(3) The form and content of informational and instructional materials to be distributed to inform enrollees of changes in program scope or administration; and

(4) Provider claim forms and instructions for their use where such claim forms are unique to this contract;

ix. The project shall provide to the Department, for written approval prior to use, the form and content of all public information releases pertaining to the project; and

x. The project shall insure that all marketing representatives have received instruction, as appropriate, from the Department, on acceptable enrollment practices.

10:49–16.5 Sanctions

The Commissioner, in addition to any and all other authority, shall have the authority to totally suspend or partially reduce payment in order to enforce compliance with this subchapter.

SUBCHAPTER 17. HOME AND COMMUNITY–BASED SERVICES WAIVERS

10:49–17.1 Introduction

(a) Home and Community–Based Services Waivers are five-year, renewable Federal waiver programs, prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981 (Section 2176, Public Law 97–35 and amendments under P.L. 99–509). These Home and Community–Based Services Waivers were submitted to the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. The purpose of these programs is to help eligible individuals remain in the community, or return to the community, rather than be cared for in a nursing facility or hospital setting.

(b) Retroactive eligibility is not available to waiver program recipients; no waiver service received prior to the date of enrollment shall be considered for reimbursement.

(c) Total program costs are restricted by limits on the number of community care slots and on per-person costs. The case manager is responsible for the development of the service plan with the client/family, with input from provider agencies, and for monitoring the cost of the service package.

(d) Any questions regarding Home and Community–Based Services Waivers may be directed to the Office of Home Care Programs, located in the Division of Medical Assistance and Health Services' Central Office, telephone number (609) 588–2620.

(e) The Division administers the following six Statewide waivers that are described in N.J.A.C. 10:49–17.2, 17.3, 17.4 and 17.5 respectively:

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

2. Home and Community–Based Services Waivers for Blind or Disabled Children and Adults (Medicaid's Model Waivers I, II, and III);

3. AIDS Community Care Alternatives Program (ACCAP); and

4. Traumatic Brain Injury Program.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

10:49–17.2 Community Care Program for the Elderly and Disabled (CCPED)

(a) CCPED became effective October 1, 1983. The program allows for community care slots, allocated on a county basis in accordance with the needs of the county.

(b) The seven services listed below are available under CCPED. Other Medicaid (Title XIX) services are not available to the waivered population. There is a cost cap on each individual service package.

1. Case management;
2. Home Health;
3. Homemaker;
4. Medical day care;
5. Medical transportation (non-emergency);
6. Respite care; and
7. Social day care.

(c) Eligibility requirements for CCPED are as follows:

1. All individuals must be assessed to be in need of nursing facility care.

2. Individuals age 65 or over must be eligible for Medicare or have other health insurance coverage which includes hospital and physician coverage.

3. Individuals under 65 must be determined disabled by the Federal Social Security Administration and be eligible for Medicare or be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section and have other health insurance, including hospital and physician coverage.

4. An individual's own income must exceed the SSI community standard up to the institutional cap or be ineligible in the community because of SSI Deeming

Rules. An individual's resources may not exceed those required in the institutional program. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49–17.3 Medicaid's Model Waivers—I, II and III

(a) The Model Waivers are Home and Community–Based Services Waivers for Blind or Disabled Children and Adults. Included are Model Waiver I (effective September 1, 1983), Model Waiver II (effective April 1, 1985) and Model Waiver III (effective April 1, 1986).

1. Model Waivers I and II serve a maximum of 50 individuals each. Model Waiver III serves 150. There are no geographic limitations nor limitations on the number of individuals who can be served within any one county.

(b) The Model Waiver programs offer, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus case management. Model Waiver III also offers private-duty nursing. "Private duty nursing" means individual and continuous care, in contrast to part-time or intermittent care, provided by licensed nurses. Private duty nursing is limited to a maximum of sixteen hours per day per person and will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24–hour responsibility for the health and welfare of the recipient.

1. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

(c) Eligibility requirements for the Model Waivers are as follows:

1. Individuals must be in need of institutional care and meet the minimum nursing facility (NF) level of care criteria. Model Waiver III also requires that individuals need private-duty nursing service.

2. For Model Waivers I and II, individuals must meet optional categorically needy standards. Total income must exceed the SSI community standard up to the institutional CAP, or the individual must be ineligible in the community because of SSI Deeming Rules. Parental income or resources are not considered in determining eligibility. While a spouse's income is not considered towards eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

3. Model Waiver III applicants can either be optional categorically eligible or categorical eligible. In other words, MW III also serves individuals who are eligible under SSI, DYFS or AFDC programs.

4. Individuals must be blind or disabled children and adults. Individuals who have not been determined disabled under the Social Security Act must be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section.

5. In order to be enrolled in the program, a waiver slot must be available.

Case Notes

Quadriplegic's death mooted appeal from denial of her application for home health care. J.C. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 42.

10:49–17.4 AIDS Community Care Alternatives Program (ACCAP)

(a) ACCAP became effective March 1, 1987. The program allows for an allocation of a specific number of slots in accordance with the needs of each county in the State.

(b) ACCAP offers, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus those listed in (a)1 through 7 below. Total program costs are restricted by the number of community care slots each year and on per-person costs. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

1. Case management;

2. For children:

i. Intensive supervision to children who reside in Division of Youth and Family Services' foster homes; and

ii. Specialized group foster home;

3. Hospice care services at home;

4. Medical day care (specialized);

5. (Certain) Narcotic and drug abuse treatments at home;

6. Personal care assistant services (no limitation on the number of hours); and

7. Private-duty nursing.

(c) Eligibility requirements for ACCAP are as follows:

1. Individuals must be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria.

2. Individuals must be diagnosed as having AIDS or ARC. Children under the age of five may also be diagnosed HIV positive.

3. Individuals who are categorically needy or optional categorically needy are served under the program.

4. There is no deeming or parental income or resources in the determination of eligibility. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. Optionally categorically eligibles under age 65 must be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section, Division of Medical Assistance and Health Services.

6. In order to be enrolled in the program, a waiver slot must be available.

10:49–17.5 Traumatic Brain Injury Program

(a) The Traumatic Brain Injury (TBI) Program is a renewable Federal waiver program under Section 1915(c) of the Social Security Act, 42 U.S.C. 1396n, which offers home and community-based services to a recipient with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible recipients to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division of Medical Assistance and Health Services (DMAHS), encourages the development of community-based services in lieu of institutionalization.

(c) The Program is Statewide, with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicant's need for care and, for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver recipients will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63–1.15

(f) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;

2. Have a diagnosis of acquired brain injury which occurred after the age of 16;

3. Exhibit medical, emotional, behavioral and/or cognitive deficits;

4. Meet the Division's nursing facility standard care criteria for Pre–Admission Screening (PAS), at N.J.A.C. 10:60–1.2;

5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix I);

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care . . . Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid recipients are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

(g) If the individual is dually diagnosed, for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the recipient's care. This decision will be made based on clinical evidence as of onset of injury, and professional evaluation.

(h) Retroactive eligibility shall not be available to waiver recipients for those Medicaid services provided only by virtue of enrollment in the waiver program. Those individuals who are not eligible for Medicaid services in the community prior to enrollment in the TBI Waiver are not eligible for retroactive Medicaid eligibility.

(i) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility identification (MEI) Card.

(j) In order for an applicant to be enrolled in the program, a waiver slot must be available.

(k) Prior to formal application for the TBI waiver, a referral shall be submitted to the Office of Home Care Programs (OHCP) of the Division, which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) recipients shall be referred to the appropriate Medicaid District Office serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application, which includes the determination of disability, and shall then be referred to the appropriate Medicaid District Office (MDO) serving the recipient's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by OHCP to the county welfare agency (CWA) located in the county where the individual resides, for a determination of financial eligibility, including the referral for determination of disability.

(*l*) After the applicant has been determined financially eligible, he or she shall be referred to the Medicaid District Office (MDO) of the applicant's residence for a determination of medical eligibility by the Regional Staff Nurse (RSN).

(m) When the applicant is judged financially and medically eligible for the TBI waiver program, the MDO shall assign the case to a case management site and notify the OHCP of the recipient's approval for participation in the program.

(n) The MDO shall review and approve the plan of care prepared by the case manager initially, and at six month intervals.

(*o*) If a waiver recipient is categorically eligible for Medicaid services under the State Plan and no waiver services are required as a part of the plan of care, the recipient shall be terminated from the TBI program.

(p) All approved services under the New Jersey Medicaid program, except for nursing facility services, are available under the TBI Waiver from approved Medicaid providers in accord with an individualized plan of care. (See N.J.A.C. 10:60–5.5 for a description of services.)

(q) An individual shall be terminated from the TBI Waiver Program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level 8 or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

(r) Where termination is sought pursuant to (q) above, an individual shall be afforded the opportunity to request a hearing pursuant to N.J.A.C. 10:49–9.10.

New Rule, R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

SUBCHAPTER 18. HOME CARE EXPANSION PROGRAM

10:49–18.1 Introduction

(a) The Home Care Expansion Program (HCEP) (P.L. 1988, c.92), as set forth in N.J.S.A. 30:4E–6, is a Casino Revenue funded program. The intent of the legislation is to offer home care services to elderly and disabled persons in New Jersey who are at risk of institutionalization and whose income and resources exceed the financial requirements for Medicaid or the Community Care Program for the Elderly and Disabled (CCPED). It is anticipated that the provision of home care service will delay or prevent institutionalization. HCEP is available Statewide. Program slots are allocated to each county.

(b) The Division of Medical Assistance and Health Services has the responsibility for overall administration of the program and for monitoring the case management sites. The determination of eligibility and cost-share billing and collection is the responsibility of the Division's Bureau of Pharmaceutical Assistance to the Aged and Disabled (PAAD).

10:49–18.2 Services

(a) HCEP can provide payment for a limited package of services including:

1. Case management services;

i. Case management is provided by a nurse or social worker. Case managers are responsible for assessing need for care, planning, locating, coordinating and monitoring the services designed to meet individual needs of persons being served. Case management services, provided by a variety of agencies, also include responsibility for the development of a service plan with input from the client/family, attending physician and provider agencies, and for monitoring the cost of the service package, and calculating cost-share liability;

2. Home health care over and above what Medicare allows;

3. Homemaker services;

4. Medical day care;