

(d) Except in emergencies, the appellant may request the [Division Director] **Assistant Commissioner** defer the placement of an individual pending resolution of an administrative appeal when the following circumstances apply:

1. (No change.)
2. If the [Division Director] **Assistant Commissioner** agrees to defer the placement, the Division shall not be responsible to maintain the status quo unless the Division was funding the placement prior to the request to defer.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services

Proposed 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, 11.2, and 10:60 Appendix A

Proposed Repeals and New Rules: N.J.A.C. 10:60-6

Proposed New Rules: N.J.A.C. 10:60-3.10

Proposed Repeals: N.J.A.C. 10:60-4, 7, 8, 9, and 10

Authorized By: Elizabeth Connolly, Acting Commissioner,
Department of Human Services.

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

Calendar Reference: See Summary below for explanation of
exception to calendar requirement.

Agency Control Number: 17-P-02.

Proposal Number: PRN 2017-181.

Submit comments by October 20, 2017, to:

Margaret M. Rose – Attn: Proposal 17-P-02
Division of Medical Assistance and Health Services
Mail Code #26
PO Box 712
Trenton, NJ 08625-0712
Fax: (609) 588-7343
E-mail: Margaret.Rose@dhs.state.nj.us
Delivery: 6 Quakerbridge Plaza
Mercerville, NJ 08619

The agency proposal follows:

Summary

The Department is proposing amendments, repeals, and new rules to N.J.A.C. 10:60, Home Care Services, which addresses the provision of nursing facility level of care to Medicaid/NJ FamilyCare beneficiaries. These changes are the result of the combination of several waiver programs providing home and community-based services into the New Jersey 1115 Comprehensive Medicaid Waiver (the Comprehensive Waiver) and the implementation of sections of the Affordable Care Act.

Home and community-based services are home care services provided to beneficiaries who require a nursing facility level of care in order to allow them to remain in their home or community to delay or avoid the need for institutional care. These services are referred to as managed long-term services and supports (MLTSS) and are provided under managed care. Although this chapter addresses fee-for-service home care services, proposed N.J.A.C. 10:60-6, described below, provides general information regarding MLTSS provided under the New Jersey 1115 Comprehensive Medicaid Waiver. Receiving MLTSS requires the beneficiary to enroll in a NJ FamilyCare managed care organization (MCO) and receive case management services. Limited MLTSS services may be authorized during any waiting period between the determination of Medicaid/NJ FamilyCare eligibility and the enrollment of the beneficiary into an MCO, allowing the provider to be reimbursed on a fee-for-service basis. The inclusion of rules relating to MLTSS services in this chapter is meant to provide guidance regarding services provided during that waiting period.

Additional amendments include, but are not limited to, the rules addressing the accreditation and/or certification requirements of specific providers, authorization for services, and private duty nursing services.

The proposed amendments comply with Federal regulations and the approved Comprehensive Waiver and do not require a State Plan Amendment.

General Amendments

Throughout the chapter references to “Medicaid” have been changed to read “Medicaid/NJ FamilyCare” to clarify that beneficiaries found eligible for either program to receive services on a fee-for-service basis are eligible for the services described in this chapter.

Throughout the chapter all references to the “Department of Health and Senior Services” are replaced with references to the “Department of Health” to reflect the current name of that Department pursuant to P.L. 2012, c. 17.

Throughout the chapter all references to the “Division of Mental Health Services” and “DMHS” are replaced with references to the “Division of Mental Health and Addiction Services” and “DMHAS,” as appropriate, to reflect the current name of that Division within the Department of Human Services.

Throughout the chapter all references to the “Division of Youth and Family Services” and “DYFS” are replaced with references to the “Division of Child Protection and Permanency” and “DCP&P,” as appropriate, to reflect the current name of that Division within the Department of Children and Families.

Throughout the chapter the term “health maintenance organization or HMO” has been replaced with “managed care organization or MCO” to reflect the correct name of the organizations.

Throughout the chapter: minor non-substantive revisions of grammar, style, spelling, and punctuation are being proposed; unnecessary cross-references and any duplicative or otherwise unnecessary text are proposed for deletion; and names and/or contact information and addresses of agencies are updated, where indicated. Parentheses are eliminated and associated text is revised, as appropriate, to maintain the grammatical integrity of the sentence.

Summary of Specific Amendments

At N.J.A.C. 10:60-1.1(a), a proposed amendment clarifies that the chapter addresses home care services provided to individuals who receive services on a fee-for-service basis.

At N.J.A.C. 10:60-1.1(b)4, proposed amendments correct the list of services and programs that are contained in the chapter.

At N.J.A.C. 10:60-1.1(c), a proposed amendment corrects the list of providers that are eligible to participate as Medicaid/NJ FamilyCare providers of home care services.

N.J.A.C. 10:60-1.1(e) is proposed for deletion because the programs listed have been subsumed by the Comprehensive Waiver and the subchapters listed are proposed for repeal.

Recodified N.J.A.C. 10:60-1.1(e) is proposed for amendment to remove references to obsolete programs whose services are now included in the Comprehensive Waiver.

At N.J.A.C. 10:60-1.2, proposed amendments add the following definitions: “accreditation organization,” “activities of daily living (ADL),” “annual cost threshold,” “calendar day,” “complexity,” “continuous ongoing,” “DoAS,” “DHS,” “DOH,” “face-to-face encounter,” “hands-on personal care,” “health care service firm,” “independent activities of daily living (IADL),” “legally responsible relative,” “managed long-term services and supports (MLTSS),” “minimal assistance,” “moderate assistance,” “nurse delegation,” “skilled nursing interventions,” “telehealth technology,” and “therapy session” because they are used in this chapter.

At N.J.A.C. 10:60-1.2, proposed amendments delete the following definitions: “vase management,” “DHSS,” “health services delivery plan (HSDP),” “homemaker agency,” “hospice service,” and “long term care field office (LTCFO)” because they are no longer needed in the chapter because of agency name changes or changes in provider type or service delivery.

At N.J.A.C. 10:60-1.2, proposed amendments revise the following definitions to make the information more accurate: “home health

agency,” “levels of care,” “on-site monitoring,” “personal care assistant,” “plan of care,” “preadmission screening (PAS),” “primary caregiver,” “private duty nursing,” “private duty nursing agency,” and “quality assurance,” as discussed in the general changes section above.

At N.J.A.C. 10:60-1.2, the definition of “personal care assistant (PCA) services” is proposed to be revised to explain that the health-related tasks performed as part of PCA services are tasks associated with helping the beneficiary with the completion of activities of daily living by providing cues, supervision, or assistance completing the activities of daily living. The services can be provided at home, school, or a place of employment and must be certified as medically necessary.

At N.J.A.C. 10:60-1.3(a)2, a proposed amendment replaces the term “homemaker agency” with the term “health care service firm” to reflect the current nomenclature for entities that employ individuals to provide health care or personal care services in the home or at a care-giving facility.

N.J.A.C. 10:60-1.3(a)2i is proposed for deletion because the CCPED program no longer exists. All waiver services are now provided under the New Jersey 1115 Comprehensive Medicaid Waiver.

At N.J.A.C. 10:60-1.3(b), proposed amendments replace the list of specific types of agencies with the encompassing term of “health care service firms” and replace the list of specific accreditation organizations and indicate that accreditation shall be done by organizations approved by the Department.

Proposed new N.J.A.C. 10:60-1.3(c) describes the procedure to be followed by organizations seeking to be designated as accreditation organizations approved by the Department.

The heading of N.J.A.C. 10:60-1.7 is proposed for amendment to replace LTCFO with “the NJ FamilyCare Managed Care Organization or DHS-designated entity” to reflect the fact that the DHSS LTCFO is no longer an entity with which the home care provider interacts.

At N.J.A.C. 10:60-1.7(a), proposed amendments clarify the evaluation, approval process, and the providers of placement counseling for individuals applying for nursing facility level of care or other home care services.

N.J.A.C. 10:60-1.7(b) is proposed for deletion because the evaluation and approval processes described are obsolete considering the amendments described above.

At N.J.A.C. 10:60-1.8(a), a proposed amendment describes the procedure that a provider of personal care assistance (PCA) services must follow to secure prior authorization for the provision of services to fee-for-service beneficiaries.

The second through sixth sentences of N.J.A.C. 10:60-1.8(a) and paragraphs (a)1, 2, 3, and 4 are proposed for deletion because they become obsolete as a result of the proposed amendments described above.

At recodified N.J.A.C. 10:60-1.8(a)1, the word “shall” is changed to “may” to indicate that post-payment quality assurance reviews will not be performed for all cases.

Proposed new N.J.A.C. 10:60-1.8(d)7 adds nurse delegated tasks to the list of provided services and specifies the professionals that are allowed to perform the tasks.

At N.J.A.C. 10:60-1.9, proposed amendments replace “homemaker agency and a private duty nursing agency” with “health care service firm” to reflect the correct name of the provider type; add the accreditation organization to the list of agencies permitted to review the agency; and remove the reference to a specific form name and number.

Proposed new N.J.A.C. 10:60-1.9(a)1 allows for post-payment quality assurance reviews to be completed by professional staff from the MACC office.

The heading of N.J.A.C. 10:60-2 is proposed to be amended to Home Health Agency (HHA) “Skilled” Services.

At N.J.A.C. 10:60-2.2, proposed amendments codify the existing text as subsection (a) with no change in the text.

Proposed new N.J.A.C. 10:60-2.2(b) requires that all home health services be provided in accordance with all of the certification and face-to-face encounter provisions of the Patient Protection and Affordable Care Act, 111 Pub.L. 148.

Proposed new N.J.A.C. 10:60-2.2(b)1 allows the use of telehealth technology to be used for the face-to-face encounter.

Proposed new N.J.A.C. 10:60-2.2(b)2 describes the timeframes to be followed when certifying and recertifying the need for home care services.

Proposed new N.J.A.C. 10:60-2.2(b)3 describes the information required to be provided by the physician to the home care provider related to the face-to-face encounter.

Proposed new N.J.A.C. 10:60-2.2(b)4 requires home care providers to maintain proof of the encounter and have it available for review by the Department or the Department’s authorized agent.

Proposed new N.J.A.C. 10:60-2.2(b)5 advises providers that failure to comply with the face-to-face encounter and documentation requirements may result in the recoupment of payments.

At N.J.A.C. 10:60-2.3(a), a proposed amendment clarifies that the plan of care shall be developed by agency personnel and approved by the attending physician; it does not have to be developed by the physician.

N.J.A.C. 10:60-2.5(a), (b), (c), and (e) are proposed for deletion because they are obsolete.

At recodified N.J.A.C. 10:60-2.5(a), the reference to “(e) below” is deleted.

At recodified N.J.A.C. 10:60-2.5(b), the reference to “(d) above” is changed to “(a) above.”

At recodified N.J.A.C. 10:60-2.5(c), conforming amendments, as discussed in the general changes section above are proposed.

At recodified N.J.A.C. 10:60-2.5(c)5, the proposed amendment removes the specific form number and replaces it with the generic name of the form.

At recodified N.J.A.C. 10:60-2.5(c)6, the reference to “(d) above” is changed to “(a) above.”

At recodified N.J.A.C. 10:60-2.5(d), the proposed amendment corrects the name and the address of the office to which the annual cost report is submitted.

Proposed new N.J.A.C. 10:60-2.5(e) describes how third-party claims for home health services that are not the responsibility of a managed care organization shall be reimbursed.

Proposed new N.J.A.C. 10:60-2.5(f) describes the Medicaid/NJ FamilyCare payment that will be paid when Medicaid/NJ FamilyCare is not the primary payer on a home health services claim.

Proposed new N.J.A.C. 10:60-2.5(g) states that the Medicaid/NJ FamilyCare payment shall not exceed the total charge submitted on the claim.

Proposed new N.J.A.C. 10:60-2.5(h) describes how the State will determine reimbursement for home health claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits become exhausted during the provision of home health services. Additionally, proposed new N.J.A.C. 10:60-2.5(h)1 requires that when benefits have been exhausted under Medicare Part A that the charges be itemized in order to determine the liability of Medicare Part B and other third-party payers.

Proposed new N.J.A.C. 10:60-2.5(i) requires that prior authorization, if required, shall be obtained and proof of the authorization submitted with the claim.

At N.J.A.C. 10:60-3.1(a), proposed amendments require personal care assistant (PCA) services to be provided by certified hospice agencies or health care service firms that have been accredited by a body approved by DMAHS, rather than by a proprietary or voluntary non-profit accredited homemaker agency.

At N.J.A.C. 10:60-3.1(b), proposed amendments describe PCA services and activities of daily living (ADL), state where such services can be provided to the beneficiary, and replace the term “homemaker agency” with “health care services firm.”

At N.J.A.C. 10:60-3.1(b)2 the term “household duties” is proposed to be replaced with the term “independent activities of daily living” to more accurately describe the service. The citation for the location of the list of IADLs is corrected to reflect a recodification described below.

Proposed new N.J.A.C. 10:60-3.1(c) describes the level of assistance a beneficiary must need in order to qualify to receive PCA services.

Proposed new N.J.A.C. 10:60-3.1(c)1 prohibits the provision of PCA as a stand-alone service for a beneficiary who only requires assistance with non-hands-on tasks.

Proposed new N.J.A.C. 10:60-3.1(c)2 states that when a beneficiary lives with a legally responsible relative, assistance with non-hands-on tasks must be provided by that person.

At N.J.A.C. 10:60-3.2(a), proposed amendments insert “NJ FamilyCare” and allow PCA services to be provided to a beneficiary at home, work, or school.

Proposed new N.J.A.C. 10:60-3.2(a)6 adds temporary emergency housing to the locations defined as a beneficiary’s place of residence.

At N.J.A.C. 10:60-3.3(a), a proposed amendment specifies that the subsection deals exclusively with “hands-on” personal care assistant services.

At N.J.A.C. 10:60-3.3(a)lii, a proposed amendment specifically describes when grooming is considered a PCA service.

At N.J.A.C. 10:60-3.3(a)lviii, a proposed amendment describes the PCA service of assistance with eating in more detail.

N.J.A.C. 10:60-3.3(a)lx is proposed for deletion from the list of hands-on PCA services and will be included in a list of non-hands-on PCA services described below.

Recodified N.J.A.C. 10:60-3.3(a)lx is amended to require that accompanying a beneficiary to a location is only considered appropriate PCA if hands-on assistance is required.

Existing N.J.A.C. 10:60-3.3(a)2 is proposed to be recodified as subsection (b) and amended to replace the term “household duties” with the term “independent activities of daily living” and defines independent activities of daily living as non-hands-on PCA services.

Recodified N.J.A.C. 10:60-3.3(b)3 is amended to specify that care of the bathroom used by the beneficiary, including the sink, is an IADL.

Recodified N.J.A.C. 10:60-3.3(b)9 is amended to add therapeutic diets as acceptable meal preparation.

Proposed new N.J.A.C. 10:60-3.3(b)10 adds relearning household skills to the list of non-hands-on PCA services.

Existing N.J.A.C. 10:60-3.3(a)3 is proposed to be recodified as subsection (c).

Proposed new N.J.A.C. 10:60-3.3(c)7 adds nurse-delegated tasks to the list of health-related tasks permissible to be performed by a personal care assistant.

At N.J.A.C. 10:60-3.4, proposed amendments codify existing text as subsection (a), replace “home health agency or homemaker agency” with “health care services firm,” allow the certification of medical necessity to be provided by a physician or an advanced practice nurse (APN) both initially and annually, and require that verbal orders given by a physician shall be signed by the physician within 30 days.

Proposed new N.J.A.C. 10:60-3.4(b) requires that the certification of need be on file prior to the provision of services and describes the procedures to be followed if the beneficiary is or was enrolled in managed care when the need for PCA was established.

Proposed new N.J.A.C. 10:60-3.4(c) provides additional details related to the certification of care, including as it relates to authorization provided by a managed care organization.

Proposed new N.J.A.C. 10:60-3.4(d) allows for more frequent recertification of need based on a change in the disability status of the beneficiary.

Proposed new N.J.A.C. 10:60-3.4(e) requires a new certification of need of the beneficiary if there is a change in the attending physician of the beneficiary.

Proposed new N.J.A.C. 10:60-3.4(f) requires that if a beneficiary transfers to a new PCA agency, a new certification of need be obtained by the new PCA agency pursuant to the requirements of proposed new N.J.A.C. 10:60-3.10, described below.

At N.J.A.C. 10:60-3.5(a)2, proposed amendments require that the registered professional nurse document that hands-on personal care is being provided, and, in situations in which multiple personal care assistants are assigned to the case, that supervisory visits be rotated until each assistant has been assessed face-to-face.

At N.J.A.C. 10:60-3.5(a)3, proposed amendments require the completion of the State-approved PCA assessment tool and dictate which agency shall be responsible for the completion of the form based on whether the beneficiary is receiving services on a fee-for-service basis or is enrolled in managed care.

Proposed new N.J.A.C. 10:60-3.6(a)2ix adds documentation of nurse delegated tasks and training on performance of those tasks to the list of PCA services to be included in the clinical records.

At N.J.A.C. 10:60-3.7(a), a proposed amendment changes the reference of hour to unit, to allow for more accuracy in billing for PCA services.

At N.J.A.C. 10:60-3.8(a), proposed amendments revise the list of locations at which Medicaid/NJ FamilyCare reimbursement shall not be provided for PCA services by adding “assisted living residence” and removing “licensed pediatric community transition homes,” “DYFS-supervised group homes for children enrolled in the ACCAP waiver,” “DHSS Enhanced Community Options (ECO) waiver programs,” “the Caregiver Assistance Program (CAP),” and “DHSS Assisted Living Waiver Programs: Assisted Living Residence and Comprehensive Personal Care Home.” The removed residences are obsolete terms since the various waivers programs have been subsumed under the Comprehensive Waiver. The codification of the list has been adjusted to reflect the addition and deletions.

At N.J.A.C. 10:60-3.8(b), proposed amendments replace the reference to “this subsection” with a more specific reference to “the personal preference program.” The existing regulation discusses when family members, other than legally responsible relatives, can be granted an exception to the general rule that PCA services provided by a family member are not covered services and are not reimbursable. An additional proposed amendment increases the amount of time between renewals of exceptions for specified family members or relatives to provide PCA assistant services from every six months to annually. This is consistent with the proposed change to N.J.A.C. 10:60-3.4(a) and will result in those exceptions and the certification for the beneficiary’s need for PCA services will both be required to be completed annually.

At N.J.A.C. 10:60-3.8(c)2, the proposed amendment clarifies that PCA services are not to be used for supervision, regardless of the age of the beneficiary.

At N.J.A.C. 10:60-3.8(c)5, the proposed amendment prohibits the use of PCA services to teach parenting skills to a beneficiary.

At N.J.A.C. 10:60-3.8(c)6, the proposed amendment deletes the inaccurate cross-reference.

Proposed new N.J.A.C. 10:60-3.8(c)7, prohibits the approval of PCA services for beneficiaries whose medical diagnosis does not indicate functional limitations.

Proposed new N.J.A.C. 10:60-3.8(c)8 prohibits the approval of PCA services for beneficiaries with acute or short-term diagnoses that are expected to be resolved.

Proposed new N.J.A.C. 10:60-3.8(c)9 prohibits the approval of PCA services that are limited to non-hands-on services.

At N.J.A.C. 10:60-3.8(g), a proposed amendment adds DMAHS as an agency that can authorize PCA services in excess of 40 hours per week if needed.

Proposed new N.J.A.C. 10:60-3.8(h) requires that a combination of individual and group PCA services be authorized in the case of two or more beneficiaries who live together in the same residence and each individual requires both hands-on and non-hands-on PCA services.

Proposed new N.J.A.C. 10:60-3.8(i) prohibits carrying over unused PCA hours to subsequent dates.

At N.J.A.C. 10:60-3.9(b)1, proposed amendments specify that the prior approval process described only applies to fee-for-service cases, delete the numerical designation for the PCA assessment form and indicate that the form must be State-approved. An additional amendment at subparagraph (b)1ix adds ability to perform housekeeping tasks to the list of skills included in the assessment of the beneficiary.

At N.J.A.C. 10:60-3.9(b)3, a proposed amendment deletes the numerical designation for the PCA assessment form and indicates that the form must be State-approved.

Proposed new N.J.A.C. 10:60-3.10, Transfer of beneficiary to a different service agency provider, contains the policy and procedure related to approving the transfer of a beneficiary from one PCA provider to another.

Proposed new N.J.A.C. 10:60-3.10(a) lists examples of good cause situations that would necessitate the transfer of a beneficiary to another provider.

Proposed new N.J.A.C. 10:60-3.10(b) requires that the beneficiary continue to receive the same level of services until the completion of a recertification by the accepting provider.

Proposed new N.J.A.C. 10:60-3.10(c) requires that a new physician's certification be obtained by the accepting provider and that the physician certification is not transferable.

N.J.A.C. 10:60-4, Personal care assistant services for the mentally ill, is proposed for repeal. These services are now provided under N.J.A.C. 10:79B, Community Support Services for Adults with Mental Illnesses.

At N.J.A.C. 10:60-5.1(a), proposed amendments replace the term "voluntary non-profit homemaker agency, private employment agency and temporary-help service agency" with the general term "health care services firm" and eliminate the names of specific accreditation organizations and insert the term "an accreditation organization approved by the Department."

Proposed new N.J.A.C. 10:60-5.1(a)1 requires health care services firms to contract with an accreditation agency to complete a comprehensive on-site organizational audit a minimum of once every three years.

At N.J.A.C. 10:60-5.1(b), proposed amendments clarify the level of care needed by an individual in order for that individual to receive private duty nursing services and remove a reference to the outdated waiver programs and indicate that beneficiaries now receive this service as part of the package of services included under MLTSS.

Proposed new N.J.A.C. 10:60-5.1(c) allows family members who are licensed as RNs or LPNs in New Jersey to be employed by the agency authorized to provide PDN services to their family members. The agency retains the responsibility of ensuring that services are provided in accordance with agency and regulatory standards. The beneficiary's family member may not be the supervising RN for the case.

N.J.A.C. 10:60-5.3(c)3 is proposed for deletion because this will no longer be a requirement for the authorization of PDN services.

At N.J.A.C. 10:60-5.4(a)2 and 3, proposed amendments delete the limitation of providing PDN services a maximum of 16 hours in a 24-hour period and indicate that the amount of authorized hours of PDN services will be based on medical necessity and the primary caretaker's ability to provide care.

At N.J.A.C. 10:60-5.4(a)4, proposed amendments allow for additional hours of PDN services to be authorized in emergency situations.

Proposed new N.J.A.C. 10:60-5.4(a)5 allows for additional PDN hours to be authorized to allow for a change in the beneficiary's medical condition, which requires the nurse to train the primary caregiver to address the change in treatment.

At N.J.A.C. 10:60-5.4(c)1, the term "parental" is changed to "primary care provider" in recognition of the fact that the child's primary caregiver may or may not be the parent.

Proposed new N.J.A.C. 10:60-5.4(c)1i requires that the additional work or sibling care related responsibilities of the primary caregiver, as well as the added stress of caring for the beneficiary needing PDN services shall be considered when determining the level of support needed.

At N.J.A.C. 10:60-5.4(c)2, proposed amendments delete the reference to "sibling care responsibilities," since that phrase is now included in proposed N.J.A.C. 10:60-5.4(c)1i described above, and add the phrase "adult care support within the household" as an additional situational criteria to be considered when determining the need for EPSDT/PDN services and the number of authorized hours.

Proposed new N.J.A.C. 10:60-5.4(g) prohibits the use of PDN services for respite, supervision, or as substitution for routine parenting tasks.

Proposed new N.J.A.C. 10:60-5.4(h) allows for one nurse to provide PDN services to a maximum of two siblings in the same household provided that there is no health risk to either child.

The heading of N.J.A.C. 10:60-5.5 is proposed for amendment to delete "nursing assessment."

At N.J.A.C. 10:60-5.5(a), proposed amendments change who is responsible for the initial nurse assessment from a DMAHS regional staff nurse to a nurse employed from a variety of agencies approved by DMAHS.

At N.J.A.C. 10:60-5.5(b), (c), and (e), proposed amendments change "nurse assessor" to "assessor" and an additional amendment at subsection (b) removes an unnecessary reference to EPSDT/PDN.

At N.J.A.C. 10:60-5.5(d), a proposed amendment adds private duty nursing provided by private insurance or in school to the list of service hours to be deducted from the total hours authorized.

At N.J.A.C. 10:60-5.6(c), proposed amendments clarify that the clinical case shall be directly supervised once every 30 days.

Proposed new N.J.A.C. 10:60-5.6(c)1 through 6 states specific requirements related to case supervision, including that the visit occur during a nurse's scheduled shift, that the times be rotated so each nurse providing services is observed, that documentation be reviewed, that any concerns raised by the client or primary caretaker must be addressed prior to that individual returning to work, and that follow-ups with staff do not need to be face-to-face.

At N.J.A.C. 10:60-5.6(f), a proposed amendment allows for a designated agency of the DHS to provide on-site monitoring in addition to DMAHS staff.

At N.J.A.C. 10:60-5.7(b), a proposed amendment changes the requirement of submitting comprehensive summaries from every two months to submitting them with every prior authorization request.

The heading of N.J.A.C. 10:60-5.8 is proposed for amendment to delete "home and community-based services waiver" and replace it with MLTSS.

At N.J.A.C. 10:60-5.8(a), proposed amendments remove references to waiver programs and replace them with references to MLTSS because the home care services once provided under those various waivers are now included in MLTSS and also indicate that prior authorization is done by the NJ FamilyCare MCO and not the individual divisions listed.

Proposed new N.J.A.C. 10:60-5.8(b) describes when MLTSS/PDN services are appropriate. These requirements include that the client must have a severe illness requiring complex skilled care; the presence of an adult primary caregiver who accepts responsibility for the beneficiary and who agrees to be trained in the care of the beneficiary and provide at least eight hours of care each day, and that the home be able to accommodate the required equipment and personnel.

The heading of N.J.A.C. 10:60-5.9 is proposed for amendment to delete "home and community services waiver" and replace it with MLTSS.

At N.J.A.C. 10:60-5.9(a), a proposed amendment replaces the term "home and community-based services waiver/private duty nursing" with "MLTSS/PDN."

At N.J.A.C. 10:60-5.9(a)1, proposed amendments replace "EPSDT" with "MLTSS" to indicate under which program these services are provided and indicates that services are authorized by the MCO and the MLTSS care manager, not the State.

At N.J.A.C. 10:60-5.9(b), proposed amendments replace references to various obsolete waiver programs with references to MLTSS and describe how MLTSS shall provide supplemental payments for PDN services when such services are at least partially covered by alternative sources, such as medical day care, school, or other insurance, including a requirement to comply with an annual cost threshold.

At N.J.A.C. 10:60-5.9(c), proposed amendments replace references to various obsolete waiver programs with a reference to MLTSS and remove reference to citations that will be made obsolete by their proposed repeal.

Proposed new N.J.A.C. 10:60-5.9(c)1, 2, and 3 describe factors used in determining how many hours of MLTSS/PDN services shall be authorized, including the assessment and review requirements; the need for an adult primary caregiver to agree to provide at least eight hours of care every 24-hour period, after proper training; and the authority of the MCO or DMAHS to authorize limited additional hours of MLTSS/PDN services in emergency circumstances.

Proposed new N.J.A.C. 10:60-5.9(d) describes how medical necessity will be determined for MLTSS/PDN services, including dependence on medical interventions or specific medical conditions.

Proposed new N.J.A.C. 10:60-5.9(e) does not allow for MLTSS/PDN services to be provided for the medical conditions listed in subsection (d) if they do not require the level of skilled nursing care described in

subsection (d), for example, a patient requiring gastrostomy feedings who does not exhibit frequent regurgitation and/or aspiration.

Proposed new N.J.A.C. 10:60-5.9(f)1 provides factors that should be considered when determining the level of assistance to be provided once medical necessity has been established. This includes responsibilities related to additional work or dependents and the stress of caring for the beneficiary requiring the PDN services; additional support available in the household; and alternative sources of nursing care.

Proposed new N.J.A.C. 10:60-5.9(g) allows for one nurse to provide MLTSS/PDN services to a maximum of two beneficiaries in the same household provided that there is no health risk to either person.

The heading of N.J.A.C. 10:60-5.10 is proposed for amendment to delete "home and community-based services waver" and replace it with MLTSS.

At N.J.A.C. 10:60-5.10(a), a proposed amendment requires services provided to be authorized by and included in the beneficiary's individual service plan.

At N.J.A.C. 10:60-5.10(c), a proposed amendment corrects the name of the form used to request reimbursement.

The heading of N.J.A.C. 10:60-5.11 is proposed for amendment to delete "home and community-based services waver" and replace it with MLTSS.

At N.J.A.C. 10:60-5.11(a), a proposed amendment indicates that authorization is no longer provided by the Office of Home and Community Services and is now provided by the MCO.

Existing N.J.A.C. 10:60-6, Home and Community-Based Services Waivers for Blind or Disabled Children and Adults Community Resources for People with Disabilities (CRPD) Waiver Program, is proposed for repeal because the CRPD waiver program has been subsumed into the New Jersey 1115 Comprehensive Medicaid Waiver.

New N.J.A.C. 10:60-6, Managed Long-Term Services and Supports (MLTSS) Provided Under the New Jersey 1115 Comprehensive Medicaid Waiver, is proposed.

Proposed new N.J.A.C. 10:60-6.1(a) sets forth the purpose and scope of the MLTSS services available under the comprehensive waiver.

Proposed new N.J.A.C. 10:60-6.1(b) requires that a beneficiary's annual cost for long-term services and support cannot exceed the annual cost threshold, unless an exception is granted during the interdisciplinary team process.

Proposed N.J.A.C. 10:60-6.2(a) states that eligibility for MLTSS is based on the individual meeting established Medicaid requirements and being determined to be in need of nursing facility level of care.

Proposed new N.J.A.C. 10:60-6.2(a)1 exempts parental income and resources when determining eligibility for children.

Proposed new N.J.A.C. 10:60-6.2(a)2 requires that individuals who qualify for MLTSS be enrolled in an MCO to access MLTSS services. The regulation allows for limited MLTSS services to be authorized during any waiting period between the determination of eligibility and enrollment into the MCO.

Proposed new N.J.A.C. 10:60-6.2(b) states that individuals who had been enrolled in certain home and community-based waiver programs on or before July 1, 2014, were automatically transferred to the MLTSS services through their managed care organization.

Proposed new N.J.A.C. 10:60-6.3(c) states that participation in MLTSS is voluntary; however, those individuals who choose to participate in MLTSS are required to receive care management services as part of the benefit package. If the individual does not comply with care management services, they will be removed from MLTSS.

N.J.A.C. 10:60-7, AIDS Community Care Alternatives Program (ACCAP) Waiver, and 8, Home and Community-Based Services Waiver for Medically Fragile Children Under Division of Youth And Family Services Supervision (ABC waiver), 9, Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI Waiver), are proposed for repeal because the programs have been subsumed into the New Jersey 1115 Comprehensive Medicaid Waiver.

N.J.A.C. 10:60-10, Home and Community-Based Services Waivers Administered By Other State Agencies, is being repealed because there are no waivers of this type being administered by other State agencies.

At N.J.A.C. 10:60-11.2, the heading is proposed for amendment to include Maximum Reimbursement Rates.

At N.J.A.C. 10:60-11.2(a), subsection text introducing the table is proposed for amendment to delete "Medicaid, NJ FamilyCare-Plan A and Community Resources for People with Disabilities (CRPD) Waiver Program." Also at N.J.A.C. 10:60-11.2(a), the HCPCS codes Z1600 and Z1614 are replaced with the HCPCS codes S9122 and S9122 TV, respectively, for use when requesting reimbursement for the provision of PCA services. Additionally, the maximum reimbursement amount for S9122 and S9122 TV are being corrected to reflect the fact that the fee-for-service rate for PCA services was raised by statute to \$18.00 effective July 1, 2015. The following codes, their descriptions, and reimbursement amounts, are proposed to be deleted because they are obsolete: Z1605, Z1610, Z1611, Z1612, Z1613, Z1615, Z1616, and Z1617.

N.J.A.C. 10:60-11.2(b), which contains HCPCS codes for PCA services for the mentally ill, is proposed for deletion as a result of the proposed repeal of N.J.A.C. 10:60-4.

N.J.A.C. 10:60-11.2(c), which contains HCPCS codes for case management under the CRPD waiver and private duty nursing services under the ACCAP waiver, is proposed for deletion since those waiver programs no longer exist.

N.J.A.C. 10:60-11.2(d), which contains HCPCS codes for additional services under the ACCAP waiver, is proposed for deletion since the waiver program no longer exists.

Recodified N.J.A.C. 10:60-11.2(b) is proposed for amendment to increase the maximum fee-for-service reimbursement rates as follows: S9123EP, for EPSDT/PDN service provided by an RN, is proposed to be changed from \$40.00 per hour to \$50.00 per hour and S9124EP, for EPSDT/PDN service provided by an LPN, is proposed to be changed from \$28.00 per hour to \$38.00 per hour.

Existing N.J.A.C. 10:60-11.2(f), which contains HCPCS for the TBI program, is proposed for deletion since the waiver program no longer exists.

At N.J.A.C. 10:60 Appendix A, the proposed amendments provide the website for the New Jersey Medicaid/NJ FamilyCare fiscal agent and correct the name of the fiscal agent on the mailing address. Revised instructions on how to access the fiscal agent billing supplement for this chapter are also being proposed.

The Department has determined that the comment period for this notice of proposal will be at least 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this proposal is excepted from the rulemaking calendar requirement.

Social Impact

The proposed amendments memorialize the positive changes that have been made in the provision of home care and nursing facility services by the Department. Although the chapter is being reorganized and several subchapters are proposed for repeal, the level of services continues to be maintained or improved for Medicaid/NJ FamilyCare beneficiaries in need of these services.

There has been a positive social impact because home and community-based services are now provided under the Comprehensive Waiver as MLTSS to all beneficiaries who require a nursing facility level of care. This results in a delay, and in some cases completely avoids, the need for institutional care.

The proposed repeal of N.J.A.C. 10:60-4, Personal Care Assistant Services for the Mentally Ill, will not have an impact on providers or beneficiaries because the deletion of this language reflects an administrative reorganization of rules and not a change in policy to deny these services. These services are regulated under N.J.A.C. 10:79B, Community Support Services for Adults with Mental Illness, and are not provided by home care services providers and, therefore, do not need to be included in N.J.A.C. 10:60. The services continue to be provided without interruption, without change in provider or beneficiary requirements, and without change in billing procedures or a reduction in reimbursement.

The proposed repeal of N.J.A.C. 10:60-6, Home and Community-Based Services Waivers for Blind or Disabled Children and Adults Community Resources for People with Disabilities (CRPD) Waiver Program, will also not have an impact on beneficiaries or providers. The subchapter is repealed because the CRPD waiver program has been

subsumed into the New Jersey 1115 Comprehensive Medicaid Waiver. Again, the services continue to be provided without interruption, without change in provider or beneficiary requirements, and without change in billing procedures or reduction in reimbursement.

N.J.A.C. 10:60-6 has been rewritten and has a positive impact on Medicaid/NJ FamilyCare beneficiaries who are in need of nursing facility level of care. The MLTSS enables beneficiaries who are eligible for nursing facility level of care to receive in-home services and avoid or delay treatment in a long-term care facility. During State fiscal year (SFY) 2016, there was a monthly average of 15,421 individuals enrolled in the MLTSS program under the New Jersey 1115 Comprehensive Medicaid Waiver (the Comprehensive Waiver).

The proposed repeal of N.J.A.C. 10:60-7, 8, 9, and 10 will also have no effect on the providers of services or the beneficiaries because the deletion of these subchapters reflect the fact that the ABC Waiver program expired in 2005, and was not renewed, and that all Home and Community-Based Services waiver programs have all been absorbed by the Comprehensive Waiver and the services are now provided under MLTSS. The beneficiaries who had been receiving services under the former waiver programs were transferred into MLTSS and continued to receive the necessary services without interruption.

Economic Impact

During State Fiscal Year 2016, a monthly average of 1,779 Medicaid and NJ FamilyCare fee-for-service beneficiaries received various home care services each month under the Medicaid and NJ FamilyCare fee-for-service programs.

During State Fiscal Year 2016, the annual payments (Federal and State share combined) for specific home care services were:

Home Health Care Services	\$921,982
Personal Care Assistant (PCA) Services	\$62,800,718
ESPDT/PDN Services	\$1,213,994
Waiver Programs	\$4,868,300
TOTAL	\$69,804,994

It should be noted that the figure for home health care services includes the costs for physical therapy, occupational therapy, home health aides, medical social services, certain medical supplies, speech-language pathology, and skilled nursing services.

The proposed amendments, repeals, and new rules are expected to have a positive impact on the State since the MLTSS program will enable the State to pay a defined monthly capitation rate for provision of services rendered to the enrolled individuals instead of long-term fee-for-service nursing facility level care. During SFY 2016, there was a monthly average of 15,421 individuals receiving MLTSS under managed care at an annual cost of approximately \$629,196,671.

There will continue to be a positive fiscal impact on beneficiaries who receive home health services, since they do not currently pay for home health services and the proposed amendments and new rules do not change that policy.

The proposed amendments may have a negative economic impact on providers of home care services, if they are not enrolled as in-network providers with the managed care organizations administering the MLTSS program since the majority of these services will be provided in this manner.

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 proposed amendments, new rules, and repeals do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department anticipates that the proposed amendments, repeals, and new rules will not have an impact on employment in the State of New Jersey, and does not expect that any jobs will be gained or lost as a result of the proposed amendments. However; those home health providers currently reimbursed fee-for-service as independently enrolled Medicaid/NJ FamilyCare providers who do not choose to enroll in the networks of the managed care organizations administering the MLTSS will experience a reduction in Medicaid/NJ FamilyCare clients, which may have a negative impact on their business.

Agriculture Industry Impact

Since the proposed amendments, new rules, and repeals concern the provision of home care services to Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed rulemaking will have no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Analysis

A regulatory flexibility analysis is necessary, because many home care providers are considered small businesses, as the term is defined in the Regulatory Flexibility Act at N.J.S.A. 52:14B-17.

Providers of home care waiver services may be adversely affected by the proposed amendments, new rules, and repeals if they choose not to become enrolled in network providers of the managed care organizations which will be administering the MLTSS program.

The new rules and proposed amendments impose only minor additional recordkeeping, compliance, or reporting requirements on small businesses that currently provide services to beneficiaries, as discussed in the Summary above; specifically, the proposed requirement to document the face-to-face encounter to certify the need for home health services.

Providers are already required by statute and other rules to maintain sufficient records to document the name of the beneficiary, date and place of services, and other pertinent details regarding the provision of services, as are required by N.J.A.C. 10:60. See N.J.S.A. 30:4D-12 and N.J.A.C. 10:49.

Providers are also currently required to use the CMS Healthcare Common Procedure Coding System (HCPCS) for billing and submission of claims.

The requirements of the chapter are uniform and applicable to all providers, regardless of business size. There is no differentiation based on business size provided in the rules, because no distinction is permitted by applicable statutes. The Department will not differentiate between large and small businesses due to the need for consistent standards for provider reimbursement and quality of beneficiary care.

There are no capital costs associated with these proposed amendments, new rules, and repeals.

Housing Affordability Impact Analysis

Since the proposed amendments, new rule, and repeals concern the provision of home care services to Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that there will be no impact on the average costs associated with housing or with the affordability of housing.

Smart Growth Development Impact Analysis

Since the proposed amendments, new rule, and repeals concern the provision of home care services to Medicaid/NJ FamilyCare beneficiaries, there will be no impact on housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:60-4 and 6 through 10.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

(a) The purpose of [the home care services program, as delineated in] this chapter[,] is to [provide] **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. Community Resources for People with Disabilities (CRPD) Waiver;

ii. Home and Community-Based Services Waiver for Persons with AIDS and Children up to the age of 13 who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP);

iii. Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI);]

[iv.] i. Home and Community-Based Services Waiver for [the Mentally Retarded and] **Intellectually and/or** Developmentally Disabled (DDD-CCW) Individuals; and

[v. Home and Community-Based Services Waiver Program for Medically Fragile Children under the Division of Youth and Family Services (DYFS) Supervision (ABC); and]

[5. Home and Community-Based Services Waiver programs (1915(c) waivers) administered by the Department of Health and Senior Services (DHSS):

i. Community Care Program for the Elderly and Disabled (CCPED); and

ii. Enhanced Community Options Waiver (ECO), which provides home and community-based services to aged or disabled adults.]

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

(d) (No change.)

[(e) Requirements of the Home and Community-Based Services Waiver Programs are provided in N.J.A.C. 10:60-6, 7, 8 and 9.]

[(f)] (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 [under the personal care assistant services program, Home and Community-Based Services Waiver programs (except CCPED, Assisted Living (AL) and ECO), Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing Services, and the Traumatic Brain Injury Program] **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.

...

["Case management" is defined as the process of on-going monitoring by Division staff, of the delivery and quality of home care services, as well as the beneficiary/caregiver's satisfaction with the services. Such case management does not include the case management services provided under the home and community-based services waiver programs (N.J.A.C. 10:60-6.3(b)1 and 10.1(i)). Case management ensures timely and appropriate provider responses to changes in care needs and assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.]

"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, which include dressing, bathing, eating, using the bathroom, and other tasks associated with hygiene. 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 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 skilled nursing intervention 24-hours per day/seven days per week.

"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.

["Health services delivery plan (HSDP)" means an initial plan of care prepared by DHSS during the preadmission screening (PAS) assessment process. The HSDP reflects individual problems and required care needs. The HSDP is to be forwarded to the authorized care setting and is to be attached to the beneficiary's medical record upon admission to a nursing facility or when the beneficiary receives services from home health care agencies. The HSDP may be updated as required to reflect changes in the beneficiary's condition.]

"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.-2. (No change.)

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

["Homemaker agency" means a proprietary or voluntary non-profit agency approved by the Department of Human Services, Division of Medical Assistance and Health Services to provide Personal Care Assistant Services, and homemaker services under any waiver program approved by the Centers for Medicare & Medicaid Services and accredited, initially and on an on-going basis, by the Commission on Accreditation for Home Care Inc., the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Association for Home Care and Hospice, or the Community Health Accreditation Program (CHAP).]

["Hospice service" means a service package provided by a Medicaid approved hospice agency to beneficiaries enrolled in the AIDS Community Care Alternatives Program (ACCAP) who are certified by an attending physician as terminally ill, with a life expectancy of up to six months. The service package supports a philosophy and method for caring for the terminally ill emphasizing supportive and palliative, rather than curative care, and includes services such as home care, bereavement counseling, and pain control. (For information regarding hospice services to regular Medicaid or NJ FamilyCare fee-for-service beneficiaries under Title XIX, see the Hospice Services Manual at N.J.A.C. 10:53A.)]

"Independent activities of daily living (IADL)" means those activities needed to support independent living, 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 [KidCare] FamilyCare fee-for-service beneficiaries, upon request of the attending physician.

1.-2. (No change.)

["Long Term Care Field Office (LTCFO)" means a unit of DHSS.]

"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 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 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 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 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).

"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, 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 [homemaker/personal care assistant provider agency] 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, 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, [as] certified [by a physician] 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 [or homemaker] 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] Medicaid/NJ FamilyCare eligible within 180 days following admission to a [Medicaid] Medicaid/NJ FamilyCare certified nursing facility, and who are seeking admission to a [Medicaid] Medicaid/NJ FamilyCare certified nursing facility or [a waiver program receive a preadmission screening by DHSS professional staff to determine appropriate placement prior to admission to a nursing facility or enrollment in a waiver program pursuant to N.J.S.A. 30:4D-17.10 (P.L. 1988, c.97).] 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] 24-hour responsibility for the health and welfare of the beneficiary. For the beneficiary to receive private duty nursing services under [ACCAP, Community Resources for People with Disabilities (CRPD), ABC,] MLTSS or EPSDT, the primary caregiver must reside with the beneficiary and provide a minimum of eight hours of [hands-on] 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 [Community Resources for People with Disabilities (CRPD), ABC, and ACCAP] MLTSS, as well as eligible EPSDT beneficiaries.

"Private duty nursing agency" means either a licensed Medicare-certified home health agency, [voluntary non-profit homemaker agency, private employment agency and temporary-help service agency] an accredited home health care services firm, or a hospice agency, approved by DMAHS to provide private duty nursing services under [the Community Resources for People with Disabilities (CRPD), ABC, ACCAP or EPSDT programs] 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 [KidCare] **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 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 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] **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] **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 [homemaker agency] **health care service firm**, as defined in N.J.A.C. 10:60-1.2;

[i. A new provider shall be issued a Medicaid Provider Billing Number by the fiscal agent. Those Personal Care Assistance (PCA) providers already enrolled as providers of homemaker services in the CCPED program (see N.J.A.C. 10:60-10.1) shall use the same Medicaid Provider Billing Number issued for CCPED.]

3.-4. (No change.)

(b) [The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency] **Health care service firms** shall be accredited, initially and on an ongoing basis, by [the Commission on Accreditation for Home Care, Inc., the Community Health Accreditation Program, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the National Association for Home Care and Hospice] **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] **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 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 DHSS Long-Term Care Field Office (LTCFO)] and the NJ FamilyCare Managed Care Organization or DHS-designated entity

(a) [Preadmission screening (PAS)] **Prior authorization** shall be required for all Medicaid-eligible or NJ [FamilyCare-Plan A-eligible] **FamilyCare-eligible** individuals and [other] **non-Medicaid eligible** individuals applying for nursing facility (NF) services [or the Home and Community-Based Services Waiver programs. DHSS]. **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 [PAS] clinical eligibility assessments and/or determinations of individuals in [hospitals] health care facilities and community settings to evaluate [need] eligibility for nursing facility [services and to determine the] 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.** [Individuals in hospitals or community settings who are referred for nursing facility care and who have been determined by the LTCFO not to require nursing facility placement, or who select alternatives to nursing facility care, will be referred for home care services.]

(b) A health services delivery plan (HSDP) will be completed by the DHSS staff at the conclusion of the PAS assessment and shall be a component of the referral package to the home care provider. The HSDP shall be forwarded to the authorized setting and shall be attached to the beneficiary’s medical record upon admission to a nursing facility or when the beneficiary receives home care services. The HSDP provides data base history that reflects current or potential health problems and required services. For individuals deemed appropriate for a Home and Community-Based Services Waiver administered by the Department of Human Services, the PAS assessment and HSDP will be forwarded to the DDD for enrollment and issuance of the approval letter.]

[(c)] **(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. [Following the initial visit, the provider shall advise DDS or DMAHS or its designated agent, using the CMS 485 form, that services have begun for the beneficiary. Providers shall use this form even when the Medicaid or NJ FamilyCare fee-for-service beneficiary is not a Medicare beneficiary. The CMS 485 form shall be submitted to the MACC that serves the county in which the beneficiary resides and shall be postmarked within five business days of initial assessment, reassessment, or termination. MACCs shall not accept faxed CMS 485 forms. If DDS or DMAHS discovers that a home health agency did not submit the documentation within the prescribed time frame, DDS or DMAHS shall recover any payments for services rendered from the sixth business day of initial assessment until a completed CMS 485 form is received by DDS or DMAHS. In cases when the beneficiary is eligible for both Medicare and Medicaid fee-for-service or NJ FamilyCare fee-for-service programs, the CMS 485 form shall be completed and submitted to the MACC within five business days of the date on which the Medicaid/NJ FamilyCare fee-for-service program becomes the primary payer.

1. The CMS 485 shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician authorizing the services, however, shall be kept on file in the agency, with the prescription, as necessary or appropriate, based on the service. Providers shall enter the Medicaid Eligibility Identification (MEI)

Number or NJ FamilyCare Identification Number in block 1 when completing the CMS 485, 486 or 487 form. For the non-Medicare certified agency, the provider shall submit to the MACC an MACC approved notification form which shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services shall be kept on file in the agency.

2. The CMS 485 shall be submitted to the MACC upon initiation of services and every 62 days thereafter on a continuing basis. If at any time there occurs a significant change in the beneficiary's plan of care and there is an increase of 50 percent or more of a particular skilled home care service, the agency shall submit a CMS 485 or 486 or 487 as the circumstances warrant to the MACC. Providers shall notify the MACC, using the CMS 485, when services have been terminated.

3. Upon receipt of the CMS 485 form, using a case screening methodology, DDS or DMAHS staff shall conduct concurrent reviews on a selected number of cases, by making on-site visits to Medicaid/NJ FamilyCare fee-for-service beneficiaries at their places of residence. DDS or DMAHS staff will use the standards listed in (c) through (j) below to conduct the review.

4. If DDS or DMAHS determines that the services provided were in compliance with the standards listed in (c) through (j) below, payment shall continue to be made to the provider. If DDS or DMAHS determines that the services provided were not in compliance, or should be reduced, DDS or DMAHS will notify the provider and beneficiary in writing if there is a disparity of need determined which would result in a change in service(s). If a provider and/or beneficiary disagrees with DDS' or DMAHS' determination, a fair hearing may be requested in accordance with procedures set forth in N.J.A.C. 10:60-1.10 and 10:49-9.14 and 10.] **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.**

[5.] 1. On a random selection basis, MACC staff [shall] 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.

[6.] 2. (No change in text.)

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

(d) [Homemaker-home] 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 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 [homemaker agency and a private duty nursing agency] **health care service firm**, 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 [(Home Care Agency Review Form, FD-342)] **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 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. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.

(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.**

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 [in cooperation with agency personnel]**. 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 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) For home health services provided before January 1, 1999, the New Jersey Medicaid and the NJ FamilyCare fee-for-service programs follow the Medicare principles of reimbursement which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or

2. The published cost limits; or

3. Covered charges.

(b) For services provided prior to January 1, 1999, interim reimbursement shall be made on the basis of 100 percent or less (if reasonable allowable cost is anticipated to be less) of covered charges.

(c) For services provided prior to January 1, 1999, retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.]

[(d)] (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 [and (e) below]. 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

[(e) Effective for services rendered on or after January 1, 1999 through December 31, 1999, home health agencies shall be reimbursed 90 percent to 100 percent of allowable cost, which is based on Medicare principles of reimbursement as defined in (a) above. To assure appropriate cash flow, the service-specific unit rates shall be modified by DMAHS to reflect provider-specific rates for each unit of service provided to Medicaid and NJ FamilyCare fee-for-service beneficiaries. The provider-specific unit rates shall be calculated by adjusting the base unit rates in (d) above to approximate the reimbursable cost the home health agency is incurring in providing covered services to Medicaid and FamilyCare fee-for-service beneficiaries. A final reconciliation shall be completed for the first 12-month period after the date of adoption. The final reconciliation shall be calculated by subtracting interim payments from reimbursable cost. Reimbursable cost, which represents the 90 percent to 100 percent range of allowable cost, is calculated as follows:

1. If the Medicaid/NJ FamilyCare fee-for-service payment under the proposed rates described in (d) above is greater than the allowable cost, reimbursable cost is equal to the allowable cost, which is defined at (a) above.

2. If the Medicaid/NJ FamilyCare fee-for-service payment under the proposed unit rates described in (d) above is less than or equal to 90 percent of the allowable cost, reimbursable cost is equal to the sum of the following:

- i. 90 percent of the allowable cost excluding escorts; and
- ii. 95 percent of the Medicaid/NJ FamilyCare fee-for-service programs' share of field security costs for the period in which the reconciliation is calculated. In order to receive this escort cost adjustment, each home health agency which incurs escort costs shall submit source documentation demonstrating the total amount of field security costs incurred and the Medicaid/NJ FamilyCare fee-for-service programs' share of such costs. This documentation shall be sent along with the submission of the Medicaid cost report to be used for this reconciliation to the following address:

Office of Financial Support
 Division of Medical Assistance and Health Services
 PO Box 712
 Mail Code #23
 Trenton, New Jersey 08625-0712

3. If the payment under the proposed unit rates described in (d) above is greater than 90 percent but less than or equal to 100 percent of the allowable cost, reimbursable cost is equal to the Medicaid/NJ FamilyCare fee-for-service payment in accordance with (d) above.]

[(f)] (b) Effective January 1, 2000, and thereafter, the reimbursement rates shall be the service-specific Statewide per unit rates found in [(d)] (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. Home health agencies shall maintain both unit and visit statistics for all services provided to [Medicaid and NJ FamilyCare] Medicaid/NJ FamilyCare fee-for-service beneficiaries.

[(g)] (c) Effective January 1, 1999, home health agencies shall bill the [Medicaid and NJ FamilyCare] 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 or NJ FamilyCare] 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 [UB-92] 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 [(d)] (a) above and Revenue Code 270. No other revenue codes will be reimbursed for home health services.

[(h)] (d) Home health agencies shall submit a cost report for each fiscal year to the Director, Office of [Financial Support] Reimbursement, Division of Medical Assistance and Health Services, [Mail Code # 23,] 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 [(h)2] (d)2 above, the provider shall submit a written request to, and obtain written approval from, the Director, [Administrative and Financial Services] Office of Reimbursement, Division of Medical Assistance and Health Services, [Mail Code #42,] 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 [KidCare] 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 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 liability for the home health services will result in a lower cost to the Division. If paying the patient'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 [or by a proprietary or voluntary non-profit accredited homemaker agency], a **certified hospice agency or by a health care service firm that is accredited, initially, and on an ongoing basis, by an accrediting body approved by DMAHS.**

(b) Personal care assistant services include [personal care, household duties and] health related tasks **associated with the cueing, supervision and/or completion of the activities of daily living (ADL), as well as independent 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 by a physician in accordance with a written plan of care.** These services are available from a home health agency or a [homemaker agency] **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. [Household duties] **Independent activities of daily living** are those [services] activities described at N.J.A.C. 10:60-[3.3(a)2]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 provide assistance with non-hands-on IADL care tasks, such as household/cleaning, laundry, and shopping.**

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[, including:] **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 [Youth and Family Services' (DYFS)] **Child Protection and Permanency** foster care home; [or]

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) [Personal] **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 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;**

iii.-vii. (No change.)

[viii. Eating and preparing meals, including special therapeutic diets for the beneficiary;]

viii. **Assistance with eating, such as, placing food and/or liquids into mouth, and assistance with swallowing difficulties;**

ix. Dressing; and

[x. Relearning household skills; and]

[xi.] x. Accompanying the beneficiary, **for the purpose of hands-on assistance**, 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.

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

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

[iii.] 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.)

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

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

10. **Relearning household skills.**

[3.] (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.)

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

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

7. **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 FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the [home health agency or homemaker agency] **health care services firm** by [the attending] a physician or 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 counter signature[, in conformance with written agency policy] **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 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 temporarily loses managed care eligibility, but is expected to re-enroll the following month, shall be provided fee-for-service until the client is reenrolled in their 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 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, and the beneficiary changes his or her physician. 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 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, [and] 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. 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 months or more frequently if the beneficiary's condition warrants, to reevaluate the beneficiary's need for continued care. **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 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; [and]

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 [hour] **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 and NJ FamilyCare-Plan 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. Licensed pediatric community transition homes;]

[6.] **5.** (No change in text.)

[7. DYFS-supervised group homes for children enrolled in the ACCAP waiver;]

[8.] **6.** (No change in text.)

[9.] **7.** TBI community residential service facilities; **and**

[10.] **8.** [DHSS Enhanced Community Options (ECO) waiver programs:] Adult Family Care, Assisted Living Program, [and the Caregiver Assistance Program (CAP).] **and Assisted Living Residence.**

[11. DHSS Assisted Living Waiver Programs: Assisted Living Residence and Comprehensive Personal Care Home.]

(b) Except as specified [in this subsection] **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 [every six months] **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, **regardless of age of the beneficiary;**

3.-4. (No change.)

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

6. Services to individuals with mental health service needs, which are provided by the Division of Mental Health **and Addiction Services** [in accordance with N.J.A.C. 10:60-4.1].

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 services that are unused for any reason including, but not limited to, illness of the client or home health aide, or hospitalization of the client 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. [A] **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 [(FD-410)], 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 [(FD-410)], 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] **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, [voluntary non-profit homemaker agency, private employment agency and temporary-help service agency] **licensed hospice agency or an accredited healthcare services firm** approved by DMAHS. The [voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency] **healthcare services firm** shall be accredited, initially and on an ongoing basis, by [the Commission on Accreditation for Home Care, Inc., the Community Health Accreditation Program, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the National Association for Home Care and Hospice] **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 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 [under Community Resources for People with Disabilities (CRPD), ABC, ACCAP,] **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 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, up to eight hours per day, 40 hours per week. The family member of the client may not serve as the supervising RN responsible for developing the treatment plan for the client. 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 [fee-for-service] program and referred by a parent, primary physician, hospital discharge planner, Special Child Health Services case manager, [Division of Developmental Disabilities (DDD),] Division of Disability Services (DDS), Division of [Youth and Family Services (DYFS)] **Child Protection and Permanency (DCP&P),** Division of Mental Health and Addiction Services ([DMHS] **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 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 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 [FFS] 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] **Medicaid/NJ FamilyCare** managed care, private duty nursing is authorized and provided by the [HMO] **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 and agrees to receive additional training for new procedures and treatments, if directed to do so by a State agency; **and**

3. The primary caregiver agrees to provide a minimum of eight hours of hands-on care to the individual during every 24-hour period; and]

[4.] 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). [A maximum of 16 hours of private duty nursing services may be provided in any 24-hour period].

3. The determination of the total EPSDT/PDN hours approved[, up to the maximum 16 hours per 24-hour period] 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 [16-hour limit] **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 [parental] **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;

2. Additional [sibling care responsibilities] **adult care support within the household;** and

3. Alternative sources of nursing care.

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

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

(h) 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 at the same time in a single household.

10:60-5.5 [Nursing assessment for the determination] **Determination** of medical necessity for EPSDT/PDN Services

(a) An initial on-site nursing assessment [by a DMAHS regional staff nurse assessor] 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 [nurse] 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 [(EPSDT/PDN)], 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 [nurse] 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 [nurse] 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. [at a minimum of one visit] **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 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, [every two months] **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 [home and community-based services waiver/private] **managed long-term supports and services (MLTSS)/private duty nursing (PDN) services**

(a) [Home and community-based services waiver/private] **MLTSS/private duty nursing** is available only to a beneficiary who meets nursing facility level of care criteria, is based on medical necessity, and is prior approved by [DMAHS/DDS/DDD] **the NJ FamilyCare MCO** in a plan of care prepared by a [waiver program case] **MLTSS care manager**. [Home and community-based services waiver/private] **Private duty nursing** is individual, continuous nursing care in the home, and is a service available to a beneficiary only after enrollment in [ABC, ACCAP, or Community Resources for People with Disabilities (CRPD)] **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 skilled nursing intervention 24 hours per day/seven days per week.

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

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 [home and services waiver/private duty nursing (waiver/PDN)] **MLTSS/PDN services**

(a) [Home and community-based services waiver/private duty nursing] **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 [EPSDT/PDN] **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 [EPSDT/PDN] **MLTSS/PDN services**. Only those [EPSDT/PDN] **MLTSS/PDN beneficiaries** who require, and are authorized by [DMAHS/DDS/DDS] **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 [Community Resources for People with Disabilities (CRPD), ABC, or ACCAP] **MLTSS**. Under [CRPD, ABC and ACCAP] **MLTSS**, when payment for private duty nursing services is being provided or paid for by another source (that is, insurance), [DDS or DMAHS] **MLTSS** shall supplement payment up to a maximum of 16

hours per [day.] 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[, if]; shall be medically necessary[.]; and, [if cost of service provided by the Division is less than institutional care] 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 [CRPD, ABC and ACCAP] 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. [(See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.)]

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 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.

(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 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 [home and community-based services waiver/PDN] MLTSS/PDN services

(a) A provider of private duty nursing services shall be reimbursed by the New Jersey [Medicaid] 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] Medicaid/NJ FamilyCare program.

1. (No change.)

(b) (No change.)

(c) Home health services are billed on the [UB-92 CMS-1450] institutional claim form (see Fiscal Agent Billing Supplement).

(d) (No change.)

10:60-5.11 Prior authorization of [home and community-based services waiver/PDN] 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 [Office of Home and Community Services] 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

HUMAN SERVICES

PROPOSALS

and face-to-face visits. Failure to comply with care management services shall result in removal from the MLTSS benefit package.

SUBCHAPTERS 7. THROUGH 10. (RESERVED)

SUBCHAPTER 11. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:60-11.2 HCPCS [Codes] codes and maximum reimbursement rates

(a) PERSONAL CARE ASSISTANT SERVICES [FOR MEDICAID, NJ Familycare-Plan A AND COMMUNITY RESOURCES FOR PEOPLE WITH DISABILITIES (CRPD) WAIVER PROGRAM]

HCPCS Code	Mod	Description	Maximum Rate
[Z1600]		Personal Care Assistant Service (Individual/hourly/weekday)	[\$15.50]
S9122			\$18.00
[Z1605]		Personal Care Assistant Service (Group/hourly/weekday)	\$11.76
Z1610		Initial Nursing Assessment Visit	\$35.00
Z1611		Personal Care Assistant Service (Individual/ 1/2 hour/weekday)	\$7.75
Z1612		Personal Care Assistant Service (Group/ 1/2 hour/weekday)	\$5.88
Z1613		Nursing Reassessment Visit	\$35.00
[Z1614]	TV	Personal Care Assistant Service (Individual/hourly/weekend/holiday)	[\$16.00]
S9122			\$18.00
[Z1615]		Personal Care Assistant Service (Individual/ 1/2 hour/weekend/holiday)	\$8.50
Z1616		Personal Care Assistant Service (Group/hourly/weekend/holiday)	\$12.00
Z1617		Personal Care Assistant Service (Group/ 1/2 hour/weekend/holiday)]	

(b) PERSONAL CARE ASSISTANT SERVICES FOR THE MENTALLY ILL
(Applicable to clinics under contract to the Division of Mental Health Services of the Department of Human Services):

HCPCS Code	Mod	Description	Maximum Fee Allowance		
			S	NS	NS
Z1600	ZI	Personal Care Assistant Services Individual, per hour	13.02	13.02	
Z1605	ZI	Personal Care Assistant Service Group, per hour	10.23	10.23	
Z1610	ZI	Personal Care Assistant Services Initial Nursing Assessment, per visit	35.00	35.00	
Z1611	ZI	Personal Care Assistant Services Individual, per hour	6.51	6.51	
Z1612	ZI	Personal Care Assistant Services Group, per half hour	5.12	5.12	
Z1613	ZI	Nursing Reassessment Visit, per visit	35.00	35.00	

(c) HCPCS CODES FOR COMMUNITY RESOURCES FOR PEOPLE WITH DISABILITIES (CRPD) PROGRAM AND AIDS COMMUNITY CARE ALTERNATIVES PROGRAM (ACCAP)

HCPCS Code	Description	Maximum Rate
COMMUNITY RESOURCES FOR PERSONS WITH DISABILITIES (CRPD)		
Z1700	Case Management, per beneficiary/per month	\$115.00
CRPD and AIDS COMMUNITY CARE ALTERNATIVES PROGRAM PDN SERVICES		
Z1710	PDN-RN, Per Hour/Weekday	\$35.00

HCPCS Code	Description	Maximum Rate
Z1715	PDN-LPN, Per Hour/Weekday	\$23.00
Z1720	PDN-RN, Per Hour/Weekend/Evening/Holiday	\$35.00
Z1725	PDN-LPN, Per Hour/Weekend/Evening/Holiday	\$23.00
Z1730	PDN-RN Specialty, Per Hour/Weekday	\$40.00
Z1735	PDN-LPN Specialty, Per Hour/Weekday	\$28.00
Z1740	PDN-RN Specialty, Per Hour/Weekend/Evening/Holiday	\$40.00
Z1745	PDN-LPN Specialty, Per Hour/Weekend/Evening/Holiday	\$28.00

(d) HCPCS CODES FOR AIDS COMMUNITY CARE ALTERNATIVES (ACCAP) PROGRAM

HCPCS Code	Description	Maximum Rate
Z1800	Case Management, Per Beneficiary/Month	\$125.00
Z1801	Case Management, Initial Month (one time only, per beneficiary)	\$200.00
Z1810	Hospice, daily	\$57.20
Z1820	Personal Care Assistant Service, Per Hour/Weekday/Individual	\$15.50
Z1821	Personal Care Assistant Service, Per 1/2 Hour/ Weekday/Individual	\$7.75
Z1822	Personal Care Assistant Service, Per Hour/Weekend/Holiday/Individual	\$17.00
Z1823	Personal Care Assistant Service, Per 1/2 Hour/ Weekend/Holiday/ Individual	\$8.50
Z1824	Personal Care Assistant Service, Per Hour/Weekday/Group	\$11.76
Z1825	Personal Care Assistant Service, Per 1/2 Hour/ Weekday/Group	\$5.88
Z1828	Initial Nursing Assessment Visit	\$35.00
Z1829	Nursing Reassessment Visit	\$35.00
Z1830	Methadone Treatment at Home provided only by narcotic and drug treatment centers	\$3.50
Z1831	Urinalysis for Drug Addiction at Home provided only by narcotic and drug treatment centers	\$4.50
Z1832	Psychotherapy, Full Session at Home provided only by narcotic and drug treatment centers	\$24.00
Z1833	Psychotherapy, Half Session at Home provided only by narcotic and drug treatment centers	\$12.00
Z1834	Family Therapy at Home provided only by narcotic and drug treatment centers	\$30.00
Z1835	Family Conference at Home provided only by narcotic and drug treatment centers	\$22.50
Z1850	Intensive Supervision for Children with AIDS in Foster Care Homes, per beneficiary, per month provided only by DYFS	\$1,050
Z1851	Specialized Group Foster Home Care for Children, daily	\$265.00
Z1853	Intensive Supervision for HIV-positive Children in Foster Care Homes, per beneficiary, per month provided only by DYFS	\$809.00]

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

HCPCS Code	Mod	Description	Maximum Rate
[S9123EP]	EP	PDN-RN, EPSDT, Per Hour	[\$40.00] \$50.00
S9123			
[S9124EP]	EP	PDN-LPN, EPSDT, Per Hour	[\$28.00] \$38.00
S9124			

(f) HCPCS CODES FOR TRAUMATIC BRAIN INJURY PROGRAM:

HCPCS Code	Description	Maximum Rate
Y7433	TBI-Case Management, Initial (First Month)	\$200.00
Y7434	TBI-Case Management, Continuing (Subsequent Month)	\$135.00
Y7435	TBI-Community Residential Services (Level I Supervision) 2-4 hours	\$ 99.00
Y7436	TBI-Community Residential Services (Level II Supervision) over 4-8 hours	\$115.00
Y7437	TBI-Community Residential Services (Level III Supervision) over 8 hours	\$147.00
S5102	ST TBI-Structured Day Program (Full Day)	\$ 87.00
S5101	ST TBI-Structured Day Program (Half Day)	\$44.00
Y7443	TBI-Supported Day Program (Per Hour)	\$30.00
Y7444	TBI-Personal Care Assistant Services (Weekdays, per hour)	\$15.50
Y7445	TBI-Personal Care Assistant Services (Weekends, and Holidays, Per Hour)	\$17.00
S5135	22 ST TBI-Companion Services (Per Hour)	\$11.00
Y7448	TBI-Night Supervision (8 hours)	\$112.00
S5120	ST TBI-Chore Services (Per hour)	\$10.00
Y7454	TBI-Personal Care Assistant Services, RN Initial Nursing Assessment	\$35.00
Y7455	TBI-Personal Care Assistant Services, RN Reassessment	\$35.00
Y7456	TBI-Respite 8 hour day	\$88.00
Y7458	TBI-Respite, greater than 8 hour to 12 hour day	\$128.00
Y7463	TBI-Respite greater than 12 hour to 24 hour day	\$160.00
S8990	ST TBI-Physical Therapy (Per 30 Minute Session)	\$73.00
97535	ST TBI-Occupational Therapy (Per 30 Minute Session)	\$73.00
Y7556	TBI-Speech Therapy (Per 30 Minute Session)	\$73.00
97532	22 ST TBI-Cognitive Therapy, (Per 30 Minute Session)	\$73.00
Y7558	TBI-Counseling (Behavior) (Per Hour)	\$65.00
Y7559	TBI-Counseling (Individual/Family) (Per Hour)	\$65.00
Y7564	TBI-Behavior Program (Assessment) (Per Hour)	\$75.00
H0004	22 ST TBI-Behavior Program (Psychologist) (Continuing) (Per Hour)	\$75.00
Y7566	TBI-Behavior Program (Continuing) (Per Hour)	\$35.00
Y7568	TBI-Environmental Modification (Per Service or Item)	\$5,000.00
S5109	TBI In-Home Supported Day Program	\$40.00
Y7733	TBI-Community Residential Services, (Level IV Supervision) over 8 hours/2 person assist	\$211.00]

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

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

(a)

DIVISION OF DISABILITY SERVICES

Personal Preference Program

Proposed New Rules: N.J.A.C. 10:142

Authorized By: Elizabeth Connolly, Acting Commissioner,
 Department of Human Services.

Authority: N.J.S.A. 30:6E-1 and the 1115 Comprehensive Medicaid Waiver Section 1915(j).

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2017-182.

Submit written comments by October 20, 2017, to:

Joseph M. Amoroso, Director
 Division of Disability Services
 PO Box 705
 Trenton, New Jersey 08625-0705
 Fax: (609) 631-2494
 TTY Fax: (609) 631-4364
Joseph.Amoroso@dhs.state.nj.us

Note: Fax, e-mail, and TTY information is provided to accommodate individuals with disabilities who may require alternative methods of communication to make comment.

The agency proposal follows:

Summary

Prior to the introduction of the Personal Preference Program, personal care assistance for individuals in New Jersey began in February 1984, with the initiation of Medicaid State Plan Services known as the Personal Care Assistant (PCA) Program, administered pursuant to N.J.A.C. 10:60-3.1. The program was offered as an optional State Plan Service offered to New Jersey Medicaid recipients who experienced some functional impairment and needed a personal care assistant to help them with some aspects of daily living, such as dressing or bathing. The purpose of the program is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care as is provided under Medicaid's home health program, in an effort to enable individuals to live independently at home rather than being cared for in congregate or institutional settings. PCA services encompass non-emergency health-related tasks performed by qualified staff in a medically eligible beneficiary's home. The PCA program was originally administered by the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and was later transferred to the Division of Disability Services, in 2002, and currently serves approximately 37,000 eligible beneficiaries.

In 1998, the Federal Health Care Financing Administration (HCFA) granted New Jersey a Section 1115 Research and Demonstration Waiver to permit the State to administer Personal Preference: New Jersey's Cash and Counseling Demonstration Project, as an alternative to the traditional agency model of service delivery. With grant funding from the Robert Wood Johnson Foundation, the Program was implemented in November 1999, to test a more consumer centered alternative to the traditional Medicaid Personal Care Assistant (PCA) services. New Jersey was selected as one of three states to participate in the demonstration. The demonstration included a paradigm shift in the delivery of PCA services from a traditional medical model to a consumer directed model.

Participants were offered a monthly budget in place of traditional agency PCA services in order to direct and manage their own PCA services. The program was designed to offer participants the opportunity for greater choice and control over how to best meet their individual