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
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Fax: (609) 631-2494
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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

personal care needs. Typically, under the traditional model, consumers received services as scheduled by an agency that often times were not conducive to their needs or quality of life. This demonstration program empowered participants by giving them the opportunity to control their own services by deciding by whom, when, and how their services would be delivered. Participants also had the opportunity to hire people they know and trust, including family and friends.

Due to the success of the demonstration program, which ended in July 2002, the Section 1115 Waiver was extended. The Centers for Medicare and Medicaid Services (CMS) approved New Jersey's Cash and Counseling Program, now titled the Personal Preference Program (PPP), under a Federal 1915(j) Waiver authority, as a permanent option for all Medicaid PCA recipients in 2008. In 2011, New Jersey's Medicaid program transitioned to a managed care model, and in 2014, PPP was rolled into New Jersey's Comprehensive Waiver.

The program has been fully operational as a Statewide option for New Jersey Medicaid PCA recipients, resulting in an enrollment that has tripled since 2011, serving 10,000 individuals as of April 2017. With these advancements and the program's success, the Division is now proposing new rules because it is impractical and improper to use N.J.A.C. 10:60 as the basis to define and clarify the newly available alternatives offered to participants and the current operations of the Personal Preference Program.

As the Department is providing a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

A summary of the proposed rule follows:

New N.J.A.C. 10:142-1.1 describes the purpose of the program and provides for the benefits afforded to participants.

New N.J.A.C. 10:142-1.2 describes the scope and nature of the program.

New N.J.A.C. 10:142-1.3 defines the participant's rights under the program.

New N.J.A.C. 10:142-1.4, defines the terms and words used in this chapter. Included in this chapter are new definitions for the following: "activities of daily living," "adverse agency action," "authorized representative," "budget," "budget authority," "care manager," "cash and counseling," "cash management plan (CMP)," "Centers for Medicare and Medicaid Services (CMS)," "consultant," "counseling agency," "Department," "Division," "Division of Medical Assistance and Health Services," "domestic household employee," "employer authority," "fair hearing," "fee for services," "managed care organization," "Medicaid fiscal agent," "Medicaid provider," "medical facility," "participant," "participant-directed goods and services," "participant-directed services," "personal care assistance services," "personal care assistant," "reassessment," "risk assessment profile," "self direction," "State program office," "vendor fiscal employer agent (VF/EA)," and "worker."

New N.J.A.C. 10:142-1.5 describes the administration and location of the program within the government of the State of New Jersey.

New N.J.A.C. 10:142-2.1 describes the eligibility requirements for the program.

New N.J.A.C. 10:142-2.2 defines the participant's responsibilities in order to be approved and maintain enrollment on the program.

New N.J.A.C. 10:142-2.3 describes the requirements for employees who are working for participants under the program, and also includes standards for hiring and termination of employment.

New N.J.A.C. 10:142-3.1 describes the screening and application process under the program for individuals who are Medicaid eligible and enrolled in a managed care organization (MCO).

New N.J.A.C. 10:142-3.2 describes the screening and application process under the program for individuals who are Medicaid fee-for-service eligible and receiving personal care assistant (PCA) services through an approved home care provider agency and for individuals newly applying for the program who are not receiving traditional agency PCA services.

New N.J.A.C. 10:142-3.3 describes the standards, roles, and responsibilities of the representative under the program. The new rules also specify procedures for addressing a change in representative, standards for representative removal, and procedures to determine approval of requests to allow participants who used a representative previously to manage services independently.

New N.J.A.C. 10:142-3.4 describes the role and responsibilities of the consultant under the program.

New N.J.A.C. 10:142-3.5 describes the standards for maintaining confidentiality and disclosure of information for program applicants and participants.

New N.J.A.C. 10:142-4.1 describes the process for determining the budget allocation for participants under the program.

New N.J.A.C. 10:142-4.2 describes the potential impact of receiving a budget allocation from the program on eligibility for other government benefits and programs, such as SSI, rental assistance, Supplemental Nutrition Assistance Program benefits (formerly known as food stamps), and student loans.

New N.J.A.C. 10:142-4.3 describes the standards for use of the budget and identifies specific expenses that may be afforded under the program. The new rules also provide for guidelines for use of the participant budget requirements for vendor documentation and procedures for obtaining environmental modifications, and documentation expenses.

New N.J.A.C. 10:142-4.4 identifies specific expense items that are prohibited under the program.

New N.J.A.C. 10:142-4.5 describes the standards and process for the development and approval of the cash management plan.

New N.J.A.C. 10:142-4.6 describes the penalties that may result in event of overspending the cash management plan and corrective action procedures for participants that may result.

New N.J.A.C. 10:142-4.7 describes the process and procedures for monitoring and modifying cash management plans.

New N.J.A.C. 10:142-5.1 describes the process for application disposition and providing for subsequent notification to participants.

New N.J.A.C. 10:142-5.2 describes the enrollment process and start date for the implementation of services under the program.

New N.J.A.C. 10:142-5.3 describes the standards for use of services under the program and includes procedures to address service provision for participants temporarily out-of-State.

New N.J.A.C. 10:142-6.1 describes the process for assessing a participant's continued ability for self-direction and management of services under the program.

New N.J.A.C. 10:142-6.2 describes the reassessment requirements for participants for continued eligibility and the penalties for non-compliance with the requirements that may result for participants.

New N.J.A.C. 10:142-6.3 describes the process for changes in scope, duration, and/or frequency of services, and procedures for notifying participants accordingly.

New N.J.A.C. 10:142-7.1 describes the responsibilities of the Vendor Fiscal Employer Agent (VF/EA).

New N.J.A.C. 10:142-8.1 describes the standards and procedures for voluntary disenrollment of services for participants enrolled under the program.

New N.J.A.C. 10:142-8.2 describes the standards and procedures for involuntary disenrollment of services for participants enrolled under the program. The rules prescribe that disenrollment due to non-compliance shall be immediate.

New N.J.A.C. 10:142-8.3 describes the process for addressing reinstatement requests back into the program, including time frames for reactivation of participant's program account to enable receipt of services. The new rules also provide for standards and conditions, including restitution, for program reinstatement in event of substantiation of Medicaid fraud or abuse.

New N.J.A.C. 10:142-9.1 describes the process for requesting an administrative review under the program conducted by the Division of Disability Services to assure that program policy is being followed.

New N.J.A.C. 10:142-9.2 describes the process and procedures for initiation of adverse agency actions and appeal rights for participants.

New N.J.A.C. 10:142-9.3 describes the fair hearing and appeal process and includes details on how to request a hearing.

New N.J.A.C. 10:142-9.4 describes the outcomes and procedures to follow regarding service provision to participants as a result of fair hearing proceedings.

New N.J.A.C. 10:142-10.1 describes the procedures and contact information for reporting allegations of Medicaid fraud and abuse.

Social Impact

In accord with the mission of the Department of Human Services and the Division of Disability Services, the Personal Preference Program has its greatest social impact by providing eligible Medicaid beneficiaries an option to self-direct their own personal care services. This option allows participants to transfer their PCA benefits from an agency into personal preference, so that they can hire whomever they want to provide their care and decide for themselves how their care will be provided. This option offers participants freedom, choices, and buying power to get the most out of their PCA benefits.

The Division finds that consumers who choose the self-direction option are getting more of the services to which they are entitled and are reporting greater satisfaction, better quality of life, and fewer unmet needs as a result of program enrollment. The Division believes that this is due to the fact that the program enables participants to choose who will render care, and to determine how and when care will be rendered to meet each of their individual needs. This level of flexibility and self-direction is not available using traditional agency services, which generally focus on a service delivery system in a more prescribed manner rather than on participant choice. The Division believes that the program addresses four main phenomena that exist in the traditional agency driven model of home care in New Jersey that limit recipient access to services for which they have been determined to be entitled:

1. New Jersey's home care agencies historically have difficulty finding and maintaining adequate numbers of home health aides to support the number of Medicaid PCA beneficiaries, due to a high attrition and turnover in the available work force. As a result of the short supply in staff, service delivery is prescribed by agency assignment based on availability and priority of need of the individual, which involves schedule rotation as deemed necessary, causing disruption of both developing and long-standing service relationships.

2. The beneficiary population is composed of diverse cultures and languages. Home care agencies are sometimes unable to provide an aide who is able to speak the participant's language and who is familiar with their culture.

3. New Jersey has many rural areas in which home care agencies are unable to staff PCA cases. Many PCA recipients in these areas have gone without care or been provided with less care than they have been approved to receive. Public transportation may be inadequate in rural areas, making it difficult for agencies to attract workers.

4. Beneficiaries are frequently left to cover an agency shortfall in service by utilizing "natural supports" of friends, neighbors, and other family members to provide care. These individuals may be happy to assist a friend or relative, but are unwilling to work for a home health agency. The program allows these individuals to be compensated and regulated to both the betterment of the caregiver and the recipient. With an eye to the future, the Division believes that as the "baby boom" generation continues to age and requires care, traditional agency recourses will be unavailable to meet their needs. The Division believes the program offers an alternative solution to the service delivery methods available at the present time.

Economic Impact

The proposed new rules will have little impact on future Medicaid costs as the majority of participants are enrolled in managed care, whereby the costs are paid out of pre-determined capitation rates determined to be cost neutral.

Federal Standards Statement

A Federal standards analysis is not required because the new rules and program operations meet compliance standards mandated by the Federal Centers for Medicare and Medicaid Services (CMS) for administration of the program, and requirements under the Americans With Disabilities Act (ADA) of 1990 (42 U.S.C. §§12101 et seq). The Division is required to adhere to all requirements established under the Federal 1915(j) Waiver authority, which granted initial and on-going approval to enable continued Medicaid funding to support the program. The program also enables continued Medicaid funding to support the program. The program also meets the requirements as established under the ADA of 1990, and as a result, a Federal standards analysis is not required.

Jobs Impact

The proposed new rules will have minimal impact on the number of jobs gained or lost in the State. The Division will continue to employ a full-time staff to oversee program operation and administration. Historically, as well as currently, the program has served as a secondary employment market for those individuals who have been volunteering care or may not have chosen to work in the first place.

Agriculture Industry Impact

The proposed new rules will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The proposed new rules have been reviewed with regard to Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The program will establish participants as the employer of record as defined by the Internal Revenue Service (IRS) at Section 3504 of the IRS Code and Revenue Procedure 70-6f. As such, for small businesses, and for the purposes of the proposed new rules, participants are subject to the same reporting, recordkeeping, and other Federal and State compliance requirements.

The Vendor Fiscal Employer Agent (VF/EA) under contract with the State provides participants with assistance with reporting and recordkeeping, for a nominal fee, which is paid for out of the State budget, to ensure compliance with all requirements. No capital costs are anticipated to be required as a result of the proposed new rules. No professional services are to be required with the new rules. Pursuant to contract, the Vendor Fiscal Employer Agent is required to routinely and annually provide reports that address areas of compliance for the program including, enrollment, cash disbursements, overall utilization, and monies unused.

Housing Affordability Impact Analysis

The proposed new rules will have an insignificant impact on the affordability of housing in New Jersey. It is unlikely that the rules would effect a change in the average costs associated with housing because the rules pertain only to the administration of the Personal Preference Program, which has no impact on housing.

Smart Growth Development Impact Analysis

The proposed new rules will have an insignificant impact on smart growth. It is unlikely that the rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules pertain only to the Personal Preference Program, which has no effect on housing.

Full text of the proposed new rules follows:

CHAPTER 142
PERSONAL PREFERENCE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

10:142-1.1 Purpose

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

1. Provide eligible Medicaid beneficiaries an option to self-direct their own personal care services;

2. Offer participants a greater opportunity for choice and control over how to best meet their individual personal care needs;

3. Empower participants by giving them the opportunity to control their own services by deciding by whom, when, and how their services would be delivered; and

4. Offer the participants buying power to get the most out of their program benefits.

10:142-1.2 Scope and nature

(a) The Personal Preference Program shall serve as an alternative delivery mechanism for eligible Medicaid PCA services.

(b) Participants in the program shall be given both employer and budget authority to hire their own care providers within the scope of this chapter and compensate the care provider(s) using financial resources that would have been paid to a provider agency within the scope of the traditional PCA delivery model.

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

(d) Participants will be educated in how to develop and generate a back-up plan independently.

(e) Participants shall be afforded an assessment and determination of needs that is similar in nature and value to that available under the traditional agency PCA model as described at N.J.A.C. 10:60-3.1.

10:142-1.3 Participant rights

(a) Participants are afforded the following rights under the Personal Preference Program:

1. To create a cash management plan and make required changes to meet their own personal needs within the program guidelines for using the budget;

2. To have the expectation of privacy and confidentiality, and to be treated with dignity and respect;

3. To make decisions about their own care;

4. To decide how to use a budget within program constraints, or to have someone of choice help with decisions about the program;

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

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

7. To change his or her representative, as appropriate, at any time;

8. To be represented at meetings pertaining to the program; and

9. To register a complaint with the State program office for any reason, on any matter related to the program.

10:142-1.4 Definitions

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

"Activities of daily living (ADLs)" are each of the six tasks that determine a participant's ability to self-care. They are: eating, bathing, dressing, toileting, transferring (walking), and continence, which can be provided by a personal care assistant.

"Adverse agency action" is defined as an administrative action performed resulting in either a denial, reduction, or disenrollment of services, a denial of a request for an exception, a denial of a request for increase in service benefits, or a failure to act upon a request for services within prescribed time frames. Such actions may be performed by either: a managed care organization (MCO) or by the Division.

"Authorized representative" is defined as a surrogate decision maker, who is at least 18 years of age, serves in an unpaid capacity, and is present and available to meet in person with the participant on a regular basis, to provide assistance with choices and decision making, and ensuring that services are being performed in accordance with the cash management plan. Types of authorized representatives include the following:

1. "Pre-determined representative" is used in circumstances where a representative has been court appointed;

2. "Voluntary representative" is used in circumstances where the participant chooses to use someone of his or her choosing to assist with managing the program;

3. "Mandated representative" is a term and condition for continued participation in the program, which is used in circumstances, such as misspending of cash allocation, or when the nature of one's disability involves diminished cognitive functioning, resulting in the inability to self-direct services; or

4. "Surrogate representative" is used in circumstances in which the pre-determined representative (under paragraph 1 above) selects another individual to act in his or her place.

"Budget" means the value of a cash management plan (CMP).

"Budget authority" means the participant, or authorized representative, where appropriate, has the responsibility to manage his/her budget, determine the types of goods and services to be purchased, and establish their worker's wage rates.

"Care manager (CM)" means an individual employed by a managed care organization (MCO), or by a State-contracted care management agency, who provides enrollee-centered, goal-oriented, culturally relevant assistance to assure that an enrollee receives needed services in a supportive, effective, efficient, timely, and cost-effective manner.

"Cash and counseling" is defined as a system for delivery of personal care services using the concept of consumer direction, which is the foundation of the Personal Preference Program. A monthly allowance is issued to the participant in place of traditional personal care assistance (PCA) services, who, with the guidance of a consultant, purchases, goods, and services to meet personal care needs.

"Cash management plan (CMP)" means a document used by the Personal Preference Program participant to define the services they need and to budget the monthly cash allowance accordingly. The CMP is a mandatory document prepared by the participant, and made effective following approval by the State Program Manager or designated State staff. The CMP serves as the participant's budget document for the program and must be adhered to for the length of enrollment in the program. The CMP shall be amended as necessary to reflect changes in the awarded and approved services.

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

"Consultant" is defined as an individual employed by the counseling agency, or counseling entity, that is under contract with the Division. The consultant provides counseling services related to consumer direction to participants and their representatives, and provides front line support to guide individuals in effectively managing their roles as a participant in a participant directed program. The consultant provides programmatic counseling and assists in the development of the participant's budget, as well as updates, as necessary.

"Counseling agency" also referred to as "counseling entity" means an agency that is under contract directly with either the State of New Jersey or the Vendor Fiscal Employer Agent to serve as a source of consultant services and provide financial counseling for Personal Preference Program participants.

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

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

"Division of Medical Assistance and Health Services (DMAHS)" means the agency within the New Jersey Department of Human Services, that administers the New Jersey managed care organization (MCO) contract on behalf of the Department. DHS is the single State Medicaid agency in New Jersey, and DMAHS is designated as the Medicaid administrative authority.

"Domestic household employee" means a person who is an employee of the participant and provides personal care services and supports to a participant, who is enrolled in the Personal Preference Program as defined in I.R.C. §§ 31.3306(c)(2)-1(a)(2).

"Employer authority" means the participant, or their authorized representative, where appropriate, has the responsibility for hiring, supervising, managing, and firing workers. If combined with budget authority, the participant, or authorized representative, sets the rate of pay for workers.

"Fair hearing" means a hearing held by the Office of Administrative Law (OAL) under N.J.S.A. 52:14B-1 et seq., and 52:14F-1 et seq., and N.J.A.C. 1:1-1 and 10:6.

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

"Home visit" means a face to face visit with a program consultant that is performed routinely, in the participant's home, with the presence of the participant and representative, where appropriate, for the purpose of evaluating how well service needs are being met through the cash management plan. Completion of the visit by telephone, "skyping," or other communications technology are not acceptable under the program.

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

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

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

"Medical facility" means a nursing home, residential, or rehabilitation facility, assisted living facility, or hospital that provides medical and personal care for individuals with chronic illness or disability(ies).

"Participant" means an individual who is receiving services under the Personal Preference Program in New Jersey.

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

"Participant directed services" means an approach to service delivery that affords participants choice and control over the services they receive and the individuals who provide them. The participant requiring services makes the choices about what, when, where, and from whom he or she receives services, based upon the underlying assumption that the participant knows best about his/her wants and needs.

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

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

"Reassessment" is a face-to-face home visit defined as N.J.A.C. 10:60-3.5(a)3. Completion of the reassessment visit by telephone, "skyping," or other communications technology are not acceptable under the program.

"Risk assessment profile" means a tool used to evaluate individual risk, safety, and planning for mitigation of risk for the participant. The tool addresses cognitive, hearing/communication, ambulation, nutritional, functional, and structural limitation factors, and evaluates a participant's need of an emergency back-up plan for incorporation into the cash management plan.

"Self-direction" also known as "consumer direction" or "participant direction," means a service delivery model that emphasizes autonomy and empowerment by expanding the participant's degree of choice and control over his or her long-term services and supports. Under this model, participants and their authorized representatives or family members serve as the common law employer, and with training and guidance, are responsible for directly hiring, training, supervising, firing their paid caregivers, and making informed decisions about their own care.

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

"Vendor fiscal employment agent (VF/EA)" means an entity, under contract with the State of New Jersey, which provides a range of fiscal and business services to participants enrolled in the Personal Preference Program.

"Worker" means a domestic household employee hired by, and who performs duties in and around the home, for a Personal Preference Program participant. A worker shall be employed for no more than 40 hours per calendar week across all programs and shall be exempt from overtime pay. Individuals who reside in the same residence as the participant they serve, and who qualify for the Live In Exception pursuant to IRS Notice 2014-7, 2014-4 I.R.B. 445, may work over 40 hours a week for their standard pay rate, and shall remain exempt from overtime pay.

10:142-1.5 Administration of the Personal Preference Program

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

SUBCHAPTER 2. ELIGIBILITY AND PARTICIPANT RESPONSIBILITIES

10:142-2.1 Eligibility requirements for the Personal Preference Program

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

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

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

ii. Participant students must provide documentation of progress towards completion of a planned educational goal, such as a degree, certification, accreditation, etc.

2. An eligible applicant or participant must be eligible for a Medicaid program pursuant to N.J.A.C. 10:49-9.14.

3. An eligible applicant or participant must have and maintain Medicaid eligibility as categorically needy as defined in N.J.A.C. 10:49.

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

5. An eligible applicant or participant must live in either a private house or apartment, college/university housing, rooming or boarding house (except for a class C boarding home), a Division of Child Protection and Permanency foster 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.

(b) Individuals who reside in, or are inpatient in, a residential care setting where personal care services are the responsibility of those entities are ineligible for the Personal Preference Program.

(c) Individuals who reside in residential care settings remain ineligible to receive services from the Personal Preference Program during periods they temporarily or intermittently leave the setting or reside elsewhere.

(d) An eligible participant may not receive Personal Preference services while attending a camp program or a day program. In these situations, PCA is the responsibility of the program.

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

10:142-2.2 Participant responsibilities

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

1. Hiring and firing employees within legal and regulatory requirements;
2. Training and supervising employees;
3. Adhering to all applicable Federal and State laws;
4. True, accurate, and timely reporting of employee time including completion of timesheets;
5. Setting of employee wages based on available funds and within State policy;
6. Determining job tasks and work schedule of employees;
7. Creating and managing the cash management plan to ensure services are provided within the allocated budget and in accordance with the plan and submitted by required deadlines;
8. Arranging to obtain goods and services, and submitting required documentation for payment of same within required timeframes;
9. Keeping required records (such as employee timesheets, hospitalization records, purchase of goods, supplies, and vendor services, etc.);
10. Accounting for and agreeing to use program funds in accordance with the approved cash management plan;
11. Arranging to obtain services, supports, and goods from available providers and suppliers;
12. Understanding and following program guidelines;
13. Maintaining scheduled appointments at required intervals, including, but not limited to, home visits and in-home nursing reassessments with a registered nurse employed by the State staff or an MCO.
14. Maintaining workers' compensation insurance coverage in accordance with N.J.S.A. 34:15-1 et seq.;
15. Informing the Division, or other agent thereof, for program purposes, of any change in the participant's contact information (such as address/phone number) or Medicaid eligibility;
16. Informing the Division if the participant is admitted to a medical facility, institutional setting, or residential facility;
17. Maintaining compliance with the Fair Labor Standards Act (FLSA);
18. Participating in a Risk Assessment Profile to evaluate the level of risk initially and at periodic intervals;
19. Preparing an emergency back-up plan that may be activated in situations in which a regular domestic household employee(s) or agency provider is unable to provide needed care;
20. Informing the program consultant in the event of a change in coverage afforded by managed care organization (MCO) providers; and
21. Participating in quality assurance reviews based on a random selection process, to be determined by the State program office, in compliance with CMS requirements.

(b) Failure to comply with requirements in (a)1 through 21 above may result in disenrollment from the program.

(c) Participants who are unable to manage their services independently or refuse to perform the responsibilities under (a)1 through 21 above, shall be mandated to use an authorized representative in order to receive program services.

(d) Prospective applicants who withdraw from the program enrollment process following prepayment of workers' compensation insurance by the VF/EV under N.J.A.C. 10:142-7.1(b), shall be responsible for reimbursement of above expenses by the program.

1. All applicants shall be required to sign a written agreement of understanding in regards to reimbursement for workers' compensation fees in the event of withdrawal from enrollment pursuant to (d) above.

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

10:142-2.3 Employee requirements

(a) Workers are eligible to be employed by participants under the program subject to the following criteria:

1. At least 18 years of age or, of age to obtain legal working papers and able to work in the State of New Jersey in accordance with N.J.S.A. 34:2-21.1 through 34:2-21.64; and
2. Considered domestic household employees as defined by the Internal Revenue Service at I.R.C. §§ 31.3306(c)(2)-1(a)(2) and shall adhere to all criteria associated with that designation.

(b) Individuals shall be excluded from working in the program under the following conditions when the:

1. Individual has a record of violent felony(ies) or other criminal convictions, or allegations of abuse of vulnerable individuals that negatively impacts his or her ability to render care; or
2. Individual is a recipient of services under the Personal Preference Program or Personal Care Assistant Services (PCA) Program or another personal care program;

(c) All workers as defined in (a) above shall be compensated in the form of payroll check (or direct deposit, or other payroll alternatives available through the VF/EA) based on signed timesheets. The amount of compensation received as an employee shall be deemed as reportable and taxable income under Federal and State taxation guidelines. Payment in cash or in other arrangements shall not be permitted for duties performed under the program.

(d) Workers shall be terminated and banned from future employment in the program when any of the following situations occur in the performance of duties while employed by a participant:

1. Substantiated allegations of drug/alcohol abuse such that it impairs their ability to render care;
2. Substantiated allegations of neglect, abuse, and/or exploitation of a program participant;
3. Documented involvement in and/or conviction of fraudulent or criminal activity; or
4. Documented situations in which a worker potentially causes harm or adversely affects the health, safety, or welfare of the participant.

SUBCHAPTER 3. SCREENING AND APPLICATION

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

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

(b) Upon receipt of a request to self-direct PCA services, the MCO shall screen the participant to determine if he or she meets program criteria and shall use the State's prescribed screening and application forms.

(c) If it is determined that the applicant meets the program criteria as described in this section, the MCO will authorize the participant for participant-directed services and refer the applicant to the Division for further action.

(d) The Division shall refer applicants to the counseling agency to continue the enrollment process according to contract provisions established between the Division and the VF/EA counseling entity.

(e) The counseling agency consultant shall establish the applicant as the employer of record and complete the enrollment process.

10:142-3.2 Screening and application process for PCA participants enrolled in Medicaid fee-for-services

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

1. If the participant is currently receiving traditional agency delivered PCA services, the Division will obtain the most recent PCA assessment and authorization of PCA service hours from the home care provider agency.

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

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

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

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

10:142-3.3 Authorized representative standards, roles, and responsibilities

(a) An authorized representative shall be interviewed and approved by the consultant. Individuals with a record of violent felony(ies) and/or other criminal convictions or allegations of abuse to vulnerable populations shall not be permitted to serve as an authorized representative under the program.

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

(c) The participant shall be permitted to use only one representative at a time to assist with managing services. The participant may change his or her representative at any time, using the following procedures:

1. A request for change in representative shall be made to the Division, for review and confirmation of agreement of the individual to serve as the new representative. The Division shall render a final decision on the participant's request.

2. Upon obtaining approval, the Division shall inform the MCO care manager and VF/EA consultant of the change in representative.

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

1. If it is determined that the participant is capable of managing his or her services independently, the consultant shall recommend the participant for continued eligibility without further need of a representative. The consultant shall submit written justification to the Division for review and final determination.

2. The Division shall evaluate the written justification submitted pursuant to (d)1 above and inform the participant and consultant of its decision.

(e) A mandated representative shall be required for participant enrollment or for reinstatement into the program, in the event an applicant or a former participant has been convicted of a felony. Failure to accept and utilize a mandated representative shall result in disenrollment from the program.

(f) An authorized representative may be involuntarily removed from program participation, at the discretion of the Division, due to non-compliance with duties and requirements as set forth in this chapter, based on the recommendations of the consultant.

(g) In the event an individual is deemed inappropriate to serve as an authorized representative pursuant to (a) or (f) above, the final determination on any future approval or opportunity for reinstatement shall be at the discretion of the Division Director.

10:142-3.4 Consultant role and responsibilities

(a) The consultant assists program participants in understanding and effectively using the cash and counseling approach.

(b) The consultant shall be responsible for specific duties and responsibilities as prescribed under contract between the Department of Human Services and the VF/EA.

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

10:142-3.5 Confidentiality and disclosure of information

All identifiable personal health information regarding program applicants or participants that is obtained or maintained under this program shall be confidential and shall not be released without the written consent of the applicant or participant or their authorized agent pursuant to N.J.A.C. 10:49-9.7. If, because of an emergency situation, time does not permit obtaining consent before release, the program shall notify the participant, his or her family, or authorized representative, immediately after releasing the information.

SUBCHAPTER 4. CASH GRANT AND CASH MANAGEMENT PLAN

10:142-4.1 Budget determination

(a) The budget shall be used for services, supports, and goods to ensure the participant is able to complete the activities of daily living consistent with the participant's individual needs.

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

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

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

10:142-4.2 Impact of budget allocation on governmental benefits

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

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

(c) Participants are responsible for consulting appropriate loan officers affiliated with benefits offered, to determine the outcome of eligibility for post-secondary educational loans, while receiving a budget allocation while enrolled in the program.

(d) In situations in which a participant hires a spouse or household member, as an employee to perform services under the program, any income derived by the spouse as an employee shall be counted as household income, and as such, may affect eligibility for benefits under Supplemental Security Income (SSI), Supplemental Nutritional Assistance Program (SNAP) (formerly known as food stamps), or for rental assistance. The participant is responsible for consulting with the appropriate social service or rental assistance agency to determine the impact of hiring a spouse or relative would have on eligibility for other governmental benefits.

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

10:142-4.3 Standards for use of the budget

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

1. Hiring and paying workers with an hourly rate of pay;
2. Purchasing home care services from an agency to supplement or back up self-hired workers;
3. Transportation services for participant and/or employees, to assist with activities of daily living and errands;
4. Household-related appliances and electronic equipment/devices;
5. Technology for safety and independence not otherwise covered by Medicaid;
6. Purchase and installation of environmental modifications;
7. Purchase and installation of vehicular modifications related to accessibility, including repairs to vehicle modifications and related equipment;
8. Purchasing health insurance for a worker;
9. Costs of training and education for a worker;
10. Purchasing a background check on workers;
11. Purchasing services (laundry or cleaning services, errands, and meal preparation) with Division approval to supplement personal care services on a time limited basis for the benefit of the participant;
12. Adult day care for the benefit of the participant only; and
13. Respite care to relieve unpaid caregivers.

(b) Participants shall submit a written description on the CMP, of any proposed purchase of goods and services as described in (a) above, and explain how the requested item/service relates directly to their individual personal care needs.

(c) Participants shall submit required invoices or receipts for above goods and services to the VF/EA before any payments will be issued. Reimbursement shall be made directly to the participant if he or she provides documentation (for example, receipt/credit card statement) showing he or she has already paid for the item or service. In all other cases, the VF/EA will issue a payment to the vendor.

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

(e) All requests for the purchase of the goods and services under (a)4 through 7 above shall require the participant to submit estimates from three different vendors verifying the item(s) of purchase and vendor's qualifications. The vendor's qualifications and proof of liability insurance shall be verified by the participant. The Division shall review all estimates and approve the final purchase of said goods and services.

(f) The participant/representative shall negotiate requests for environmental or vehicular modifications as described in (a)6 and 7 above, and obtain a written estimate, for the total cost of the work to be performed by a vendor/contractor, including fees for permits and applicable taxes. Administrative costs may not be included in the estimate.

1. A start-up payment, not to exceed 50 percent of the total estimate, may be issued to the vendor/contractor to begin the modification, at the discretion of the participant/authorized representative. The remaining balance shall be paid upon successful completion of the job.

2. Written permission from the property owner must be obtained for any work to be performed to a residence that is owned by someone other than the participant.

(g) In situations in which a participant resides in a rental property any request to use the cash allocation for a home appliance or environmental modification as described in (a)4 and 6 above shall not be afforded, subject to the Fair Housing Act of 1984.

10:142-4.4 Non-permissible expense items

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

1. Goods and services covered by Medicaid or other public entitlement programs;
2. Goods and services provided to or supporting persons other than the individual participant;
3. Personal items not directly related to the participant's disability or individual personal care needs;
4. Room/board, rent, mortgage payments, and other normative living expenses;
5. Routine household expenses including utilities and regular maintenance;
6. Experimental goods/services;
7. Costs associated with travel (airfare, train, bus, rental cars, lodging, meals, etc.) for vacations or entertainment;
8. Food, vitamins, food or vitamin supplements, or medications;
9. Entertainment equipment and related supplies;
10. Recreational activities, exercise/fitness equipment, and/or memberships;
11. Household appliances not directly related to personal care needs;
12. Personal items (clothing and accessories) or social expenses (gambling, alcohol, recreational drugs, both legal and illegal);
13. Household furnishings, routine maintenance, and/or cleaning supplies;
14. Normative vehicle expenses, including routine maintenance, repairs, or insurance;
15. Landscape and yard work;
16. Salon services (manicures, pedicures, haircuts) and spa treatments (massages);
17. Computers for routine use only, and unrelated to accommodations due to a physical limitation or with speech;
18. Routine pet care or service animal expenses;
19. Environmental or vehicular modifications that are afforded under other available resources, or being procured under new residential construction, even if the new dwelling is designed to accommodate the personal care needs of a participant.
20. Services that are intended or provided for supervision and monitoring; or
21. Overtime, bonuses, or any type for remuneration other than salary as defined in the CMP.

10:142-4.5 Cash management plan standards

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

(b) The participant or representative shall decide which services, supports, and goods to purchase and document each item, with the corresponding expense(s), for inclusion in the development of the CMP. The plan shall indicate the monthly cost and frequency of each service, and rate of pay for all individual(s) or vendor(s) hired.

(c) The participant/representative will be granted budget authority to expend funds to meet personal care needs as identified within the plan and approved by the Division.

(d) The participant, or representative, is responsible for managing the CMP and requesting guidance from the consultant when changes need to be made.

(e) All CMPs shall be reviewed by and given final approval by the State program office. Payments for services based on an unapproved CMP, will be denied.

(f) All payments for services under the plan shall be made by the vendor fiscal employer agent (VF/EA), based upon approved items in the CMP and submission of required documentation. Any request to use funds to pay for unauthorized expenses shall be denied.

(g) The start date for initiating an approved CMP shall be effective on the 1st of the following month, to be determined by the State program office as follows:

1. The determination of CMP approval dates shall be in accordance with a schedule prepared by the State program office that includes information on required dates of receipt and corresponding effective dates.

2. The schedule shall be updated annually, at a minimum, in order to ensure appropriate implementation in a manner requested by the participant and to enable changes to be initiated and shared with participants and consultants, as requested.

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

10:142-4.6 Penalties for overspending the cash management plan

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

(b) The VF/EA staff shall monitor the participant's expenditures under the cash management plan and are responsible for informing the participant (and representative, as appropriate) and the Division of any overspending.

1. The VF/EA shall provide necessary information on the amount of funds overspent pursuant to (b) above.

2. The Division shall advise the participant and consultant of the need for a corrective action to modify the cash management plan to effectively reduce the monthly cash allocation to enable recoupment of the amount overspent.

3. Upon recoupment of the over-expenditure in (b)2 above, the participant will be permitted to modify the cash management plan to its original form, in accordance with cash allocation based upon the current PCA assessment.

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

10:142-4.7 Cash management plan monitoring and modification

(a) The consultant shall periodically review and monitor service provisions with the participant to determine whether needs for personal care are being met through services identified in the cash management plan (CMP).

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

1. The participant shall be notified of the need to modify the CMP in order to effect a change in service hours and monthly budget allocation, resulting from a reassessment determination and subsequent change in services, and must submit the revised plan to the Division within 45 days of the original notification or by the deadline required within the notification, whichever comes first, for final review and determination.

2. Until such time that a modified cash management plan is obtained and approved by the Division, the participant will continue to manage services in accordance with his or her last approved CMP.

(c) Any revised CMP shall be completed by the participant/representative with the assistance of the consultant, and submitted to the Division for review and determination for execution by the vendor fiscal employer agent (VF/EA).

1. Approval of revised CMPs by the Division shall be submitted to the VF/EA to implement changes and enable payment for services.

2. The State program office shall notify the consultant and participant of any disapproved CMP, either in whole or in part. The consultant shall work with the participant to assist with exploring other options, including possible resubmission of another revised CMP.

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

SUBCHAPTER 5. APPLICATION DISPOSITION, ENROLLMENT, AND SERVICES

10:142-5.1 Application disposition

(a) The Division shall review the self-direction enrollment package and cash management plan, as submitted by the consultant, and affirm the establishment of the applicant as employer of record under the program.

(b) Division staff shall verify Medicaid eligibility as defined in N.J.A.C. 10:142-2.1.

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

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

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

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

10:142-5.2 Enrollment

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

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

10:142-5.3 Service standards

(a) For the purposes of this program, the following service standards shall be met:

1. An individual approved for participant-directed services may use traditional provider agency services only when indicated as a private purchase arrangement under an approved cash management plan (CMP);

2. Program funds shall not be used for the performance or arrangement of skilled professional medical services;

3. Services under the program shall be suspended during a period of stay in a medical facility and resumed automatically upon discharge to the participant's residence, if the stay is not more than 30 days, otherwise, authorization from the MCO is required.

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

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

2. Participants must be accompanied by their current employees while out-of-State, who may continue to receive payment for services performed, in accordance with the CMP.

3. Failure to provide contact information, return when indicated, and/or comply with consultant visits reassessment requirements described in (b)1 above, may result in disenrollment.

SUBCHAPTER 6. PARTICIPANT SELF-DIRECTION AND REASSESSMENT

10:142-6.1 Participant self-direction

(a) The Division shall retain sole authority in determining an individual's appropriateness for participant-directed services under the program.

(b) In the event of a change in the participant's condition, negatively impacting his or her continued ability to self-direct activities of daily living, that is detected by the MCO liaison care manager or program consultant, concerns must be provided to the Division along with supporting evidence to document the situation. The Division shall investigate all concerns and review information pursuant to this section, as well as from other sources, and shall render a determination regarding continuation of program eligibility, including the potential mitigation of circumstances.

(c) If the participant is determined to be incapable of participant-direction, the Division shall inform the participant in writing and notify the MCO liaison accordingly, so they can obtain traditional agency delivered PCA services.

10:142-6.2 Reassessment requirements

(a) A personal care assistant nursing reassessment visit shall be conducted every six months. A reassessment may be conducted more frequently at the discretion of the MCO or Division, as appropriate. A reassessment may be required in the event of a change in the participant's health condition or needs, support system, or the duration of a period of disenrollment from the program if those circumstances affect the need for personal care assistance. The following documents must be submitted in support of a request for reassessment:

1. Certification from a physician indicating a change in condition;

2. Verification indicating the loss of primary support; or

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

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

(c) A participant's eligibility for the Personal Preference Program may be terminated, due to non-compliance with the reassessment requirements, at the discretion of the Division. The MCO shall inform the Division of any situation of non-compliance with the reassessment process, resulting in a termination of the PCA service benefit for participants enrolled in managed care.

10:142-6.3 Change in scope, duration, and/or amount of services

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

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

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

(d) The Division will provide a time frame for completion and deadline for submission by participant of any modified CMP. Failure to complete a modified CMP by the requested date assigned by the State program office may result in disenrollment from the program due to non-compliance.

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

10:142-7.1 Responsibilities of the VF/EA

(a) The VF/EA shall be an agency under contract with the Division that shall serve as a business agent as defined in Section 3504 of the IRS Code and Revenue Procedure 70-6f, for all participants of the program.

(b) The VF/EA shall perform the following financial administration functions, at a minimum:

1. Assist participants to enroll as the "common-law" employer for program purposes and grant rights permitting budget authority and employer authority;

2. Assist participants in establishing and maintaining a bank account for the purpose of payroll distribution and program related expenses;

3. Develop and implement a system for documenting participant's cash allocation determination and tracking receipt and disbursement of funds and any remaining balances;

4. Perform bookkeeping services for participants;

5. Process forms as required by the Internal Revenue Service (IRS), the New Jersey Department of the Treasury, and/or the New Jersey Department of Labor and Workforce Development, to establish and maintain each program participant as a business entity;

6. Review and process required employment information for workers employed by program participants;

7. Withhold and pay all applicable business taxes for participants;

8. Withhold and pay all applicable employment taxes for workers employed by participants;

9. Review worker timesheets, to assure accuracy and compliance with the CMP;

10. Issue payments to vendors and service providers pursuant to the CMP;

11. Assist participants in obtaining and retaining workers' compensation coverage in accordance with State and Federal law, including prepayment prior to enrollment;

12. Prepare and issue reports as required by the IRS or New Jersey Department of Labor and Workforce Development, and share copies with participants (and representatives, as appropriate); and

13. Function as a payroll agent for workers employed by program participants, and perform the following tasks that include, but are not limited to:

i. Issuing paychecks to employees hired by consumers;

ii. Processing unemployment, New Jersey State Temporary Disability, and Family Medical Leave Act (FMLA) claims; and

iii. Issuing employment and wage verification letters.

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

SUBCHAPTER 8. DISENROLLMENT AND REINSTATEMENT

10:142-8.1 Voluntary disenrollment

(a) Voluntary disenrollment of service involves situations in which eligible individuals request and/or agree to the cessation of participant-directed services.

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

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

1. The Division shall inform the MCO of the disenrollment, for individuals enrolled in managed care, to enable transition to traditional PCA services, as requested by the participant.

2. Upon agreeing on a disenrollment date with the MCO as described in (c)1 above, the Division shall instruct the VF/EA to deactivate the participant-directed services account accordingly to avoid duplication of services, upon selection of a provider agency and the effective date of the transition.

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

10:142-8.2 Involuntary disenrollment

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

1. Failure to submit information necessary to determine or reaffirm social or financial program eligibility;

2. Documented abuse or misuse of program services or employees as verified by the Division, with or without the provision of technical assistance and support from the consultant and/or financial management agent;

3. Failure of the participant to manage their own care needs, which results in placing the health or welfare of a participant or an employee at increased risk, as determined by the consultant, representative, vendor fiscal employer agent, or through substantiated allocations of abuse, neglect, or exploitation by Adult Protective Services (APS);

4. Duplication of program services through other service programs or funding sources as verified by the Division;

5. Verified, willful or knowing falsification of employee timesheets, vendor invoices, or other required program documents;

6. Participant is no longer eligible for Medicaid benefits;

7. Commission of other acts identified as program fraud or abuse of program services that have been substantiated;

8. Failure to notify a consultant of admission to a medical facility;

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

10. Failure to submit timesheets and invoices/bills in accordance with prescribed time frames set forth by the VF/EA;

11. Documented non-response by the participant to attempts to make contact by the Division or agents thereof in the administration of the program;

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

13. Documented inability to comply with participant responsibilities as identified under N.J.A.C. 10:142-2.2;

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

15. Failure to act with good moral character or acting under questionable pretense.

(b) All decisions to involuntarily disenroll an individual from participant directed services shall be made by the Division. In determining an involuntary disenrollment based on action(s) as described under (a) above, the Division shall consider the specifics of the situation, on a case-by-case basis, including, but not limited to, the following:

1. The severity of the situation;

2. Any recurrences or patterns in the situation; and

3. The effort and willingness demonstrated by the participant to resolve the issue or to mitigate the problem.

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

1. The Division, in collaboration with the MCO, will assist the participant in accessing Medicaid State Plan PCA services through traditional provider agencies, following an involuntary disenrollment.

2. The Division shall assist the participant with the transition process as described in (c)1 above, but cannot guarantee the acceptance by a PCA provider agency or the time it may take for the transition to be completed.

(d) In situations in which it has been identified that the participant is unable to direct and manage services as described in (a) above, an option may be afforded to designate the use of a representative, where appropriate, to maintain enrollment in the program.

10:142-8.3 Reinstatement standards and procedures

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

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

(c) Upon submission of a request for reinstatement to the program, participants will be required to contact the VF/EA to determine if new employer registration forms are required, at the discretion of the VF/EA, to enable reactivation of the program account.

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

(e) Participants involuntarily disenrolled as a result of substantiated Medicaid fraud or abuse, and confirmed by the New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD), may be reinstated onto participant-directed services at the discretion of the Division Director, subject to the following standards and procedures:

1. The participant shall be required to make financial restitution to the State of New Jersey prior to granting any reinstatement.

2. The participant shall agree in writing to a corrective action plan, set forth by the Division, and complete all required remedial action(s) as set forth in the plan, to return to good standing with program guidelines and retain eligibility. Failure of a participant to adhere to a mandatory correction plan shall result in a lifetime ban from the program, whereby all future reinstatement requests shall be automatically denied.

3. Any substantiated Medicaid fraud or abuse that has been referred to the New Jersey Office of Attorney General for possible criminal action may result in an automatic denial of any request for reinstatement and a lifetime ban from re-entry into the program, as determined by the Division Director.

(f) In reviewing a request for reinstatement for participant-directed services, in which there is a substantiation of Medicaid fraud or abuse by a participant, the Division shall give consideration to the following:

1. The availability and overall benefit of returning to traditional agency services;

2. The impact of the determination on the participant's health and/or welfare; and

3. The participant's willingness and cooperation in making any required restitution and/or remedial action(s) pursuant to (e)1 and 2 above.

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

10:142-9.1 Request for administrative review

(a) Applicant/participant complaints, are defined as criticisms, protests, objections, concerns, or dissatisfaction related to any aspect of the Personal Preference Program.

(b) An applicant or participant may request an administrative review of any complaint(s), as described in (a) above, by contacting the Division in writing.

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

State Program Manager
Personal Preference Program
Division of Disability Services
PO Box 705
Trenton, New Jersey 08625-0705

(d) The State Program Administrator shall render a decision and respond in writing to all complaints within 30 days of receipt, and provide the applicant or participant the final decision on the matter in dispute.

(e) Applicants or participants who disagree with the decision of the administrative review, wherein the outcome results in an adverse agency action as described in N.J.A.C. 10:142-9.2, may request a fair hearing before an Administrative Law Judge pursuant to N.J.A.C. 10:142-9.3. Instructions for such requests shall be incorporated into the written response noted in (d) above.

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

10:142-9.2 Adverse agency actions and appeal rights

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

1. Determinations involving a need for personal care services or level of benefits and award of services, involving reduction in hours, denial of benefits due to non-need, or denial of request for increased benefits, shall be the responsibility of the managed care organization (MCO) for participants enrolled in managed care.

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

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

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

(e) In addition to appeal rights afforded under (b) above, MCOs shall offer participants enrolled under managed care internal appeal rights that are available as a member of each respective plan, on any adverse action under (a) above. If a participant elects an internal appeal offered through an MCO, and a final decision is rendered on the matter in dispute, the MCO shall inform the Division of the outcome regarding any changes in scope, frequency, and/or amount of services to determine the impact on the budget allocation and cash management plan.

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

10:142-9.3 Fair hearings

(a) Fair hearings under this chapter shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) A fair hearing must be requested within 20 days of receipt of the adverse agency decision by writing or faxing to:

Division of Medical Assistance and Health Services
Fair Hearings Unit
PO Box 712
Trenton, New Jersey 08625-0712
Fax: (609) 588-2435

(c) A fair hearing request will operate as a stay of any adverse agency action pending the outcome of the matter under appeal.

(d) Once a stay of the adverse agency action is applied, participant directed services shall not be suspended, reduced, or terminated prior to the completion of the fair hearing and the rendering a final decision.

(e) An exception to (d) above shall be afforded when a change in the participant's situation occurs, affecting eligibility or award of services under the program, while the decision of the administrative review is still pending and the participant does not request an additional administrative review related to the subsequent adverse agency action.

(f) Upon completion of the fair hearing process, a final decision regarding the matter in dispute shall be rendered by the Director of the Division of Medical Assistance and Health Services.

(g) If the applicant or eligible consumer objects to the final decision made in accordance with (f) above, a notice of appeal may be filed by the applicant or eligible participant with the Appellate Division of the Superior Court of New Jersey. Such appeals shall be made within 45 days of the final decision date pursuant to R. 2:4-1(b).

(h) Further information about filing a notice of appeal may be obtained by calling or writing the Appellate Division of the Superior Court of New Jersey at:

Richard J. Hughes Justice Complex
PO Box 006
Trenton, New Jersey 08625-0006
(609) 292-4822

10:142-9.4 Outcome of fair hearings

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

1. The MCO shall issue a new service authorization to the Division to execute changes to the budget allocation. Upon receipt of such authorization, the Division shall inform the participant and VF/EA of the changes.

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

(b) If the outcome of a fair hearing proceeding results in upholding the appeal filed by the participant on an adverse action initiated by either the MCO or State program agency, the provision of services shall be continued without change, however, future changes may be impacted by any subsequent nursing reassessment.

(c) If a settlement is obtained during a hearing proceeding, whereby the applicant or participant resolve a matter in dispute, the agreement terms and conditions shall be communicated with the Division or MCO, as appropriate, as a part of final outcome.

SUBCHAPTER 10. MEDICAID FRAUD AND ABUSE

10:142-10.1 Medicaid fraud and abuse

(a) The Division, and agents thereof, responsible for the administration of the Personal Preference Program shall employ methods, including, but not limited to, offering training, issuing written materials, etc., to identify situations in which a case of fraud and/or abuse in the program may exist.

(b) Any suspected situation of a Medicaid fraud or abuse should be reported immediately to the Division.

(c) The Division shall refer to the Office of State Comptroller, Medicaid Fraud Division (MFD), any situation(s) in which there is valid reason to suspect that Medicaid fraud has or may have been committed in accordance with N.J.A.C. 10:49-9.12.

(d) Willful or knowing acceptance of provider agency services by an applicant approved for participant-directed services, shall constitute fraud and may result in program disenrollment.

(e) Reporting may be performed by contacting the Medicaid Fraud and Abuse hotline at 1-888-937-2835 (toll free), or electronically by using the following website address: http://www.nj.gov/comptroller/divisions/medicaid/complaint.html.

INSURANCE

(a)

DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF CONSUMER PROTECTION SERVICES
Pharmacy Benefits Managers
Proposed New Rules: N.J.A.C. 11:4-62

Authorized By: Richard J. Badolato, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 17B:27F-1 et seq.

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

Proposal Number: PRN 2017-193.

Submit written comments by October 20, 2017, to:

Denise M. Illes, Chief
Legislation and Regulation
Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
E-mail: Legsregs@dobi.nj.gov