moderate assistance" are defined at N.J.A.C. 10:60-1.2. The PCA Nursing Assessment Tool is designed to enable the provider to determine the specific level of PCA services required to adequately address the needs of the beneficiary. If a beneficiary would like to see a copy of the assessment tool they can ask the provider performing the assessment to show them a copy.

31. COMMENT: N.J.A.C. 10:60-1.8(d)7. Home Care and Hospice Association of NJ. The commenter submits that the term "nurse" should be changed to read "registered nurse" to specify that those professionals are responsible for any delegation of duties.

RESPONSE: The Department agrees that such a change would clarify the language of the rule and would not constitute a significant change upon adoption and the text will be changed upon adoption.

32. COMMENT: N.J.A.C. 10:60-1.9(a). Home Care and Hospice Association of NJ. The commenter submits that the terms "home health agency" and "hospice" be added to this text, so that all three agency types who provide services under this chapter are included in this rule to make the intent of the rule clearer. Additionally, it was suggested to add "accredited" to "health care service firm" to be consistent with the rest of the chapter.

RESPONSE: The Department agrees and will make the suggested changes upon adoption.

33. COMMENT: N.J.A.C. 10:60-1.9(a)1. DRNJ. The commenter states that the acronym "MACC" is used but it is not defined and the

commenter suggests that the full name of the entity be used prior to the use of the acronym.

RESPONSE: This acronym stands for Medical Assistance Customer Center, which is defined at N.J.A.C. 10:60-1.2.

34. COMMENT: N.J.A.C. 10:60-2.2. Home Care and Hospice Association of NJ. The commenter submits that Federal Medicaid regulations exclude Medicaid managed care from the face-to-face requirement so this section should clearly state that this requirement applies only to fee-for-service Medicaid home health services.

RESPONSE: The commenter is correct; the Federal Medicaid regulations do not require the face-to-face encounter for beneficiaries receiving home health services under managed care. When the final rule was published on February 2, 2016, (see 81 CFR 5529) in response to a comment regarding this topic, CMS stated that they would defer to the individual states how to determine the application of the face-to-face requirement in managed care plans to best meet the needs of their beneficiaries. New Jersey does not require a separate and distinct face-to-face encounter to certify the need for home health services because the MCOs are required to prior authorize such services and those services must be certified as medically necessary to be authorized. The Department believes that this process is adequate in ensuring the most appropriate level of care is provided to a beneficiary who is enrolled in an MCO. The Department will add new N.J.A.C. 10:60-2.2(c) upon adoption to clarify this position. This is not considered a substantial change because the requirement is in accordance with the Managed Health Care Services for Medicaid and NJ FamilyCare Beneficiaries rules at N.J.A.C. 10:74-3.1(c), which requires that "the standard service package shall be provided in accordance with medical necessity without any predetermined limits, unless specifically stated; service utilization shall be controlled by the MCO through pre-certification programs and prior authorization for medical necessity."

35. COMMENT: N.J.A.C. 10:60-2.2(a). Home Care and Hospice Association of NJ. The commenter suggests removing the word "attending" in reference to physician because a physician other than the beneficiary's attending physician can certify the need for services. The commenter also recommends changing the term to "physician/ practitioner" to be consistent with the proposed language at N.J.A.C. 10:60-2.2(b). Additionally, the commenter suggests replacing the phrase "in conformance with written agency policy" with the phrase "within 30 days of the date of the order" to be consistent with New Jersey Department of Health policy.

RESPONSE: The term "attending physician" is appropriate since the attending physician is the physician who would normally be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care. The Department agrees with changing the term to read "physician/practitioner" for the reasons expressed by the commenter and will make the change upon adoption. The Department also agrees with the commenter regarding the specification of the 30-day time frame to be consistent with the DOH policy and will change the regulation upon adoption.

36. COMMENT: N.J.A.C. 10:60-2.2(b)1i. The Arc of New Jersey. The commenter submits that for individuals with intellectual/developmental disabilities (I/DD), who have a life-long condition, it is unnecessary to require a recertification of need for home health services every 60 days. The commenter feels that doing so creates a bureaucratic hurdle for the individual and their families throughout the year. The commenter suggests that the State change the requirement to every six months.

RESPONSE: The Department does not have the authority to eliminate the requirement for recertification of home care services every 60 days because that requirement is Federally required pursuant to 42 CFR 424.22(a) and (b); therefore, the Department must retain the 60-day recertification requirement for home health services. However, it should be noted that home care services refers to intermittent skilled nursing services and the 60-day recertification requirement does not apply to PDN or PCA services that may be provided to individuals with chronic conditions including, but not limited to, I/DD unless there is a separate physical need for skilled home health care services. No change is being made in response to this comment.

37. COMMENT: N.J.A.C. 10:60-2.2(b)1 through 5. Home Care and Hospice Association of NJ. The commenter submits that the term for the person who conducts a face-to-face encounter should be "physician/approved non-physician practitioner."

RESPONSE: The section was written to conform to the requirements of Sections 6407(a) and (d) of the Patient Protection and Affordable Care Act, 111 Pub.L. 148, as amended and supplemented. The Department maintains that the use of the term "authorized physician/practitioner" is appropriate; therefore, no changes will be made upon adoption in response to the comment.

38. COMMENT: N.J.A.C. 10:60-2.3. Home Care and Hospice Association of NJ. The commenter suggests adding "therapy" and "psycho-social assessments and interventions" to the list of services to be included in the plan of care. The commenter also suggests adding licensed physical, occupational, and speech therapists as professionals who can re-evaluate the plan of care and changing the reference "two months" to read "60 days."

RESPONSE: The list at N.J.A.C. 10:60-2.3(a) are examples of general treatment areas and not meant to be an exhaustive list of services, as indicated by the phrase "including, but not limited to" as part of the sentence. More specific requirements that must be included in the plan of care are listed at N.J.A.C. 10:60-2.3(a)1 through 12 and a requirement to include a determination of the beneficiary's psycho-social needs is codified at N.J.A.C. 10:60-2.3(d). Therefore, no changes will be made in response to this part of the comment.

Regarding adding other professionals to perform the re-evaluations other than the nursing staff, other professionals involved in the care of the beneficiary can recommend adjustments in the beneficiary's plan of care, but the nurse must evaluate the recommendation, as part of the re-evaluation process, as it relates to the beneficiary's condition and approve the plan of care, including any changes made to the plan. Therefore, no change regarding the type of professional allowed to complete the re-evaluation will be made. However, the Department agrees with the commenter that 60 days is more precise than two months since the start of the 60-day period is more date specific, therefore, this change will be made upon adoption.

39. COMMENT: N.J.A.C. 10:60-2.5(a) and 11.2. Home Health and Hospice Association of NJ. The commenter requests that either the service-specific Statewide unit rates by each service be updated or that this section be removed completely and the rule provide a link to a website or other resource that lists the current correct rates. If this section is not deleted, the commenter also requests that a definition of "unit" be added.

RESPONSE: As stated at N.J.A.C. 10:60-2.5(a), the base rate was set in January 1999. N.J.A.C. 10:60-2.5(b) states that effective January 1, 2000, and thereafter, the reimbursement rates shall be the service-specific Statewide per unit rates listed in N.J.A.C. 10:60-2.5(a), which shall be incrementally adjusted each January 1, beginning on January 1, 2000, using Standard and Poor's DRI Home Health Market Basket Index. When the rule was originally adopted, posting the updated rates online was not an available option and the annual updates could only be published by a notice of administrative change in the New Jersey Register. The technology is now available allowing the rates to also be posted on the fiscal agent website subsequent to the annual adjustment each January 1st. Upon adoption, the reference to publishing the rates on the website of the fiscal agent will be added to the existing language referencing a notice of administrative change will be replaced with the website of the fiscal agent since that is where the adjusted rates are now posted. Additionally, in response to the commenter's request for a definition of "unit," it is noted that N.J.A.C. 10:60-2.5(c)2 defines a unit as a "full 15 minute interval of face-to-face service."

40. COMMENT: N.J.A.C. 10:60-2.5(h)1. Home Care and Hospice Association of NJ. The commenter submits that Medicare Part A services do not "exhaust" but instead the services provided under Part A could become non-covered services and suggests that the term "exhausted" should be removed as it related to traditional Medicare.

RESPONSE: The Department maintains that the term "exhausted" as used in this context indicates that any home health services provided would be paid for using Medicare Part A funds up to the point that they would no longer be a covered service under Medicare Part A prior to

reimbursement for these services being billed to another agency. No change will be made in response to the comment.

41. COMMENT: N.J.A.C. 10:60-2.5(h)1i. Home Care and Hospice Association of NJ. The commenter submits that prior authorization for Medicaid/NJ FamilyCare services is not routinely obtained when the beneficiary is eligible for both Medicare and Medicaid (dual eligible). Since authorization for Medicare benefits would be obtained if the dual eligible has a managed Medicare plan and by virtue of the fact that Medicare would be paying the home health agency's claims, medical necessity, and certification for level of care would have already been established. The commenter suggests that Medicaid not seek authorization at the start of care for a dual eligible beneficiary but defer to Medicare and pay for non-Medicare covered services based on the post payment review of the Medicare claims data and Medicare's payment or denial determination.

RESPONSE: Medicaid does not require a prior authorization for any service that is covered by Medicare. However, prior authorization is required for services that are not covered by Medicare and those authorizations continue to be required to be submitted with the claim. Therefore, no change will be made upon adoption.

42. COMMENT: N.J.A.C. 10:60-3. NJACP. The commenter submits that Subchapter 3 expands home care to authorize PCA services, which are very similar in nature to services provided by I/DD providers to individuals with I/DD receiving support services at home under the Community Care Waiver (CCW). Although the option of accessing PCA services has the potential to create additional resources and choices for individuals who qualify for home care, I/DD providers would be prohibited from providing these services unless they qualify under this medical model rather than a focus on community services.

RESPONSE: Effective November 1, 2017, the Division's 1915(c) CCW was incorporated into New Jersey's larger and more wide-ranging 1115(a) demonstration waiver, known as the Comprehensive Medicaid Waiver, and was renamed the Community Care Program. Since reimbursement is processed by the Medicaid fiscal agent, all providers must be approved by both DDD and DMAHS and enrolled as Medicaid providers. Current I/DD providers are not prohibited from providing services, as long as they enroll as Medicaid providers. Therefore, no changes are being made in response to the comment.

43. COMMENT: N.J.A.C. 10:60-3.1(a). Home Care and Hospice Association of NJ. The commenter submits that this subsection references a certified hospice agency as a provider of PCA services but that N.J.A.C. 10:60-3.1(b) omits hospice as a provider of PCA services. Additionally, the commenter submits that subsection (a) contradicts the deletion of the definition of "hospice service agency" from N.J.A.C. 10:60-1.2 and recommends that the definition be included since hospice services are rendered to Medicaid beneficiaries.

RESPONSE: As previously stated, the term "hospice service" was deleted from N.J.A.C. 10:60-1.2 because the provision of hospice services is regulated under N.J.A.C. 10:53A. Hospice agencies are included in this rule to the extent that they are legally permitted to provide home health services that are not hospice services, including PCA services. The term "hospice agency" will be added to N.J.A.C. 10:60-3.1(b) upon adoption to clarify that a hospice agency is eligible to provide PCA services.

44. COMMENT: N.J.A.C. 10:60-3.1(b). Home Care and Hospice Association of NJ. The commenter submits that the description of personal care assistance described here does not match the definition at N.J.A.C. 10:60-1.2 and suggests that they be revised to be consistent and to allow for non-physician practitioners to certify the medical necessity of PCA services.

RESPONSE: As noted in the Response to Comment 44, the definition for "personal care assistant (PCA) services" has been revised to be consistent with the description at N.J.A.C. 10:60-3.1(b) by including assistance with instrumental activities of daily living (IADL) related tasks as a component of PCA services. The Department agrees with the commenter that certification for PCA services does not have to be done by a physician. As noted in the response to prior comments, pursuant to N.J.A.C. 10:60-3.4, PCA services can be certified as medically necessary by a physician or an advanced practice nurse (APN); that is why the word "physician" was removed from the definition at N.J.A.C. 10:60-1.2. In response to the comment, the term "physician" is being replaced with the term "physician or advanced practice nurse" to indicate that other medical professionals can authorize medical necessity. These changes, along with the changed definition of "personal care assistant services" at N.J.A.C. 10:60-1.2, will make the text at these two rules consistent with each other.

45. COMMENT: N.J.A.C. 10:60-3.1(b) and 3.2(a). DRNJ. The commenter approves of the extension of the definition of PCA services to include work and school settings in addition to home. DRNJ points out that the Centers for Medicare and Medicaid Services (CMS) has clearly provided that PCA cannot be limited to a person's home, subject to the Americans with Disabilities Act. DRNJ maintains that in light of that guidance, a beneficiary must have the opportunity to spend time within the community and DMAHS should encourage community integration and not limit PCA to only home, work, and school settings. Additionally, DRNJ requests that the term "qualified individual" be defined.

RESPONSE: The PCA rules support a beneficiary's opportunity to spend time within the community and do not limit PCA to only home. The term "qualified individual" is defined at N.J.A.C. 10:60-3.1(b)4. A component of PCA services is the provision of IADLs, which are defined at N.J.A.C. 10:60-1.2 as including non-hands-on personal care assistance services essential to the beneficiary's health and comfort; this would include appropriate PCA assistant services for activities that occur in and out of the home.

46. COMMENT: N.J.A.C. 10:60-3.1(c). The Arc of New Jersey. The commenter asks how the State will make the determination regarding if the hands-on assistance needed by an individual is "moderate or greater" regarding an activity of daily living?

RESPONSE: The term "moderate assistance" is defined at N.J.A.C. 10:60-1.2. The initial determination is made by the physician or APN certifying the medical necessity of the PCA services pursuant to N.J.A.C. 10:60-3.4. The level of services is reevaluated a minimum of once a year, more frequently if the beneficiary's condition changes, pursuant to N.J.A.C. 10:60-3.5.

47. COMMENT: N.J.A.C. 10:60-3.1(c). DRNJ. The commenter disagrees with the proposed eligibility standard requiring "moderate or greater hands-on assistance" with ADLs. DRNJ submits that if home health services are intended to be an alternative to nursing facility care, then the home health services must not have a more restrictive standard than must be met for nursing facility admission. Pursuant to N.J.A.C. 8:85-2.1, nursing facility residents must be dependent in several ADLs regardless of cueing, supervision, or hands-on assistance. DRNJ also submits that because PCA is defined at N.J.A.C. 10:60-1.2 as "… health related tasks associated with the cueing, supervision, and/or the completion of the activities of daily living," the requirement that hands-on assistance be needed is misplaced here.

RESPONSE: The Department maintains that moderate or greater hands-on-assistance is a reasonable standard for establishing the need for PCA services that would be provided in the beneficiary's home. The standard referenced by the commenter at N.J.A.C. 8:85-2.1 would indicate a beneficiary who would need hands-on assistance with more than one ADL where cueing, supervision, and/or hands-on assistance would not be sufficient to maintain the beneficiary in a private home.

48. COMMENT: N.J.A.C. 10:60-3.1(c)2. DRNJ and Home Care and Hospice Association of NJ. The commenters submit that the proposed rule requiring a legally responsible relative (LRR) who lives with a beneficiary receiving PCA services to provide assistance with housekeeping, cleaning, shopping, and other IADLs is onerous and unfair because spouses are not legally required to provide such care for their spouses and it is not possible to mandate or direct a relative to guarantee such assistance. It was suggested that DHS not mandate such in the rule and delete paragraph (c)2.

RESPONSE: The Department agrees that it is not possible to mandate or direct the behavior of a relative sharing living space with a beneficiary; this language is intended to emphasize that the PCA services are being provided to the eligible beneficiary and not the household. In order to clarify that intention, the text will be changed upon adoption.

49. COMMENT: N.J.A.C. 10:60-3.1(c)2. Health Force. The commenter requests that a definition of "legally responsible relative" be provided and seeks clarification as to if the legally responsible relative is required to be, or must be ready, willing, and able to be, the beneficiary's power of attorney?

RESPONSE: The term "legally responsible relative" is defined at N.J.A.C. 10:60-1.2. The legally responsible relative is under no obligation to be power of attorney for the beneficiary.

50. COMMENT: N.J.A.C. 10:60-3.3(a). DRNJ. The commenter submits that as written, only "hands-on personal care" to aid with ADLs will be covered as PCA services and maintains that this is inconsistent with N.J.A.C. 10:60-1.2 and 3.1(b), which include cueing, supervision, and/or completion of ADLs. The commenter maintains that the language in this section would result in limitations of current services for people who require supervision, cueing, and only limited hands-on assistance.

RESPONSE: The Department disagrees with the commenter that this rule would result in limitations of services because, as stated in N.J.A.C. 10:60-3.1(c), "[i]n order to qualify for PCA services, beneficiaries must be in need of moderate, or greater, hands-on assistance in at least one ADL, or, minimal assistance or greater in three different ADLs, one of which must require hands-on assistance." The latter part of this regulation allows for PCA services to those individuals who require supervision, cueing, and only limited hands-on assistance.

51. COMMENT: N.J.A.C. 10:60-3.3(a)1. DRNJ. DMAHS should change the phrase "but not be limited to" to read "but are not limited to" consistent with the change made at subsection (b).

RESPONSE: The Department agrees with the commenter's suggestion and the subsection will be changed upon adoption.

52. COMMENT: N.J.A.C. 10:60-3.3(a)1ii. The Arc of New Jersey, DRNJ, and Home Care and Hospice Association. The commenters suggested that "cognitive impairment" be added to the already proposed language related to covered hands-on PCA services, including assistance with grooming because some individuals with cognitive impairment often need assistance with these tasks, even if their upper limbs function.

RESPONSE: The Department agrees with the commenter's suggestion and the rule will be changed upon adoption to include the suggested language.

53. COMMENT: N.J.A.C. 10:60-3.3(a)1viii. DRNJ and Home Care and Hospice Association of NJ. The commenters asked DHS to confirm that cutting food for a beneficiary is considered assistance with eating and, therefore, a covered service; and it was suggested to include the phrase "including, but not limited to" prior to the list of examples, so that it is clear that the list is not inclusive of all assistance that may be required with eating.

RESPONSE: The Department confirms that cutting food for a beneficiary who is unable to do so does qualify as assistance with eating and is, therefore, a covered PCA service. The Department also agrees with the suggested changes to the sentence and will make them upon adoption, as the suggested changes clarify that the list of examples is not an all-inclusive list of assistance that may be required with eating.

54. COMMENT: N.J.A.C. 10:60-3.3(a)1x. DRNJ. The commenter submits that the restriction that hands-on assistance be required to allow a personal care assistant to accompany a beneficiary to medical appointments is restrictive and prohibits PCA care for people with disabilities who may not need hands-on assistance to keep medical appointments, but may require reminders, cueing, and guiding to doctor appointments.

RESPONSE: The Department disagrees that this restriction is improper because as stated in N.J.A.C. 10:60-3.1(c), "[i]n order to qualify for PCA services, beneficiaries must be in need of moderate, or greater, hands-on assistance in at least one ADL or minimal assistance or greater in three different ADLs, one of which must require hands-on assistance." The latter part of this regulation would allow the personal care assistant to provide reminders, cueing, and guiding to doctor appointments. However, in order to clarify the Department's intent, the rule will be changed upon adoption.

55. COMMENT: N.J.A.C. 10:60-3.3(c)6. Home Care and Hospice Association of NJ. The commenter submits that this pargraph can be deleted since the activities of taking the beneficiary's temperature, pulse, and respiration rate would be delegated by the supervising registered nurse.

RESPONSE: The Department agrees with the commenter and will delete the paragraph upon adoption.

56. COMMENT: N.J.A.C. 10:60-3.3(h). Health Force. When there are two or more beneficiaries living in same residence is there a formula to determine the number of group hours to be provided for non-hands-on services as opposed to individual hours for hands-on care needs?

RESPONSE: Personal care assistant services authorized for two or more beneficiaries living in the same residence shall require a combination of ADL and IADL services. Individual hours should be used to address hands-on care needs for ADL services and group hours to address the IADL care needs (that is, meal preparation, shopping, laundry, housekeeping) for billing purposes.

57. COMMENT: N.J.A.C. 10:60-3.4(a). DRNJ. The acronym "APN" is used in this section but it is not defined in this section or elsewhere, therefore, the full term should be used prior to using the acronym.

RESPONSE: The Department agrees with the commenter and will spell out the term before abbreviating it. The text will be changed upon adoption to include "advance practice nurse (APN)."

58. COMMENT: N.J.A.C. 10:60-3.4(a) through (e). Home Care and Hospice Association of NJ. The commenter disagrees with the requirement for annual recertification for PCA services and recommends that the reference be removed. The commenter submits that PCA services are provided to maintain routine ADLs and the comfort and safety of the beneficiary and that these services are not considered skilled and clinically should not require a physician's certification of medical necessity because it is within an RN's scope of practice to assess, evaluate, and design a PCA plan of care. The commenter maintains that the authorization for PCA services should be based on the RN's assessment and submission of the need for ADL/IADL assistance using the DMAHS-approved assessment tool. However, if the physician certification remains, the commenter requests that the certification also be allowed to be completed by a non-physician practitioner.

RESPONSE: The Department requires periodic recertification to ensure that the beneficiary's service level matches his or her level of need; this is done at annual intervals, unless a noticeable change in the beneficiary's status requires an earlier re-evaluation of his or her level of need. Regarding the request that the recertification be allowed to be completed by a non-physician practitioner, as stated at N.J.A.C. 10:60-3.4(a), the certification of need for PCA services can be completed by either a physician or an advanced practice nurse (APN). The Department views this rule as necessary and reasonable to ensure the appropriate level of services are provided and, therefore, will not be making any changes upon adoption in response to this comment.

59. COMMENT: N.J.A.C. 10:60-3.4(b). Health Force and DRNJ. The commenters request clarification regarding the meaning of the phrase "the managed care plan authorization is based on medical necessity and shall serve as the certification of medical necessity for personal care assistance services." The commenters request confirmation that a home care agency can forego the process of obtaining a physician certification in this situation.

RESPONSE: An MCO uses a variety of widely accepted methods, performed by appropriate medical professionals, to evaluate the health of a patient. The plan of care that is developed by those medical professionals and the components of the plan of care for that patient are based on the medical necessity of each condition identified by the results of those evaluations. As such, if an MCO certifies that an individual is in need of PCA services then the home care agency may forego obtaining the initial physician certification but must work with the beneficiary and his or her doctors, whether part of the MCO or not, to obtain subsequent certification as required by this rule.

60. COMMENT: N.J.A.C. 10:60-3.4(b). Health Force. The commenter asks if a physician's certification of need is required to come back in the mail with an original signature or can a faxed copy countersigned by the physician suffice.

RESPONSE: Home care providers are required to maintain proof of a face-to-face encounter, including the date, time, location, and signature of the practitioner for visiting nurse services. A faxed copy is considered proof of a face-to-face encounter. For PCA services, authorization by the

MCO may be in the form of an authorization code. For services authorized by a primary care provider, the PCA provider may obtain an original or a mailed/faxed copy of the original signature and keep it on file.

61. COMMENT: N.J.A.C. 10:60-3.4(b). DRNJ. The commenter requests a definition of the standard of medical necessity that the MCO authorization is based upon in order to ensure comparability of services and to inform Medicaid/NJ FamilyCare beneficiaries of the service standard.

RESPONSE: Medical necessity is specifically applied at the time the physician or APN (including those at the MCO) certify the treatment plan and determine that the services being proposed are medically necessary to keep the client in a home setting. In the context of this rule, the physician or APN certify that in the absence of alternative support, the health-related tasks identified require a qualified individual under the supervision of a registered professional nurse to perform the identified tasks.

62. COMMENT: N.J.A.C. 10:60-3.4(c). Health Force. The commenter asks if managed care organizations will be required to utilize the same criteria as fee-for-service providers when evaluating an individual for managed long-term services and supports (MLTSS).

RESPONSE: Yes, the managed care organizations will be required to use the same criteria as fee-for-service providers to ensure that a consistent standard of care exists for all Medicaid/NJ FamilyCare beneficiaries requiring PCA services.

63. COMMENT: N.J.A.C. 10:60-3.4(d). DRNJ. The commenter submits that this subsection, which states that a recertification of need may be required in the event of a change in disability status, is vague and likely to be abused; therefore, the subsection should be more specific as to when recertification could be required.

RESPONSE: N.J.A.C. 10:60-3.4(a) requires that certification be completed upon initial application and recertifications be completed annually; the language at subsection (d) is meant to allow for flexibility to complete a recertification prior to the required annual recertification if there is a noticeable change, positive or negative, in the level of disability of the beneficiary. This flexibility is intended to ensure that the appropriate adjustments to a beneficiary's treatment plan be made as soon as possible, rather than waiting for the annual recertification, to meet the level of care required to effectively manage the condition of the beneficiary. The Department believes the language is adequate and, therefore, no change will be made in response to the comment.

64. COMMENT: N.J.A.C. 10:60-3.4(f). Home Care and Hospice Association of NJ. The commenter requests clarification as to what constitutes a transfer from one provider agency to another.

RESPONSE: The intent of the language is clear, that is, a beneficiary is to be considered transferred from one provider agency to another when the beneficiary ceases to receive services from the original provider and instead receives services from a new provider, consistent with the procedure as described at N.J.A.C. 10:60-3.10. No change will be made in response to the comment.

65. COMMENT: N.J.A.C. 10:60-3.5(a)2. NJACP. The commenter submits that the requirement of PCAs receiving supervision by a registered nurse is not consistent with a person-centered approach when the services appear not to be medical in nature but habilitative or occupational. The commenter maintains that the regulations are based on an older medical model that was accepted practice when the regulations were originally written; however, due to significant system changes that are more responsive to an individual's wants and needs as defined by that individual, the commenter suggests the entire regulation be reviewed to ensure that it is focused on person-centered planning where appropriate.

RESPONSE: The RN supervision visits are required to ensure that the plan of care that was developed based on the certification of need is being properly implemented. Since the services are required to be certified as medically necessary, it is a reasonable expectation to have a medical professional supervise the provision of the services to ensure they are being properly administered to, and assess if there is a change in the level of services needed to, ensure the beneficiary's needs are being adequately addressed by the plan of care. The Department believes the language is adequate and no change will be made in response to the comment.

66. COMMENT: N.J.A.C. 10:60-3.5(a)2. Home Care and Hospice Association of NJ. Regarding the initial PCA supervisory visit by the RN, the commenter suggests revising the language of the rule to indicate it is only "as needed."

RESPONSE: The Department agrees and will make the suggested change upon adoption.

67. COMMENT: N.J.A.C. 10:60-3.5(a)3. The Arc of New Jersey and Home Care and Hospice Association of NJ. The Arc submits that individuals with I/DD will not experience "recovery" from their conditions as other populations receiving PCA services may; therefore, the PCA nursing reassessment should be changed to annually. The Home Health and Hospice Care Association of NJ suggests changing the phrase "need for continued care" to read "need for continued personal care assistance."

RESPONSE: The Department agrees with the commenter that the phrase "need for continued personal care assistance" is more accurate in describing the services addressed at N.J.A.C. 10:60-3.5 and will be making that change upon adoption. Additionally, the Department agrees with the commenters that the nursing reassessments should be done annually. The requirement for the nursing reassessment will be changed to annually to be consistent with the requirement for the annual recertification for the certificate of need at N.J.A.C. 10:60-3.4(a); this will allow the nursing reassessment using the PCA assessment tool and the certification of need for services to be done on the same schedule while allowing the flexibility to complete a supplemental nursing assessment using the PCA assessment tool if there is a change in the beneficiary's condition.

68. COMMENT: N.J.A.C. 10:60-3.7(a). Home Care and Hospice Association of NJ. The commenter requests that "unit of service" be defined.

RESPONSE: The term "unit of service" is defined at N.J.A.C. 10:60-2.5(c)2 as a "full 15-minute interval of face-to-face service."

69. COMMENT: N.J.A.C. 10:60-3.7(a). Home Care and Hospice Association of NJ. The commenter submits that the future of home care will mandate the use of electronic visit verification (EVV) technology that tracks and documents the time spent during the visit and can include services provided and visit documentation. The commenter maintains that tracking units of service using EVV is not appropriate and recommends that payment for services be based on actual time spent in the home.

RESPONSE: This comment is beyond the scope of these amendments; electronic visit verification is not a DMAHS requirement.

70. COMMENT: N.J.A.C. 10:60-3.8(c). Home Care and Hospice Association of NJ. The commenter submits that additions to the list of exclusion examples are ill defined or described, particularly in relation to the fact that a diagnosis alone does not determine the need for hands-on assistance with ADLs and submits that PCA services should be authorized based on an assessment of the beneficiary's rehabilitation potential, functional status, and prognosis.

RESPONSE: PCA services are designed to accommodate long-term chronic or maintenance health care needs, as opposed to short-term skilled care required for acute short-term conditions or medical diagnoses, such as high cholesterol, which do not result in functional limitations. The Department maintains that the language of each addition to the exclusion list is adequate to address the beneficiary's rehabilitation potential, functional status, and prognosis. Therefore, no changes will be made in response to this comment.

71. COMMENT: N.J.A.C. 10:60-3.8(c)2. DRNJ. The commenter suggests that the Department revise this paragraph to be consistent with the definition of PCA services at N.J.A.C. 10:60-1.2, which includes supervision as an aspect of PCA services.

RESPONSE: The Department acknowledges that supervision is acceptable as part of providing a package of PCA services as described elsewhere in this chapter, including the definition referenced by the commenter at N.J.A.C. 10:60-1.2. However, the intent of N.J.A.C. 10:60-3.8(c) is to not approve or authorize PCA services when supervision of the beneficiary is the only service that is requested. To

provide clarification of this intent, N.J.A.C. 10:60-3.8(c)2 shall be changed upon adoption include "as a stand-alone service."

72. COMMENT: N.J.A.C. 10:60-3.8(h). DRNJ. The commenter submits that group hours are not appropriate in all situations where multiple persons receive PCA services. For example, if there are multiple persons who require hands-on assistance and the personal assistant leaves the residence to go food shopping, that would leave other household members without assistance. A qualification such as "for billing purposes, if such group hours may be achieved without impact on an individual's care needs" would be better.

RESPONSE: The intent of the rule is to prohibit billing for multiple persons living in one residence for non-personal care needs that can be accomplished for all beneficiaries at one time, as is indicated by stating that a combination of individual and group services shall be used to meet all the needs, both ADLs and IADLs, of the beneficiaries sharing the residence. The Department maintains that the language is adequate and, therefore, no changes will be made in response to the comment.

73. COMMENT: N.J.A.C. 10:60-3.8(h). Home Care and Hospice Association of NJ. The commenter suggests that it be indicated that personal care assistant (PCA) services authorized for two or more beneficiaries living in the same residence only be provided group hours to address the non-personal care needs (that is, meal preparation, shopping, laundry, housekeeping) if all beneficiaries receiving services are enrolled in the same managed care organization (MCO).

RESPONSE: Services provided to an individual enrolled in an MCO must be authorized by that MCO and included in the treatment plan of the individual. The agency providing the PCA services is then reimbursed by the authorizing MCO for providing the service. Therefore, coordination of services, such as the provision of group hours of PCA services to some or all of the beneficiaries residing in the home, can only be accomplished if the individuals receiving the group PCA services are enrolled in the same MCO. The Department maintains that the language is adequate and, therefore, no changes will be made in response to the comments.

74. COMMENT: N.J.A.C. 10:60-3.8(i). DRNJ, Health Force, and Health Care and Hospice Association of NJ. The commenters requested clarification as to whether units could be carried over from day to day, particularly if the cancellation was not the fault of the beneficiary. Additionally, it was suggested that the language be revised to add the word "hours" to indicate that this rule applies to a limited amount of service time.

RESPONSE: PCA units are authorized by the week, so there is no need to carry over units from one day to another during the authorized week. The Department agrees that the rule should clearly indicate that this applies to a specific authorized timeframe and not the blanket authorization for services; however, since a unit of service for PCA is 15 minutes and not an hour, the text will be changed upon adoption using the phrase "unit of service."

75. COMMENT: N.J.A.C. 10:60-3.10. DRNJ, Health Force, and Home Care and Hospice Association of NJ. The commenters request clarification as to whether the reasons stated for transfer of an individual from one agency to another agency also apply to fee-for-service beneficiaries, managed care beneficiaries, or both? Federal law permits beneficiaries to obtain services from any qualified Medicaid provider that provides the appropriate service, so DMAHS is not allowed to limit transfers to good cause only. (See 42 CFR 431.51 and 431.54(e).) DRNJ submits that CMS waived that requirement only in the case of requiring mandatory enrollment in an MCO.

RESPONSE: The Department acknowledges that all Medicaid/NJ FamilyCare beneficiaries have freedom of choice in choosing providers either in the community on a fee-for-service basis, or within their MCO network. N.J.A.C. 10:60-3.10 provides examples of instances in which a beneficiary would be transferred from one provider agency to another, whether the transfer was initiated by the beneficiary or the agency, to ensure the beneficiary receives quality care. This transfer could be temporary, as in the case of a provider experiencing a staff shortage, with the beneficiary offered the chance to return once staffing levels are restored; or permanent, as in the case of the beneficiary moving to another location not served by that provider.

76. COMMENT: N.J.A.C. 10:60-5.1(c). DRNJ. The commenter fully supports allowing a family member who is also an RN or an LPN to provide PDN care to a family member as an employee of the providing agency but believes there should not be a cap of eight hours per day.

RESPONSE: The Department believes that the eight hour per day cap is reasonable, considering that an eight-hour work day is a standard work day. Therefore, no changes will be made in response to the comment.

77. COMMENT: N.J.A.C. 10:60-5.1(a)1. Home Care and Hospice Association of NJ. The commenter suggests removing the requirement that private duty nursing (PDN) provider agencies be accredited from this section since accreditation is already required pursuant to N.J.A.C. 10:60-1.3.

RESPONSE: The language is repeated for emphasis of the requirement within the chapter, therefore, no changes will be made in response to the comment.

78. COMMENT: N.J.A.C. 10:60-5.1(c). DRNJ and Home Care and Hospice Association of NJ. The commenters express concerns that the language "private duty nursing shall exceed normal parental and/or familial responsibilities" will be misapplied to situations and result in a limitation of services. The commenters seek clarification as to what is meant by "familial responsibilities." Concern was also expressed that allowing family members employed to care for the beneficiary could lead to a conflict of interest.

RESPONSE: The Department views familial responsibilities as those functions that would be part of a parent or guardian's responsibility in providing care for a child who did not present medical needs requiring nursing intervention. These would include, but not be limited to, activities such as non-medical supervision, feeding, bathing, standard administration of over-the-counter and prescription medications, etc. Regarding the concern related to a conflict of interest for relatives being compensated for providing PDN services, the Department disagrees with the commenters that this will be a concern. The family member is required to have the appropriate professional license, be employed by the agency hired to service the child, and is not allowed to be the supervising RN. In addition, it is the responsibility of the agency to ensure that PDN services are provided in accordance with all agency standards and regulatory requirements. The Department maintains that these requirements will provide necessary safeguards against conflicts of interest.

79. COMMENT: N.J.A.C. 10:60-5.2(a). The Arc of New Jersey. The commenter requests that the Department add those receiving care under the Children's System of Care, within the Department of Children and Families, as a category of beneficiary under age 21 who is entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/PDN services. Since this population no longer receives services from the Division of Developmental Disabilities, it is important to update the language.

RESPONSE: The mission of the Children's System of Care (CSOC) within the Department of Children and Families is to address a child's mental and/or behavioral health. All children who are enrolled in NJ FamilyCare Plans A, B, or C are entitled to receive EPSDT/PDN services regardless of their enrollment in CSOC services. Therefore, no change is being made in response to the comment.

80. COMMENT: N.J.A.C. 10:60-5.2(b). DRNJ. The commenter asks if a DMAHS regional staff nurse will continue to perform the assessments for PDN services or will all such assessments be performed by an MCO, regardless of whether the services will be provided by the MCO or fee-for-service. If the latter scenario is true the rule should be clarified.

RESPONSE: Services provided under fee-for-service are authorized by DMAHS. Upon enrollment into an MCO, the MCO is responsible for the completion of the nursing assessment.

81. COMMENT: N.J.A.C. 10:60-5.3(c)2. DRNJ. The commenter objects to the requirement that an adult primary caregiver must agree to be trained to provide care to the beneficiary and agree to additional training as directed by a State agency in order to secure EPSDT/PDN services.

RESPONSE: The Department notes that as a condition of receiving EPSDT/PDN services, N.J.A.C. 10:60-5.3(c)1 requires that there be "a capable adult primary caregiver residing with the individual who accepts

ongoing 24-hour responsibility for the health and welfare of the beneficiary" and N.J.A.C. 10:60-5.3(c)3 requires that the primary caregiver "agrees to provide a minimum of eight hours of hands-on care to the individual during every 24-hour period." The Department maintains that in order to comply with these requirements, and, therefore, continue to be eligible to receive the EPSDT/PDN services, the primary caregiver must be required to receive appropriate training of any new procedures that are inherent in the care of the beneficiary.

82. COMMENT: N.J.A.C. 10:60-5.4(b). DRNJ. The commenter submits that while there are no proposed changes to this subsection, the language has been repeatedly misapplied with the omission of the words "including, but not limited to," which results in requiring a beneficiary to meet at least one of the listed criteria. In 2003, DRNJ (then known as New Jersey Protection and Advocacy) made a similar comment and the response from the State said: "This subsection (b), 'Medical necessity for PDN services shall be based upon, but may not be limited to, the following criteria:' is correct. The criteria given are for clarification purposes and not considered an all-inclusive list. The Division based the need for EPSDT/PDN services on medical necessity for a specific child." The commenter submits that in spite of that position voiced by the Department in 2003, this list has been treated as an exhaustive list and beneficiaries have been denied PDN because they do not require one of the interventions listed as examples, but still require ongoing skilled nursing care. It is suggested that the language be replaced with, or modified to include, language consistent with the Federal EPSDT requirements: "Approval for EPSDT/PDN services shall be based upon medical necessity and provided when needed to correct or ameliorate physical or mental illnesses and conditions in a child."

RESPONSE: The Department maintains that the language is adequate. As previously stated, the criteria listed are given only as examples for clarification and not considered an all-inclusive list and the need for EPSDT/PDN services is based on the medical needs presented in each individual case for a specific child. Therefore, no changes will be made in response to the comment.

83. COMMENT: N.J.A.C. 10:60-5.4(c) and 5.9(f). DRNJ. The commenter commends DMAHS for the addition of the language acknowledging the range of factors affecting the ability and availability of the primary caregiver in regards to caring for the child receiving EPSDT/PDN services. However, they expressed concern that stating that each of the situational criteria "shall" be considered may result in these factors being interpreted as requirements. Specifically, the commenter expressed concern that DMAHS may look to additional adults living in the household and require them to provide care on a level similar to the primary caregiver, regardless of their ability or willingness to do so.

RESPONSE: The Department maintains that the current rule is adequate. The requirement is that the availability of "additional adult care support within the household" be considered, not mandated. Therefore, no changes will be made in response to the comment.

84. COMMENT: N.J.A.C. 10:60-5.4(d) and 5.9(e). DRNJ. The commenter submits that although there are no proposed changes to this rule, the limitations of N.J.A.C. 10:60-5.4(d)1 through 4 have resulted in situations where beneficiaries do not meet the DMAHS criteria for PDN, but have skilled nursing needs that cannot be provided under PCA services, either because it is prohibited by law for a personal care assistant to provide the care or because the provider agency's supervising nurses do not believe the task is one that can be safely delegated. The result is that the beneficiaries do not receive the care that they need.

RESPONSE: The Department maintains that the rule is adequate to address the provision of PCA and PDN services. However, if the commenter has specific examples of the situations about which they are concerned, the Department encourages the commenter to contact DMAHS to further discuss its concerns.

85. COMMENT: N.J.A.C. 10:60-5.4(e). DRNJ. While there are no proposed amendments to this rule, this section should be modified to indicate that PDN is available as a service to children under EPSDT and to those on MLTSS.

RESPONSE: N.J.A.C. 10:60-5.4 addresses the limitation, duration, and location of EPSDT/PDN services. EPSDT/PDN services are services that are only provided to children under age 21 under EPSDT. N.J.A.C. 10:60-5.8 addresses PDN services for all beneficiaries, regardless of age who are receiving services under MLTSS. The Department believes that this is adequate to address the provision of PDN services to beneficiaries who require those services; therefore, no changes will be made in response to the comment.

86. COMMENT: N.J.A.C. 10:60-5.4(f). DRNJ. The commenter submits that, although there are no proposed amendments to this rule, subsection (f) should be deleted since it refers to waiver programs that are no longer available and is in direct conflict with proposed N.J.A.C. 10:60-5.4(g), which states that "private duty nursing services shall not include respite or supervision, or serve as a substitution for routine parenting tasks." Regarding the language at subsection (g), there is concern that this language will lead beneficiaries to believe that respite care is not available to anyone, even though it is an available service under MLTSS.

RESPONSE: The Department agrees with the commenter. New N.J.A.C. 10:60-5.4(g) clearly states that PDN services shall not include respite care and existing N.J.A.C. 10:60-5.4(f) does refer to waivers that are no longer available. In response to the comment, existing subsection (f) will be deleted. In response to the commenter's second concern, the language at proposed N.J.A.C. 10:60-5.4(g), the subsection simply states that PDN services shall not be used for respite care; respite services are available, if necessary, to any beneficiary receiving MLTSS.

87. COMMENT: N.J.A.C. 10:60-5.4(h). Home Care and Hospice Association of NJ. The commenter suggests language be added allowing the same nurse to provide PDN services to two beneficiaries residing in the same house only if it is deemed medically appropriate and clinically safe for the beneficiaries.

RESPONSE: The Department notes that N.J.A.C. 10:60-5.4(h) requires that "[t]he agency providing the nursing services shall document that having one nurse does not pose a health risk to either beneficiary in the plan of care which shall be signed by the physician." The Department maintains that the language is adequate and, therefore, no change will be made in response to the comment.

88. COMMENT: N.J.A.C. 10:60-5.5(a). Home Care and Hospice Association of NJ. The commenter requested clarification of the term "assessor" and an explanation as to why the assessment did not include a physical examination of the beneficiary. The commenter submits that failure to complete a comprehensive physical assessment is clinically inappropriate and unsafe.

RESPONSE: In regard to the definition of "assessor," as stated at N.J.A.C. 10:60-5.5(a), the assessment shall be completed by a nurse employed by a licensed certified home health agency, an accredited healthcare services firm, or licensed hospice agency approved by DMAHS; any subsequent references to "assessor" refer to that nurse. Regarding the need for a physical examination of the beneficiary, a comprehensive physical examination and assessment of the beneficiary would have been completed prior to the request for PDN services being completed by the beneficiary's physician and agreed to by the parent or guardian pursuant to N.J.A.C. 10:60-5.2(a), as that request is required to contain the comprehensive medical history, current treatment plan, and the current medical status of the individual and documentation of the need for ongoing (not intermittent) complex skilled nursing interventions by a licensed nurse.

89. COMMENT: N.J.A.C. 10:60-5.5(c). DRNJ. What is meant by the phrase "intensity of skilled nursing interventions?"

RESPONSE: Intensity means how frequently a skilled nursing intervention must be provided to demonstrate that the treatment of the condition is a continuous need that requires ongoing skilled nursing services to effectively manage the condition.

90. COMMENT: N.J.A.C. 10:60-5.5(d). The Arc of New Jersey. The commenter expressed concern regarding the language that states that PDN services provided by a child's school will be deducted from the total hours approved. The commenter urges the State to add language to allow for limited exceptions based on the unique needs of the family.

RESPONSE: N.J.A.C. 10:60-5.3(c) states that EPSDT/PDN services are only appropriate when certain conditions are met, including that there be a capable adult primary caregiver residing with the individual who accepts ongoing 24-hour responsibility for the health and welfare of the beneficiary and that the primary caregiver agrees to provide a

minimum of eight hours of hands-on care to the individual during every 24-hour period. This requirement, when combined with EPSDT/PDN services provided during the other 16 hours of the 24-hour period, are intended to provide care for the beneficiary receiving the services. If the child is receiving PDN services provided by his or her school, there is no reason for the Department to authorize service hours during school days. Additionally, N.J.A.C. 10:60-5.4(a)4 allows the authorization, for a limited time, of additional hours beyond the 16-hour limit to account for emergency situations the family may face. Given those additional rules, the Department believes the rule is necessary and adequately explains the requirements, therefore, no changes will be made in response to the comment.

91. COMMENT: N.J.A.C. 10:60-5.8(a). DRNJ. This subsection requires that an individual meet a "nursing facility level of care" but the term is not defined. DMAHS should either define the term or provide a cross reference to an N.J.A.C. cite in which the term is defined.

RESPONSE: The Department will change the language upon adoption to provide a cross-reference to the appropriate rule regarding eligibility for nursing facility level of care for beneficiaries enrolled in MLTSS.

92. COMMENT: N.J.A.C. 10:60-5.8(b). Home Care and Hospice Association of NJ. The commenter recommends that there be an allowance by MLTSS to authorize 24 hours of PDN services if special circumstances exist.

RESPONSE: This allowance has already been included in the rule. N.J.A.C. 10:60-5.9(c)3 allows the MCO or DMAHS to authorize, for a limited time, additional hours beyond the 16-hour limit in emergency circumstances. No changes will be made in response to the comment.

93. COMMENT: N.J.A.C. 10:60-5.9(b). The Arc of New Jersey. The commenter stated that they were pleased to see exceptions to the annual cost threshold (ACT) made regarding MLTSS. The commenter submits that due to the complex and complicated issues associated with certain cognitive challenges due to I/DD, the Department should acknowledge the need for exceptions in certain situations when providing PDN or PCA services to those populations.

RESPONSE: The Department did not make exceptions regarding MLTSS. All PDN services are required to comply with the ACT threshold. The replacement of the acronyms "CRPD, ABC, ACCAP, DDS, and DMAHS" with "MLTSS" only signify that MLTSS has replaced the now-defunct waiver programs CRPD, ABC, and ACCAP and that supplemental payments are now paid under the MLTSS service package and not directly by DDS or DMAHS. The hours of PDN services provided as part of the MLTSS service package are still intended to supplement PDN service hours provided by, or paid for by, other sources, such as medical day care, school, or services paid for by insurance coverage.

94. COMMENT: N.J.A.C. 10:60-5.9(c). The Arc of New Jersey. The commenter submits that individuals with I/DD will not experience "recovery" from their conditions as other populations receiving PCA services may; therefore, the timeline for reviewing the approved hours should be changed to annually.

RESPONSE: N.J.A.C. 10:60-5.9(c) does not address PCA services; the rule addresses the provision of PDN services under the EPSDT program. PDN services are significantly more medical in nature and the level of services required can fluctuate, even in patients with a chronic condition, requiring more frequent review of the provided interventions. Because the language addresses PDN services and not PCA services, the Department maintains that the language is adequate and appropriate and, therefore, no changes will be made in response to the comment.

95. COMMENT: N.J.A.C. 10:60-5.9(c)2. The Arc of New Jersey. The commenter submits that due to the ongoing challenges for parents who are caregivers to adult children with I/DD whose condition is such that PDN is required, and who may be in poor health themselves or have other family responsibilities that are time-consuming and significant, the commenter requests that the rule be amended to allow for exceptions to the requirement that parents provide eight hours a day of care.

RESPONSE: The Department acknowledges that caring for an adult child or other adult family member in the example above could be difficult. However, in order to ensure the safety of the beneficiary, the necessary care must be available and it is the responsibility of the live-in adult primary caregiver to ensure that this care is provided a minimum of eight hours during each 24-hour period. The language at N.J.A.C. 10:60-5.9(c)2 will be changed upon adoption to include "meet the beneficiary's skilled needs for" a minimum of eight hours of care every 24-hour period. This language will allow the adult primary caregiver, although still required to live with and be trained in the care of the individual and still responsible for providing that care, the flexibility to arrange, at his or her own cost, for the beneficiary's needs to be met without necessarily personally providing the care required.

96. COMMENT: N.J.A.C. 10:60-5.9(c)2. DRNJ. The commenter submits that the requirement that a competent adult must have an adult primary caregiver who resides with them is a form of discrimination and a violation of *Olmstead v. L.C.,* 527 *U.S.* 581 (1999). This requirement, and related requirements, should be removed, including the requirement that an adult primary caregiver must agree to be trained to provide care to a competent adult beneficiary and agree to additional training as directed by a State agency in order to secure PDN services.

RESPONSE: As noted in the Response to Comment 21, the requirement that a recipient of PDN services must have a live-in primary caregiver is not a new requirement and that existing requirement was not changed by the instant rulemaking. The Department understands the commenter's desire to allow a PDN beneficiary the highest level of independence possible; however, for a person to simply agree to meet the needs of the PDN beneficiary a minimum of eight hours a day without being present poses an undue risk to the health and safety of the beneficiary. Therefore, in order to ensure the safety of the Medicaid/NJ FamilyCare beneficiary receiving PDN services, the Department is retaining the existing requirement that the beneficiary must have a live-in primary caregiver. However, the Department will continue to work with the stakeholder community on this issue to ensure that beneficiaries have appropriate access to PDN services. With regards to providing services, please see the Response to Comment 95 for an explanation regarding the change being made upon adoption to address this issue.

97. COMMENT: N.J.A.C. 10:60-5.9(d). DRNJ. The commenter submits that the use of an exclusive list of medical conditions and interventions required in order for a beneficiary to receive PDN services fails to accommodate all possible medical conditions or necessary interventions that warrant PDN services. The commenter suggests that DMAHS base PDN eligibility on medical necessity as documented by the beneficiary's doctor or include the phrase "including but not limited to" as found in N.J.A.C. 10:60-5.4(b).

RESPONSE: The Department agrees with the commenter that the intent of the rule was that PDN eligibility should be based on medical necessity as documented by the beneficiary's doctor. The Department also acknowledges that, although the listed conditions are the most common conditions requiring skilled intervention, there are other conditions that also require medically necessary skilled nursing interventions. In response to the comment, and to clarify the original intent of the rule, the Department will add N.J.A.C. 10:60-5.9(d)2iv upon adoption to ensure that medically necessary PDN services are provided to a beneficiary who is receiving the MLTSS service package.

98. COMMENT: N.J.A.C. 10:60-5.10(c). Home Care and Hospice Association of NJ. The commenter suggests removing "home health services" and replacing it with "private duty nursing services."

RESPONSE: The reference to home health services being billed using the UB-92 CMS-1450 form is correct. N.J.A.C. 10:60-5.10(b) directs providers to bill for PDN services using the CMS-1500 claim form. This information is provided, so that provider agencies who provide both home health services and PDN services have an easy reference as to which form to use for which service. No changes will be made in response to the comment.

99. COMMENT: N.J.A.C. 10:60-6.2(a)2. DRNJ. The commenter seeks clarifications to what limited services will be authorized by DMAHS prior to enrollment into an MCO.

RESPONSE: The needs of each individual beneficiary shall be addressed on a case-by-case basis and any medically necessary services shall be authorized for a limited time prior to the beneficiary's enrollment into an MCO.

100. COMMENT: N.J.A.C. 10:60-6.2(c). DRNJ. The commenter recognizes that individuals in MLTSS must receive case management

services, but is concerned that the use of the term "failure to comply" will result in the removal of the individual from the MLTSS benefit package because "failure to comply" is not defined and there are no rights to appeal a decision to remove the individual from MLTSS services included in the chapter.

RESPONSE: Care management services are an integral part of the MLTSS benefit package and the beneficiary is required to cooperate with the care manager, so that the necessary evaluations and assessments can be completed to ensure that the services provided continue to be adequate to address the needs of the beneficiary. The Department will change the term "comply" to "cooperate" upon adoption to indicate this relationship between the beneficiary and the care manager. Additionally, the Department will change the word "shall" to "may" upon adoption to indicate that there is the opportunity to consider all possible exigent circumstances of individual cases before making a final decision regarding removal from the benefit package. Regarding the rights to appeal a decision to remove a beneficiary from the MLTSS benefit package, the Department will add a reference to N.J.A.C. 10:49-10 upon adoption, which contains the appeal and fair hearing rights available to beneficiaries who believe the Medicaid program has erroneously terminated, reduced, or suspended their assistance.

101. COMMENT: N.J.A.C. 10:60-11.2. NJACP. The commenter submits that the published maximum fee schedule may be outdated prior to the end of the review period for the rules and suggests not publishing the reimbursement rates in the regulations, so that there is flexibility to perform rate reviews prior to the expiration date of the rule to continue quality services.

RESPONSE: Publication of the current rate does not impact the Department's ability to perform rate reviews prior to the expiration date of the rule and adjust the rate as indicated based on the findings of the review. No changes will be made in response to the comment.

Summary of Agency-Initiated Changes:

At N.J.A.C. 10:60-1.2, changes are made upon adoption to change the name of the "New Jersey Department of Health and Senior Services" to the "New Jersey Department of Health" to reflect the current name of that Department pursuant to P.L. 2012, c. 17; additionally, the term "Medicaid or NJ FamilyCare" is changed to "Medicaid/NJ FamilyCare." These changes were made in other sections of the chapter as part of the rulemaking but were inadvertently not made everywhere.

At N.J.A.C. 10:60-3.2(a)4 and 5.2(a), changes are made upon adoption correct the name of "Division of Child Protection and Permanency" to "Child Protection and Permanency," the term used by the Department of Children and Families for that office.

At N.J.A.C. 10:60-3.2(a)4, the term "foster care home" is changed to "resource family home," which is the term that is now used by the Department of Children and Families.

At N.J.A.C. 10:60-3.4(c), (e), and (f), the Department is changing the term "physician" to "physician/practitioner" to be consistent with the language at N.J.A.C. 10:60-3.4(a), which allows an advanced practice nurse to certify the medical necessity of the services.

At N.J.A.C. 10:60-11.2(a), the maximum reimbursement amount for S9122 and S9122 TV are corrected to reflect the fact that the fee-for-service rate for PCA services was raised by statute to $19.00 by P.L. 2017, c. 239 while the rulemaking was pending.

Federal Standards Statement

Sections 1902(a)(10) and 1905(a) of the Social Security Act, 42 U.S.C. §§ 1396a(a)(10) and 1396d(a), respectively, specify who may receive services through a Title XIX Medicaid program and which services may be provided under the program, including home health services. Section 1814(a)(2)(C) of the Social Security Act, 42 U.S.C. § 1395f, requires face-to-face encounters between the patient and the physician/practitioner authorizing the need for the provision of home health services.

Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n, 42 CFR 440, 441, and 484 allow a state Medicaid program to provide in-home community-based waiver services. Home and community-based services, provided under Federally approved waivers, and home care services, are governed by 42 CFR 440.70 and 440.180, which list services eligible for reimbursement as home care services.

Title XXI of the Social Security Act allows a state, at its option, to provide a state child health insurance plan (SCHIP). New Jersey has elected this option with the development of the NJ FamilyCare Program. Sections 2103 and 2110 of the Social Security Act, 42 U.S.C. §§ 1397cc and 1397jj, respectively, describe services that a state may provide to targeted, low-income children.

Section 2110 of the Act (42 U.S.C. § 1397jj) allows a state to provide home care services for the state children's health insurance program.

The Division has reviewed the Federal statutory and regulatory requirements and has determined that the adopted amendments, new rules, and repeals do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

(a) The purpose of this chapter is to explain the rules under which home care services are administered to those individuals determined eligible to receive such services on a fee-for-service basis.

(b) This chapter provides requirements for, and information about, the following services and programs:

1.-3. (No change.)

4. Home and Community-Based Services Waiver programs, which are administered by the Department of Human Services through 42 U.S.C. § 1915(c) waivers, as follows:

i. Home and Community-Based Services Waiver for Intellectually and/or Developmentally Disabled (DDD-CCW) Individuals; and

5. The New Jersey Comprehensive Waiver demonstration programs (Section 1115): NJ FamilyCare managed long-term services and supports (MLTSS).

(c) Home health agencies*[, homemaker agencies,]* and health care service firm agencies are eligible to participate as Medicaid and NJ FamilyCare fee-for-service home care services providers. The services that each type of agency may provide and the qualifications required to participate as a Medicaid/NJ FamilyCare provider are listed in N.J.A.C. 10:60-1.2 and 1.3.

(d) (No change.)

(e) N.J.A.C. 10:60-11, CMS Common Procedure Coding System–HCPCS, outlines the procedure codes used to submit a claim for services provided in accordance with this chapter.

10:60-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise.

…

"Accreditation organization" means an agency approved by the Department of Human Services to provide quality oversight of Medicaid/NJ FamilyCare home care agencies and certify that services are being performed in accordance with acceptable practices and established standards. A current list of entities approved by the Department as accreditation organizations can be obtained by contacting the Department. Interested parties should ensure that the most current list is obtained before taking any action based on such a list. The Department can be contacted by calling (609) 292-3717 or online at http://www.state.nj.us/humanservices/index.shtml.

"Activities of daily living (ADL)" means activities related to self-care, ***performed either independently or with supervision or assistance,*** which include***, but are not limited to,*** dressing ***and undressing***, bathing, eating, *[using the bathroom, and other tasks associated with hygiene]* ***grooming, ambulation, transferring, toileting, and mobility***. The inability to independently perform such tasks may be used as a measure to determine a person's level of disability.

"Annual cost threshold (ACT)" means the annualized long-term services and support portion of the capitation rate for residence in a nursing facility or special care nursing facility as appropriate to a beneficiary's needs as determined by the Office of Community Options.

[This is] ***The ACT is determined by the Department of Health*** in accordance with N.J.A.C. 8:85 *[and any relative resource intensity allocation strategies employed by the State]*.

"Calendar day" means from 12:00 A.M. up to, but not including, the following 12:00 A.M.

…

"Complexity" means the degree of difficulty and/or intensity of treatment/procedures.

"Continuous ongoing" means that the beneficiary *[needs]* ***requires the provision of*** skilled nursing intervention***, on an ongoing basis, up to*** 24-hours per day/seven days per week***, where the beneficiary cannot be taught to self-perform the task and alternative support is not available***.

"DDD" means the Division of Developmental Disabilities in the New Jersey Department of Human Services.

"DDS" means the Division of Disability Services in the New Jersey Department of Human Services.

"DoAS" means the Division of Aging Services in the New Jersey Department of Human Services.

"DHS" means the New Jersey Department of Human Services.

"DOH" means the New Jersey Department of Health.

…

"Face-to-face encounter" means direct contact between a beneficiary and a physician/practitioner authorized to certify home care services.

…

"Hands-on personal care" means physical assistance given to a Medicaid/NJ FamilyCare beneficiary with bathing, dressing, grooming, toileting, mobility/ambulation, feeding, and transfers.

"Health care service firm" means any person who operates a firm, registered with the Division of Consumer Affairs, that employs individuals directly or indirectly for the purpose of assigning the employed individuals to provide health care or personal care services either directly in the home or at a care-giving facility, and who, in addition to paying wages or salaries to the employed individuals while on assignment, pays or is required to pay Federal Social Security taxes and State and Federal unemployment insurance; carries, or is required to carry, worker's compensation insurance; and sustains responsibility for the action of the employed individuals while they render health care services.

"Home health agency" means a public or private agency or organization, either proprietary or non-profit, or a subdivision of such an agency or organization, which qualifies as follows:

1. Is approved by the New Jersey State Department of Health *[and Senior Services]*, including requirements for Certificate of Need and licensure when applicable;

2. (No change.)

3. Is approved for participation as a home health agency provider by the New Jersey *[Medicaid or NJ]* ***Medicaid/NJ*** FamilyCare program or the Medicaid/NJ FamilyCare agent.

…

"*[Independent]* ***Instrumental*** activities of daily living (IADL)" means those *[activities needed to support independent living]* ***non-hands-on personal care assistance services that are essential to the beneficiary's health and comfort***, including, but not limited to, housekeeping, food preparation, doing laundry, *[assisting with finances,]* and shopping.

"Legally responsible relative" means the spouse of an adult or the parent or legal guardian of a minor child.

"Levels of care" means two levels of home health care services, acute and chronic, provided by a certified, licensed home health agency, as needed, to Medicaid or NJ FamilyCare fee-for-service beneficiaries, upon request of the attending physician.

1.-2. (No change.)

…

"Managed long-term services and supports (MLTSS)" means services that are provided under the Comprehensive Waiver through Medicaid/NJ FamilyCare managed care organization plans, the purpose of which is to support *[clients]* ***beneficiaries*** who meet nursing home level of care in the most appropriate setting to meet their specific needs.

…

"Minimal assistance" means non-weight bearing support with minimal physical assistance from the caregiver, when the *[client]* ***beneficiary*** needs physical help in guided maneuvering of limbs or other non-weight bearing assistance such as getting in and out of the tub, dressing, or assistance in washing difficult to reach places.

"Moderate assistance" means weight bearing support, hand-over-hand assistance, in which the *[client]* ***beneficiary*** is involved with physically performing less than 50 percent of the tasks on their own.

…

"Nurse delegation" means that the registered professional nurse is responsible for the nature and quality of all nursing care, including the assessment of the nursing needs, the plan of nursing care, the implementation of the plan of nursing care, and the monitoring and evaluation of the plan. The ***treating*** registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel, including certified nursing assistants (CNAs) and certified homemaker-home health aides (CHHA) ***pursuant to N.J.A.C. 10:37-6.2***.

…

"On-site monitoring" means a visit by Division of Medical Assistance and Health Services or Division of Disability Services staff, or an agent designated by either Division, to a *[personal care agency, private duty nursing agency, provider of waiver services,]* ***home health agency, accredited health care services firm,*** or hospice agency to monitor compliance with this chapter.

…

"Personal care assistant" means a person who:

1.-2. (No change)

3. Is supervised by a registered professional nurse employed by a Division-approved healthcare services firm, home health agency, or hospice agency.

"Personal care assistant (PCA) services" means health related tasks associated with the cueing, supervision, and/or the completion of the activities of daily living, *** as well as instrumental activities of daily living (IADL) related tasks*** performed by a qualified individual in a beneficiary's home, or at a place of employment or post-secondary educational or training program, under the supervision of a registered professional nurse, certified as medically necessary, in accordance with a beneficiary's written plan of care.

…

"Plan of care" means the individualized and documented program of health care services provided by all members of the home health agency, health care services firm, or hospice agency involved in the delivery of home care services to a beneficiary. The plan includes short-term and long-term goals for rehabilitation, restoration or maintenance made in cooperation with the beneficiary and/or responsible family members or interested person. Appropriate instruction of beneficiary, and/or the family or interested person as well as a plan for discharge are also essential components of the treatment plan. The plan shall be reviewed periodically and revised appropriately according to the observed changes in the beneficiary's condition.

"Preadmission screening (PAS)" means that process by which all eligible Medicaid and NJ FamilyCare fee-for-service beneficiaries, and individuals who may become Medicaid/NJ FamilyCare eligible within 180 days following admission to a Medicaid/NJ FamilyCare certified nursing facility, and who are seeking admission to a Medicaid/NJ FamilyCare certified nursing facility or requesting MLTSS services under the comprehensive waiver program receive an in-person standardized assessment by professional staff designated by the DoAS to determine nursing facility (NF) level of care and to provide counseling on options for care.

"Primary caregiver" means an adult relative or significant other adult, at least 18 years of age, who resides with the beneficiary and accepts 24-hour responsibility for the health and welfare of the beneficiary. For the beneficiary to receive private duty nursing services under MLTSS or EPSDT, the primary caregiver must reside with the beneficiary and provide a minimum of eight hours of care to the beneficiary in any 24 hour period.

. . .

"Private duty nursing" means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to beneficiaries under MLTSS, as well as eligible EPSDT beneficiaries.

"Private duty nursing agency" means either a licensed Medicare-certified home health agency, an accredited home health care services firm, or a hospice agency, approved by DMAHS to provide private duty nursing services under MLTSS and to eligible EPSDT beneficiaries. The private duty nursing agency shall be located/have an office in New Jersey and shall have been in operation and actively engaged in home health care services in New Jersey for a period of not less than one year prior to application.

. . .

"Quality assurance," for the purpose of this chapter, means a system by which Division staff shall conduct post payment reviews to determine the beneficiary/caregiver's satisfaction with the quality, quantity and appropriateness of home health care services provided to Medicaid and NJ FamilyCare fee-for-service beneficiaries.

…

"Skilled nursing interventions" means procedures that require the knowledge and experience of a licensed registered nurse. The needed services are of such complexity that the skills of a registered nurse ***(RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse*** are required to furnish the services. Services must be so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. ***The term "professional or technical personnel" refers to the RN who is responsible for the provision of the skilled nursing intervention, or the delegation of these duties to an LPN who provides the service under the supervision of the RN.*** The registered nurse shall determine if the intervention could be or should be taught to and delegated to a caregiver who could safely perform it so as to not endanger or risk the beneficiary's health and safety.

…

"Telehealth technology" means the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient, and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

"Therapy session" means an occupational, physical, cognitive, or speech therapy, hands-on and/or face-to-face, interaction of the participant and therapist, performed individually or in group settings, not including the preparation of reports or progress notes. A session is equal to a unit of service for billing purposes.

…

10:60-1.3 Providers eligible to participate

(a) A home care agency or organization, as described in (a)1 through 4 below, is eligible to participate as a New Jersey Medicaid/NJ FamilyCare provider of specified home care services in accordance with N.J.A.C. 10:49-3.2:

1. A home health agency, as defined in N.J.A.C. 10:60-1.2.

i. Out-of-State home health agencies providing services to Medicaid/NJ FamilyCare beneficiaries out of State, must meet the requirements of that state, including licensure, if applicable, and must meet all applicable Federal requirements;

2. A health care service firm, as defined in N.J.A.C. 10:60-1.2;

3.-4. (No change.)

(b) Health care service firms shall be accredited, initially and on an ongoing basis, by an accreditation organization approved by the Department.

(c) Entities seeking to become accreditation organizations approved by the Department shall petition the Division of Disability Services (DDS) in writing to become a Medicaid-approved accrediting entity. DDS will oversee the process, review credentials, and, within 90 days of the date of the initial request for consideration, make a recommendation to the DMAHS Director for final decision. DDS may, at its discretion, request documentation from the party to support the request. In such case, the 90-day timeframe shall be tolled pending responsive submission of all such necessary documentation.

10:60-1.6 Advance directives

All agencies providing home health, private duty nursing, hospice***,*** and personal care participating in the New Jersey Medicaid/NJ FamilyCare program are subject to the provisions of State and Federal statutes regarding advance directives, including, but not limited to, appropriate notification to *[patients]* ***beneficiaries*** of their rights, development of policies and practices, and communication to and education of staff, community***,*** and interested parties. Detailed information may be located at N.J.A.C. 10:49-9.15, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (42 U.S.C. §§ 1396a(a)(58) and 1396a(w)).

10:60-1.7 Relationship of the home care provider with the Medical Assistance Customer Center (MACC) and the NJ FamilyCare Managed Care Organization or DHS-designated entity

(a) Prior authorization shall be required for all Medicaid-eligible or NJ FamilyCare-eligible individuals and non-Medicaid eligible individuals applying for nursing facility (NF) services. Managed long-term services and supports (MLTSS) provided under the 1115 New Jersey Comprehensive Medicaid Waiver may require determination of clinical eligibility through the pre-admission screening (PAS) process. DoAS professional staff will conduct clinical eligibility assessments and/or determinations of individuals in health care facilities and community settings to evaluate eligibility for nursing facility level of care. Counseling on options for care including potential appropriate setting for the delivery of services is conducted by the Office of Community Choice Options (OCCO) or professional staff designated by DoAS.

(b) (No change in text.)

10:60-1.8 Standards of performance for concurrent and post payment quality assurance review

(a) An initial visit to evaluate the need for home health services or personal care assistant (PCA) services for a fee-for-service beneficiary shall be made by the provider. For PCA services, the provider agency shall request prior authorization using form FD-365 and a State-approved PCA Assessment tool in accordance with procedures as described under N.J.A.C. 10:60-3.9. PCA services for fee-for-service beneficiaries shall not be rendered until authorization is provided by DDS.

1. On a random selection basis, MACC staff may conduct post-payment quality assurance reviews. At the specific request of the MACC, the provider shall submit a plan of care and other documentation for those Medicaid and NJ FamilyCare fee-for-service beneficiaries selected for a quality assurance review.

2. (No change in text.)

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

(d) Home health aide and personal care assistant services shall be provided by the agency in accordance with the plan of care.

1.-6. (No change.)

7. *[Nurse]* ***Registered nurse*** delegated tasks shall be provided by licensed practical nurses (LPN), certified nursing assistants (CNA), or certified home health aides (CHHA).

(e)-(j) (No change.)

10:60-1.9 On-site monitoring visits

(a) For *[a]****an accredited*** health care service firm, ***home health agency, or hospice agency,*** on-site monitoring visits will be made periodically by DDS or DMAHS staff, or by staff of an accreditation organization, as approved by DMAHS, to the agency to review compliance with personnel, recordkeeping, and service delivery requirements using forms as approved by either Division. The results of such monitoring visits shall be reported to the agency, by DDS or DMAHS, or by staff of an accreditation organization, as approved by DMAHS, and when indicated, a plan of correction shall be required. Continued non-compliance with requirements shall result in such sanctions as curtailment of accepting new beneficiaries for services, suspension***,*** or rescission of the agency's provider agreement.

1. The professional staff from the MACC will use the standards listed in this chapter to conduct a post-payment quality assurance review of home care services as provided to the Medicaid or NJ FamilyCare fee-for-service beneficiary.

(b) (No change.)

SUBCHAPTER 2. HOME HEALTH AGENCY (HHA) SKILLED SERVICES

10:60-2.2 Certification of need for home health services

(a) To qualify for payment of home health services by the New Jersey *[Medicaid and NJ]* ***Medicaid/NJ*** FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency by the attending *[physician]* ***physician/practitioner***. The nurse or therapist shall immediately record and sign verbal orders and obtain the *[physician's]* ***physician's/practitioner's*** counter signature, *[in conformance with written agency policy]* * **within 30 days of the date of the order***.

(b) Except as provided in (b)1 below, home health services shall not be provided or reimbursed, except when provided in accordance with all of the certification and face-to-face encounter provisions of Sections 6407(a) and (d), 3108 and 10605 of the Patient Protection and Affordable Care Act, 111 Pub.L. 148, as amended and supplemented, incorporated herein by reference, 42 U.S.C. § 1395n, incorporated herein by reference, and 42 CFR 424.22(a) and (b), incorporated herein by reference.

1. Telehealth technology may be used to provide the face-to-face encounter required under (b) above.

2. The "face-to-face encounter" between an authorized physician/practitioner and a NJ Medicaid/FamilyCare beneficiary for the initial certification for the provision of home care services must occur no more than 90 days prior to the date home care is started or within 30 days of the start of home care, including the date of the encounter.

i. Recertification of the need for home care services shall be done at least every 60 days and must be signed and dated by the physician/ practitioner who reviews the plan of care. A face-to-face encounter is not required for recertification.

3. An authorized physician/practitioner must provide the home care provider the date, time, and location of the "face-to-face encounter" and his or her signature confirming that the encounter was conducted.

4. Home care providers are required to maintain proof of a "face-to-face encounter" including the date, time, location, and signature of the authorizing physician/practitioner. Such documentation may be subject to review by the New Jersey Department of Human Services or its authorized agent.

5. Failure to comply with the "face-to-face encounter" and documentation requirements in (b) and (b)2, 3, and 4 above, may result in the recoupment of Medicaid/NJ FamilyCare payments for home care services.

(c) For beneficiaries who are enrolled in managed care, all home health services must be determined to be medically necessary and prior authorized by the MCO before services are rendered.

10:60-2.3 Plan of care

(a) The plan of care shall be developed by agency personnel in cooperation with the attending physician, and be approved by the attending physician. It shall include, but not be limited to, medical, nursing, and social care information. The plan shall be re-evaluated by the nursing staff at least every *[two months]* ***60 days*** and revised as necessary, appropriate to the beneficiary's condition. The following shall be part of the plan of care:

1.-12. (No change.)

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

10:60-2.5 Basis of payment for home health services

(a) Effective for services rendered on or after January 1, 1999, home health agencies shall be reimbursed the lesser of reasonable and customary charges or the service-specific unit rates described in this subsection. The following are the service-specific Statewide unit rates by each service:

Revenue Code	Description	Base amount Per Unit
420	Physical Therapy	$24.06
430	Occupational Therapy	$23.81
440	Speech Therapy	$20.27
550	Skilled Nursing	$29.14
560	Medical Social Services and Dietary/Nutritional Services	$25.90
570	Home Health Aide	$6.22

(b) Effective January 1, 2000, and thereafter, the reimbursement rates shall be the service-specific Statewide per unit rates found in (a) above, incrementally adjusted each January 1, beginning on January 1, 2000, using Standard and Poor's DRI Home Health Market Basket Index, *[and]* published in the New Jersey Register as a notice of administrative change, in accordance with N.J.A.C. 1:30-2.7***, and posted on the DMAHS' fiscal agent's website https://www.njmmis.com under "Rate and Code Information"***. Home health agencies shall maintain both unit and visit statistics for all services provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries.

(c) Effective January 1, 1999, home health agencies shall bill the Medicaid/NJ FamilyCare fiscal agent as follows:

1. (No change.)

2. The service-specific Statewide rate shall be billed for each full 15 minute interval of face-to-face service in which hands-on medical care was provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary;

i. (No change.)

3.-4. (No change.)

5. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non-routine supplies shall be billed using Revenue Code 270 on the institutional claim form and HCPCS codes in accordance with N.J.A.C. 10:59-2;

6. A home health agency shall only bill the revenue codes listed in (a) above and Revenue Code 270. No other revenue codes will be reimbursed for home health services.

(d) Home health agencies shall submit a cost report for each fiscal year to the Director, Office of Reimbursement, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712 or the Director's designee. The cost report shall be legible and complete in order to be considered acceptable.

1.-2. (No change.)

3. To be granted the extension in (d)2 above, the provider shall submit a written request to, and obtain written approval from, the Director, Office of Reimbursement, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712 or the Director's designee, at least 30 days before the due date of the cost report.

4. If a provider's agreement to participate in the Medicaid/NJ FamilyCare fee-for-service program terminates or the provider experiences a change of ownership, the cost report is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

5. (No change.)

(e) Medicare/Medicaid and Medicaid/NJ FamilyCare third-party claims for home health services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of this chapter.

(f) When Medicaid/NJ FamilyCare is not the primary payer on a home health services claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:

1. The Medicaid/NJ FamilyCare allowed amount minus any other payment(s); or

2. The *[patient]* ***beneficiary*** liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

(g) In no event will a Medicaid/NJ FamilyCare payment for home health services exceed the total charge amount submitted on the claim.

(h) The State will perform a post-payment review of home health claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits exhaust during home health services. Based on the post-payment review, the Division will determine whether paying the *[patient's]* ***beneficiary's*** liability for the home health services will result in a lower cost to the Division. If paying the *[patient's]* ***beneficiary's*** liability results in a lower cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

1. Where benefits have been exhausted under Medicare Part A, the charges to be billed to the Medicaid/NJ FamilyCare Program must be itemized for the Medicare Part A non-covered services in order to determine the liability of Medicare Part B and other third-party payers.

(i) If prior authorization is required for Medicaid/NJ FamilyCare program purposes, it shall be obtained and shall be submitted with the institutional claim form.

SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

10:60-3.1 Purpose and scope

(a) Personal care assistant services shall be provided by a certified licensed home health agency, a certified hospice agency or by a health care service firm that is accredited, initially, and on an on-going basis, by an accrediting body approved by DMAHS.

(b) Personal care assistant services include health related tasks associated with the cueing, supervision***,*** and/or completion of the activities of daily living (ADL), as well as *[independent]* ***instrumental*** activities of daily living (IADL) related tasks performed by a qualified individual in a beneficiary's place of residence or place of employment, or at a post-secondary educational or training program, under the supervision of a registered professional nurse, *[as]* certified ***as medically necessary*** by a physician ***or advanced practice nurse*** in accordance with a written plan of care. These services are available from a home health agency***, hospice agency,*** or a health care services firm. The purpose of personal care assistant services is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses.

1. (No change.)

2. *[Independent]* ***Instrumental*** activities of daily living are those activities described at N.J.A.C. 10:60-3.3(b).

3.-4. (No change.)

(c) In order to qualify for PCA services, beneficiaries must be in need of moderate, or greater, hands-on assistance in at least one activity of daily living (ADL), or, minimal assistance or greater in three different ADLs, one of which must require hands-on assistance.

1. Assistance with IADLs, such as meal preparation, laundry, housekeeping/cleaning, shopping, or other non-hands-on personal care tasks shall not be permitted as a stand-alone PCA service.

2. When a beneficiary lives with a legally responsible relative, the LRR *[must]* ***is expected to*** provide assistance with non-hands-on IADL care tasks ***that benefit the household as a whole***, such as household/cleaning ***of shared living spaces***, laundry ***of common use items***, *[and]* shopping ***for items to be shared among household members, such as cleaning supplies or food for shared meals, and meal preparation***.

10:60-3.2 Basis for reimbursement for personal care assistant services

(a) Personal care assistant services shall be reimbursable when provided to Medicaid/NJ FamilyCare beneficiaries in their place of residence or place of employment, or at a post-secondary educational or training program. The term "place of residence" shall include, but is not limited to:

1.-3. (No change.)

4. A *[Division of]* Child Protection and Permanency *[foster care]* ***resource family*** home;

5. A Division of Developmental Disabilities (DDD) group home, skill development home, supervised apartment, or other congregate living program where personal care assistance is not provided as part of the service package which is included in the beneficiary's living arrangement; or

6. Temporary emergency housing arrangements including, but not limited to, a hotel or shelter.

10:60-3.3 Covered personal care assistant services

(a) Hands-on personal care assistant services are described as follows:

1. Activities of daily living (ADL) shall be performed by a personal care assistant, and include, but *[not be]* ***are not*** limited to:

i. (No change.)

ii. Grooming***,*** such as*[,]* care of hair, including shampooing, shaving, and the ordinary care of nails if the need for such assistance is due to the beneficiary's upper extremities or motor skills being affected by a disability***, or whose level of cognitive disability requires such assistance regardless of mobility level of the upper extremities***;

iii.-vii. (No change.)

viii. Assistance with eating, *[such as]* ***including, but not limited to***, placing food and/or liquids into mouth, and assistance with swallowing difficulties;

ix. Dressing; and

x. Accompanying the beneficiary, for the purpose of *[hands-on]* ***providing personal care*** assistance ***services***, to clinics, physician office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment or to otherwise serve a therapeutic purpose.

(b) *[Independent]* ***Instrumental*** activities of daily living (IADL) services are non-hands-on personal care assistant services that are essential to the beneficiary's health and comfort and shall include, but are not limited to:

Recodify existing i.-ii. as 1.-2. (No change in text.)

3. Care of bathroom used by the beneficiary, including maintaining cleanliness of toilet, tub, shower, sink, and floor;

Recodify existing iv.-vii. as 4.-7. (No change in text.)

8. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands;

9. Planning, preparing (including special therapeutic diets for the beneficiary), and serving meals; and

10. Relearning household skills.

(c) Health related activities, performed by a personal care assistant, shall be limited to:

Recodify existing i.–iv. as 1.–4. (No change in text.)

5. Assisting the beneficiary with simple procedures as an extension of physical or occupational therapy, or speech-language pathology services; ***and***

[6. Taking oral and rectal temperature, radial pulse and respiration; and]

[7.] ***6.*** Nurse delegated tasks approved by the supervising registered professional nurse.

10:60-3.4 Certification of need for personal care assistant services

(a) To qualify for payment of personal care assistant services by the New Jersey *[Medicaid and NJ]* ***Medicaid/NJ*** FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the health care services firm by a physician or ***advanced practice nurse (*APN*)*** as medically necessary, at the time of initial application for services and annually thereafter for recertification. The nurse shall immediately record and sign verbal orders and obtain the *[physician's]* ***physician's/APN's*** counter signature within 30 days.

(b) The certification of need for services must be on file in the beneficiary record at the service provider agency before the home health aide begins providing services for the beneficiary. For those cases that originate while a *[client]* ***beneficiary*** is enrolled in a New Jersey Medicaid/NJ FamilyCare managed care plan, the managed care plan authorization is based on medical necessity and shall serve as the certification of medical necessity for personal care assistant services. Services provided during a period where a *[client]* ***beneficiary*** temporarily loses managed care eligibility, but is expected to reenroll the following month, shall be provided fee-for-service until the *[client]*

beneficiary is reenrolled in *[their]* ***his or her**** managed care plan as a continuation of services without the need to obtain any additional certification.

(c) The physician's certification as described in (a) above must confirm that the home care assistance for the beneficiary is medically necessary. Such certification may be contained in a *[physician's]* ***physician/practitioner's**** order, a prior authorization by a Medical Director in a managed care plan, a prescription, or documentation in the beneficiary Plan of Care (POC).

(d) A recertification of the beneficiary's need for services may be required more frequently in the event of a change in the disability status of the beneficiary enrolled in the PCA program.

(e) For fee-for-service beneficiaries, a recertification of the beneficiary's need for services shall be required in situations in which a certification was obtained from the beneficiary's attending *[physician]* ***physician/practitioner****, and the beneficiary changes his or her *[physician]* ***physician/practitioner****. Managed care plans can recertify the continued need for PCA services through continued prior authorization of services.

(f) For fee-for-service beneficiaries, if a beneficiary is approved to transfer his or her PCA services to another provider agency pursuant to N.J.A.C. 10:60-3.10, the new agency is responsible to obtain a new *[physician's]* ***physician/practitioner's**** certification.

10:60-3.5 Duties of the registered professional nurse

(a) The duties of the registered professional nurse in the PCA program are as follows:

1. (No change.)

2. Direct supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the beneficiary's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance, to determine that the plan of care has been properly implemented, and to document that hands-on personal care is being provided. At this time, appropriate revisions to the plan of care shall be made ***as needed***. Additional supervisory visits shall be made as the situation warrants, such as a new PCA, nurse delegation***,*** or in response to the physical or other needs of the beneficiary. In situations in which multiple personal care assistants are assigned to a case, the in-home supervisory visits shall be rotated until all staff have been assessed during each covered shift. All shift visits must be performed to allow face-to-face supervision of the aide being assessed.

3. A personal care assistant nursing reassessment visit shall be provided at least once every *[six]* ***12*** months or more frequently if the beneficiary's condition warrants, to reevaluate the beneficiary's need for continued ***personal*** care ***assistance services***. When a case is initiated under fee-for-service, the provider agency nurse shall complete the State-approved PCA Assessment tool at the time of the visit. When a *[client]* ***beneficiary*** is enrolled in a Medicaid/NJ FamilyCare managed care plan, completing the State-approved PCA Assessment tool and subsequent authorization of hours shall be the responsibility of the managed care plan.

10:60-3.6 Clinical records

(a) Recordkeeping for personal care assistant services shall include the following:

1. (No change.)

2. Clinical records shall contain, at a minimum:

i.-vi. (No change.)

vii. Documentation that the beneficiary has been informed of rights to make decisions concerning his or her medical care;

viii. Documentation of the formulation of an advance directive; and

ix. Documentation of approved nurse delegated tasks and documentation of training on performance of those tasks.

3. (No change.)

10:60-3.7 Basis of payment for personal care assistant services

(a) Personal care assistant services shall be reimbursed on a per unit, fee-for-service basis for weekday, weekend, and holiday services. Nursing assessment and reassessment visits under this program shall be reimbursed on a per visit, fee-for-service basis.

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

10:60-3.8 Limitations on personal care assistant services

(a) Medicaid/NJ FamilyCare reimbursement shall not be made for personal care assistant services provided to Medicaid or NJ FamilyCare-Plan A beneficiaries in the following settings:

1.-4. (No change.)

5. (No change in text.)

6. (No change in text.)

7. TBI community residential service facilities; and

8. Adult Family Care, Assisted Living Program, and Assisted Living Residence.

(b) Except as specified under the personal preference program, personal care assistant services provided by a family member shall not be considered covered services and shall not be reimbursed by the New Jersey Medicaid or NJ FamilyCare-Plan B and C programs. No exceptions will be granted for legally responsible relatives (that is, a spouse, or a parent of a minor child). Exceptions for other family members or relatives to provide personal care assistant services may be granted on a case-by-case basis at the discretion of the Director of the Division of Disability Services, if requested by the PCA provider agency. Such exceptions may be granted only with valid justification regarding the need for the service and documentation of the unavailability of another PCA. Renewal of approved exceptions shall be requested annually, accompanied by valid justification and documentation of the beneficiary's circumstances. Exceptions and renewals shall be based on the individual circumstances of the beneficiary and in all cases shall require the PCA to be:

1.-3. (No change.)

(c) Personal care assistance services shall not be approved or authorized when the purpose of the request is to provide:

1. (No change.)

2. Supervision, ***as a stand-alone service,*** regardless of age of the beneficiary;

3.-4. (No change.)

5. Routine parenting tasks and/or teaching of parenting skills;

6. Services to individuals with mental health service needs, which are provided by the Division of Mental Health and Addiction Services.

7. Services to beneficiaries with a medical diagnosis that does not indicate functional limitations (for example, high cholesterol);

8. Services to beneficiaries with acute short-term diagnosis (for example, a fracture) that is expected to heal;

9. Services to beneficiaries that are limited to non-hands-on personal care needs as described in N.J.A.C. 10:60-3.3(b) and (c).

(d)-(f) (No change.)

(g) Personal care assistant services shall be limited to a maximum of 40 hours per calendar work week and shall be prior authorized in accordance with N.J.A.C. 10:60-3.9. Additional hours of service may be approved by the Division of Disability Services (DDS) or DMAHS on a case-by-case basis, based on exceptional circumstances.

(h) Personal care assistant services authorized for two or more beneficiaries living in the same residence shall require a combination of individual personal care services to address hands-on care needs and group hours to address the non-personal care needs (that is, meal preparation, shopping, laundry, housekeeping) for billing purposes.

(i) *[Personal care assistant]* ***PCA units of*** service*[s]* that are unused for any reason including, but not limited to, illness of the *[client]* ***beneficiary*** or home health aide, or hospitalization of the *[client]* ***beneficiary*** or aide, are not permitted to be saved and carried over for use on a subsequent date(s).

10:60-3.9 Prior authorization for personal care assistant (PCA) services

(a) (No change.)

(b) Prior approval for PCA services shall be obtained in accordance with the following procedures:

1. For fee-for-service cases, a registered nurse employed by the PCA provider agency shall complete a face-to-face evaluation of the beneficiary, at the beneficiary's home, and shall complete the State-

approved PCA Assessment form, including information regarding the beneficiary's:

i.-viii. (No change.)

ix. Ability to perform housekeeping and shopping tasks; and

x. (No change.)

2. (No change.)

3. The provider agency shall submit the State-approved PCA Assessment form, in electronic or paper format, and the prior authorization request form (FD-365) to the Division of Disability Services; and

4. (No change.)

(c) Failure to comply with the prior authorization requirements shall result in denial of Medicaid/NJ FamilyCare reimbursement and recoupment of funds for any services provided without documented prior authorization.

10:60-3.10 Transfer of beneficiary to a different service agency provider

(a) Beneficiaries may be approved for a transfer of service agency provider for good cause situations, including, but not limited to:

1. The current provider agency is unable to staff the case at the level of care approved by the Division; that is, staffing shortages, staffing cases with multiple home health aides when it is determined to be inappropriate;

2. The current provider agency is unable to staff the case due to a beneficiary change of residence; or

3. The current provider agency is unable to staff the case due to language or cultural barrier.

(b) Beneficiaries shall be awarded the same level of services previously approved upon approval of a transfer pursuant to (a) above until the completion of a recertification by the new provider agency.

(c) If a beneficiary is approved to transfer his or her PCA services to another provider agency, an entirely new physician's certification process is required of the new provider. A physician certification is not transferable from one provider agency to another.

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

10:60-5.1 Purpose and scope

(a) Private duty nursing (PDN) services shall be provided by a licensed certified home health agency, licensed hospice agency or an accredited healthcare services firm approved by DMAHS. The healthcare services firm shall be accredited, initially and on an ongoing basis, by an accreditation organization approved by the Department.

1. A healthcare services firm shall contract with an accreditation organization to complete a comprehensive on-site organizational audit a minimum of once every three years.

(b) The purpose of private duty nursing services is to provide individual and continuous nursing care, as different from part-time intermittent care, to *[individuals]* ***beneficiaries*** who exhibit a severity of illness that requires complex skilled nursing interventions on a continuous ongoing basis. PDN services are provided by licensed nurses in the home to beneficiaries receiving managed long-term support services (MLTSS), as well as eligible EPSDT beneficiaries.

(c) Private duty nursing services exceed normal parental and/or familial responsibilities; therefore, family members of *[clients]* ***beneficiaries*** who are receiving PDN services, who are licensed as an RN or an LPN in the State of New Jersey, may be employed by the agency authorized to provide PDN services to the *[client]* ***beneficiary***, up to eight hours per day, 40 hours per week. The family member of the *[client]* ***beneficiary*** may not serve as the supervising RN responsible for developing the treatment plan for the *[client]* ***beneficiary***. The agency employing the family member is responsible to ensure that the PDN services are properly provided and meet all agency standards and regulatory requirements.

10:60-5.2 Basis for reimbursement for EPSDT/PDN

(a) To be considered for EPSDT/PDN services, the beneficiary shall be under 21 years of age, enrolled in the Medicaid/NJ FamilyCare program and referred by a parent, primary physician, hospital discharge planner, Special Child Health Services case manager, Division of Disability Services (DDS), *[Division of]* Child Protection and Permanency (*[DCP&P]****CP&P***), Division of Mental Health and Addiction Services (DMHAS)***,*** or current PDN provider. Requests for services shall be submitted to the Division of Medical Assistance and Health Services (DMAHS) using a "Request for EPSDT Private Duty Nursing Services (FD-389)" form, incorporated herein by reference (see ***N.J.A.C. 10:60*** Appendix C). The Request shall be completed and signed by the referring physician and agreed to and signed by a parent or guardian. All sections of the Request shall be completed and a current comprehensive medical history and current treatment plan, completed by the referring physician, shall be attached. The comprehensive medical history, current treatment plan and other documents submitted with the request shall reflect the current medical status of the *[individual]* ***beneficiary*** and shall document the need for ongoing (not intermittent) complex skilled nursing interventions by a licensed nurse. Incomplete requests shall be returned to the referral source for completion prior to further action by DMAHS.

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

10:60-5.3 Eligibility for Early and Periodic Screening Diagnosis and Treatment/Private Duty Nursing (PDN) Services

(a) Individuals under 21 years of age who are enrolled in the Medicaid/NJ FamilyCare programs, and who require private duty nursing services, which will allow them to be cared for in a community setting, may be referred for EPSDT/PDN services.

1. (No change.)

2. For individuals who are enrolled in Medicaid/NJ FamilyCare managed care, private duty nursing is authorized and provided by the MCO.

(b) (No change.)

(c) EPSDT/PDN services are only appropriate when the following requirements are satisfied:

1. (No change.)

2. The adult primary caregiver agrees to be trained or has been trained in the care of the *[individual]* ***beneficiary*** and agrees to receive additional training for new procedures and treatments, if directed to do so by a State agency; and

3. (No change in text.)

10:60-5.4 Limitation, duration, and location of EPSDT/PDN

(a) The following requirements shall apply to EPSDT/ PDN services:

1. (No change.)

2. DMAHS shall determine and approve the total PDN hours for reimbursement, in accordance with N.J.A.C. 10:60-5.2(b).

3. The determination of the total EPSDT/PDN hours approved shall take into account the primary caretaker's ability to provide care, as well as alternative sources of PDN care available to the caregiver, such as medical day care or a school program.

4. In emergency situations, for example, when the sole caregiver has been hospitalized, DMAHS may authorize, for a limited time, additional hours beyond the authorized amount.

5. DMAHS may also approve, for a limited time, additional hours when a change in the child's medical condition requires additional training for the primary caregiver to address changes in the care needs of the beneficiary.

(b) (No change.)

(c) The following situational criteria shall be considered, once medical necessity has been established in accordance with (b) above, when determining the extent of the need for EPSDT/PDN services and the authorized hours of service:

1. Available primary care provider support.

i. Determining the level of support should take into account any additional work related or sibling care responsibilities, as well as increased physical or mental demands related to the care of the *[individual]* ***beneficiary***;

2. Additional adult care support within the household; and

3. Alternative sources of nursing care.

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

[(f) While private duty nursing is a form of respite service available under the Division of Development Disabilities - Community Care Waiver (CCW-DDD), respite services are distinct from EPSDT/PDN services and are not eligible for reimbursement as EPSDT/PDN services. Respite care is not a covered service under Medicaid/NJ FamilyCare.]

[(g)] ***(f)*** Private duty nursing services shall not include respite or supervision, or serve as a substitution for routine parenting tasks.

[(h)] ***(g)*** In the event that two Medicaid/NJ FamilyCare beneficiaries are receiving PDN services in the same household, the family may elect to have one nurse provide services for both children. The agency providing the nursing services shall document that having one nurse does not pose a health risk to either beneficiary in the plan of care which shall be signed by the physician. At no time shall a nurse provide care for more than two *[recipients]* ***beneficiaries*** at the same time in a single household.

10:60-5.5 Determination of medical necessity for EPSDT/PDN Services

(a) An initial on-site nursing assessment is necessary in order to review the complexity of the child's care. A hands-on examination of the child is not included in the assessment. The nursing assessment shall include an hour-by-hour inventory of all care-related activities over a 24-hour period, which accurately describes the child's current care. The assessment shall be completed by a nurse employed by a licensed certified home health agency, an accredited healthcare services firm, or licensed hospice agency approved by DMAHS.

(b) The assessor shall describe the specific elements of care, and the individual who rendered the service. Frequency of skilled nursing interventions shall be noted, for example, indicating whether suctioning is occasional, or frequently required or regularly scheduled with chest PT, such as twice a day or every six hours.

(c) Activities that constitute skilled nursing interventions shall be identified by the assessor, separate from non-skilled nursing activities. The presence and intensity of skilled nursing interventions shall determine whether EPSDT/PDN hours should be authorized.

(d) The presence or absence of alternative care, such as medical day care, private duty nursing services provided by private insurance, or private duty nursing services provided by the child's school, shall be identified and recorded, and those hours shall be deducted from the total hours of EPSDT/PDN services to be authorized in accordance with N.J.A.C. 10:60-5.4.

(e) If EPSDT/PDN hours are authorized, the assessor shall indicate the duration of the prior authorization (PA) period (not to exceed six months) and the time frame for reassessment.

(f) (No change.)

10:60-5.6 Clinical records and personnel files

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

(c) Direct supervision of the private duty nurse shall be provided by a registered nurse. Direct supervision of the clinical case shall be completed every 30 days at the beneficiary's home during the private duty nurse's assigned time. Additional supervisory visits shall be made as the situation warrants.

1. The visit to provide direct in-home supervision must occur during a nurse's scheduled shift to allow face-to-face supervision for that individual.

2. The direct in-home supervision shall be rotated among each private duty nurse until each staff member has been assessed.

3. The direct in-home supervision shall consist of a review of all documentation from each nurse assigned to the case***,*** as well as a review of any concerns raised by the *[client]* ***beneficiary*** or primary caretaker.

4. Concerns involving staff not present during the on-site visit shall be addressed with that staff member before they provide any care.

5. If required, follow-up interventions with the assessed staff may be by telephone or provided off-site.

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

(f) On-site monitoring visits shall be made periodically by DMAHS staff, or a designated agency as approved by DHS, to the private duty nursing agency to review compliance with personnel, recordkeeping, and service delivery requirements.

10:60-5.7 Payment for EPSDT/PDN

(a) (No change.)

(b) EPSDT/PDN providers shall submit to DMAHS, with each prior authorization request, comprehensive clinical summaries reflecting beneficiaries' medical status and need for ongoing services. DMAHS staff shall review the submitted clinical data and may conduct on-site home visits before reauthorizing PDN services. In addition, DMAHS staff shall perform Home Care Quality Assurance Reviews of these individuals. In accordance with N.J.A.C. 10:60-1.9, DMAHS shall continue on-site monitoring of private duty nursing agencies to review compliance with this chapter.

10:60-5.8 Eligibility for managed long-term supports and services (MLTSS)/private duty nursing (PDN) services

(a) MLTSS/private duty nursing is available only to a beneficiary who meets nursing facility level of care criteria ***(see N.J.A.C. 10:60-6.2)***, is based on medical necessity, and is prior approved by the NJ FamilyCare MCO in a plan of care prepared by a MLTSS care manager. Private duty nursing is individual, continuous nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS.

(b) MLTSS/PDN services are only appropriate when the following requirements are satisfied:

1. An individual must exhibit a severity of illness that requires complex skilled nursing interventions on a continuous ongoing basis.

i. "Ongoing" means that the beneficiary *[needs]* ***requires the provision of*** skilled nursing intervention ***on an ongoing basis, up to*** 24 hours per day/seven days per week.

iii. "Skilled nursing interventions" means procedures that require the knowledge and experience of licensed nursing personnel, or a trained primary caregiver.

2. There must be a capable adult primary caregiver residing with the individual who accepts ongoing 24-hour responsibility for the health and welfare of the beneficiary;

3. The adult primary caregiver must agree to be trained, or have been trained, in the care of the individual and must agree to receive additional training for new procedures and treatments if directed to do so by a State agency;

4. The adult primary caregiver must agree to provide a minimum of eight hours of care to the individual during every 24-hour period; and

5. The home environment must accommodate the required equipment and licensed PDN personnel.

10:60-5.9 Limitation, duration, and location of MLTSS/PDN services

(a) MLTSS/PDN services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

1. Private duty nursing services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain MLTSS/PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing MLTSS/PDN services. Only those MLTSS/PDN beneficiaries who require, and are authorized by the MCO and the MLTSS care manager to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home.

2. (No change.)

(b) Private duty nursing shall be a covered service only for those beneficiaries enrolled in MLTSS. Under MLTSS, when payment for private duty nursing services is being provided or paid for by another source (that is, insurance), MLTSS shall supplement payment up to a maximum of 16 hours per 24-hour period. The hours approved shall supplement alternative sources of PDN care available, such as medical day care or a school program, including services provided or paid for by the other sources or other insurance available to the beneficiary; shall be medically necessary; and, shall comply with the annual cost threshold.

(c) Private duty nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person in MLTSS. There shall be a live-in primary adult

caregiver*[, as defined in N.J.A.C. 10:60-1.2,]* who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy.

1. The MLTSS care manager or DMAHS shall conduct an assessment to determine the need for MLTSS/PDN services, the required provider skill level (LPN or RN), and the amount of service required. The number of hours approved and the skill level of services shall be noted in the individual's service plan and be reviewed by the care manager and/or designated DMAHS staff person every six months.

2. The adult primary caregiver must be trained in the care of the individual and agree to *[provide]* ***meet the beneficiary's skilled needs during*** a minimum of eight hours of care to the individual during every 24-hour period.

3. In emergency circumstances, for example, when the sole caregiver has been hospitalized or brief post-hospital periods while the caregiver(s) adjust(s) to the new responsibilities of caring for the discharged beneficiary, the MCO or DMAHS may authorize, for a limited time, additional hours beyond the 16-hour limit.

(d) Medical necessity for MLTSS/PDN services shall be based upon the following criteria *[in (d)1 or 2 below]*:

1. A requirement for all of the following medical interventions:

i. Dependence on mechanical ventilation;

ii. The presence of an active tracheostomy; and

iii. The need for deep suctioning; or

2. A requirement for any of the following medical interventions:

i. The need for around-the-clock nebulizer treatments, with chest physiotherapy;

ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; *[or]*

iii. A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anti-convulsants*[.]****; or***

iv. The need for other skilled nursing interventions on an ongoing basis.

(e) Medical interventions that shall not, in and of themselves, constitute a need for MLTSS/PDN services, in the absence of the skilled nursing interventions listed in (d) above, shall include, but shall not be limited to:

1. *[Patient]* ***Beneficiary*** observation, monitoring, recording, or assessment;

2. Occasional suctioning;

3. Gastrostomy feedings, unless complicated as described in (d)2ii above; and

4. Seizure disorders controlled with medication and/or seizure disorders manifested by frequent minor seizures not occurring in clusters or associated with status epilepticus.

(f) The following situational criteria shall be considered, once medical necessity has been established in accordance with (d) above, when determining the extent of the need for MLTSS/PDN services in addition to the primary caregiver(s) eight-hour responsibility and the authorized hours of service:

1. Available primary care provider support.

i. Determining the level of support should take into account any additional work related or dependent(s) care responsibilities, as well as increased physical or mental demands related to the care of the individual;

2. Additional adult care support within the household; and

3. Alternative sources of nursing care.

(g) In the event that two Medicaid/NJ FamilyCare MLTSS beneficiaries are receiving PDN services in the same household, the beneficiary or legal guardian may elect to have one nurse provide services for both beneficiaries. The agency providing the nursing services shall document that having one nurse does not pose a health risk to either beneficiary in the plan of care, which shall be signed by the physician. At no time, shall a nurse provide care for more than two beneficiaries at the same time in a single household.

10:60-5.10 Basis for reimbursement for MLTSS/PDN services

(a) A provider of private duty nursing services shall be reimbursed by the New Jersey Medicaid/NJ FamilyCare program on a fee-for-service basis for services provided as authorized by the individual's service plan prepared by the waiver case manager. Providers shall be precluded from receiving additional reimbursement for the cost of these services above the fee established by the Medicaid/NJ FamilyCare program.

1. (No change.)

(b) (No change.)

(c) Home health services are billed on the institutional claim form (see Fiscal Agent Billing Supplement).

(d) (No change.)

10:60-5.11 Prior authorization of MLTSS/PDN services

(a) There is no 24-hour coverage except for a limited period of time under the following emergency circumstances and when prior authorized by the MCO:

1.-2. (No change.)

SUBCHAPTER 6. MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS) PROVIDED UNDER THE NEW JERSEY 1115 COMPREHENSIVE MEDICAID WAIVER

10:60-6.1 Managed long-term services and supports (MLTSS)

(a) Managed long-term services and supports (MLTSS) under the New Jersey 1115 Comprehensive Medicaid Waiver expands existing managed care programs to include managed long-term care services and supports and expands home and community-based services. The purpose of MLTSS is to increase the availability and utilization of home and community-based services for seniors and individuals with disabilities, allowing them to remain at home in the community instead of living in a nursing facility.

(b) The beneficiary's annual long-term services and support cost cannot exceed the annual cost threshold, unless he or she is granted an exception due to temporary higher care needs or long-term complex medical needs, as identified in the interdisciplinary team process.

10:60-6.2 Eligibility for MLTSS

(a) Individuals qualify for MLTSS by meeting established Medicaid financial requirements and Medicaid clinical and age and/or disability requirements for nursing facility services contained in N.J.A.C. 10:69, 70, 71, or 72.

1. For children who meet the nursing home level of care, and who are applying for MLTSS, there is no deeming of parental income or resources in the determination of eligibility.

2. Once qualified to receive MLTSS, the individual must be enrolled with a managed care organization (MCO) in order to receive MLTSS services. Limited MLTSS services may be authorized by DMAHS after the individual has been determined clinically eligible for MLTSS and prior to enrollment into the MCO.

(b) Individuals who were enrolled in the Home and Community-Based Waiver programs listed below with an enrollment date of on or before July 1, 2014, were automatically transferred into MLTSS through their managed care organization (MCO).

1. Global Options (GO);

2. Community Resources for People with Disabilities (CRPD);

3. Traumatic Brain Injury (TBI); and

4. AIDS Community Care Alternatives Program (ACCAP).

(c) Participation in managed long-term services and supports is voluntary. Individuals receiving MLTSS are required to receive care management services including, but not limited to, outreach and face-to-face visits. Failure to *[comply]* ***cooperate*** with care management services *[shall]* ***may*** result in removal from the MLTSS benefit package. ***Individuals who have been removed from the MLTSS benefit package may file an appeal of the removal in accordance with N.J.A.C. 10:49-10.***

SUBCHAPTERS 7. THROUGH 10. (RESERVED)

SUBCHAPTER 11. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:60-11.2 HCPCS codes and maximum reimbursement rates

(a) PERSONAL CARE ASSISTANT SERVICES

HCPCS Code	Mod	Description	Maximum Rate
S9122		Personal Care Assistant Service (Individual/hourly/weekday)	*[$18.00]* ***$19.00***
S9122	TV	Personal Care Assistant Service (Individual/hourly/weekend/ holiday)	*[$18.00]* ***$19.00***

(b) HCPCS CODES FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT/PRIVATE DUTY NURSING:

HCPCS Code	Mod	Description	Maximum Rate
S9123	EP	PDN-RN, EPSDT, Per Hour	$50.00
S9124	EP	PDN-LPN, EPSDT, Per Hour	$38.00

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law.

The Fiscal Agent Billing Supplement is available on the website of the New Jersey Medicaid/NJ FamilyCare fiscal agent: www.njmmis.com

If you do not have internet access and would like to request a copy of the Fiscal Agent Billing Supplement, write to:

Molina Medicaid Systems
PO Box 4801
Trenton, New Jersey 08650-4801
or contact:
Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

LABOR AND WORKFORCE DEVELOPMENT

(a)

INCOME SECURITY

Contributions, Records, and Reports

Readoption with Amendments: N.J.A.C. 12:16

Proposed: March 19, 2018, at 50 N.J.R. 1026(a).

Adopted: July 27, 2018, by Robert Asaro-Angelo, Commissioner, Department of Labor and Workforce Development.

Filed: July 27, 2018, as R.2018 d.162, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 43:21-1 et seq.

Effective Date: July 27, 2018, Readoption;
September 17, 2018, Amendments.

Expiration Date: July 27, 2025.

Summary of Hearing Officer's Recommendation and Agency's Response:

A public hearing regarding the proposed readoption with amendment was held on April 10, 2018, at the Department of Labor and Workforce Development (Department). David Fish, Executive Director, Legal and Regulatory Services, was available to preside at the public hearing and to receive testimony. No one testified at the public hearing. Written comments were submitted directly to the Office of Legal and Regulatory Services. After reviewing the written comments, the hearing officer recommended that the Department proceed with the readoption with amendment with non-substantial changes not requiring additional public notice or comment (see N.J.A.C. 1:30-6.3).

Summary of Public Comments and Agency Responses:

Written comments were submitted by the following individuals.

1. Gail Toth, Executive Director, New Jersey Motor Truck Association, East Brunswick, New Jersey.

2. Jeff Bader, President, The Association of Bi-State Motor Carriers and President and CEO of Golden Carriers, Inc., Paramus, New Jersey.

3. Dick Jones, Executive Director, The Association of Bi-State Motor Carriers, Inc., Port Newark, New Jersey.

4. Phillip Gigante, President BBT Logistics, Inc., Newark, New Jersey.

5. Phillip Gigante, President BBT Logistics, Inc., Newark, New Jersey, submitted a single package containing form letters signed by individuals each of whom indicated that he or she is an owner-operator. Since the form letters submitted by the following commenters came in a single package from Mr. Gigante and since none of the letters contains an address for the individual commenter, no addresses will appear in the following list.

Lenin Ayala, Licinio Casho, Hermogenes E. Davila, Carter Pasteur, (illegible), Mark Kovalich, Samedi Hairry, Carlos Reynoso, Alexis Echeverria, Amilcar Gutierrez, Cabenson Casseus, Daniel Silva, Juan Areuab, Melchor Topia, (illegible), Flavio Garcia, Robert Ortiz, Delval Wint, Irving Povia, (illegible), Edward Pujols, Eiulin Pena, Juan Carlos Marlon Landais, (illegible), Fortunato Chavez, Perry Mancheon, Basil Smith, Ever Auguste, Chesnel Dorce, (illegible), John F. Santos, Jean Michel (illegible surname), Sederne Jean Jacques, Joaquin Rea, Bernard Saintelus, Jean Luxama, Hector R. Diaz.

6. John J. Nardi, President, New York Shipping Association, Inc., Edison, New Jersey.

7. James H. Cobb, Jr. Director of Governmental Affairs, New York Shipping Association, Inc., Edison, New Jersey.

8. Linda M. Doherty, President, New Jersey Food Council, Trenton, New Jersey.

9. Fred Potter, Vice President-at-Large and Port Division Director, International Brotherhood of Teamsters, Hazlet, New Jersey.