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HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Community Support Services for Adults with Mental Illnesses

Adopted New Rules: N.J.A.C. 10:79B

Proposed: August 3, 2015, at 47 N.J.R. 1899(a).

Adopted: June 6, 2016, by Elizabeth Connolly, Acting Commissioner, Department of Human Services.

Filed: July 20, 2016, as R.2016 d.099, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3), **and with proposed amendments to N.J.A.C. 10:77A-2.2 and 3.2 not adopted but still pending.**

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

Agency Control Number: 13-A-17

Effective Date: August 15, 2016.

Expiration Date: August 15, 2023.

Summary of Public Comments and Agency Responses:

Comments were received from: 1) Debra L. Wentz, Ph.D., Chief Executive Officer of the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA); 2) Kevin McHugh, Executive Director of Helping Arms, Inc.; 3) Harry J. Postel, MSW, LSW, Associate Executive Director of Operations, Catholic Charities, Diocese of Trenton; 4) Nora Barret, Associate Professor / Director, B.S. Program in Psychiatric Rehabilitation & Psychology, Department of Psychiatric Rehabilitation & Counseling Professions, Rutgers-

SHRP, Scotch Plains, NJ; and, 5) Deborah Hartel, Administrative Director, Behavioral Health Services, St. Joseph's Regional Medical Center, Paterson, NJ.

Comment Regarding the Regulatory Flexibility Analysis

1. COMMENT: NJAMHAA requested clarification regarding the first sentence in the "regulatory flexibility analysis" section, which states: "Providers affected by the proposed new rules will not have more than 100 full-time employees." The commenter asked whether that applied agency-wide or for community support services (CSS) only.

RESPONSE: A proposing agency must include a regulatory flexibility analysis in a notice of proposal of rules that impose reporting, recordkeeping, or other compliance requirements on small businesses, which are defined as independently owned and operated businesses that employ fewer than 100 full-time employees. See N.J.S.A. 52:14B-17 and 19. Thus, the first sentence in the regulatory flexibility analysis does not impose any obligations on the providers; rather, it is an acknowledgement that some providers subject to the proposed rules are small businesses and, consequently, the Department was required to include a regulatory flexibility analysis in the notice of proposal.

General Comments Regarding N.J.A.C. 10:79B, Community Support Services for Adults with Mental Illnesses

2. COMMENT: Helping Arms, Inc., generally supported the efforts of the Division of Medical Assistance and Health Services (DMAHS) and the Division of Mental Health and

Addiction Services (DMHAS) to promulgate rules that would permit Medicaid/NJ Family Care reimbursement for community support services.

RESPONSE: The Department appreciates the commenter's support.

3. Comment: Helping Arms, Inc. requested two changes for the purpose of consistency with the DMHAS licensing rules at N.J.A.C. 10:190, which will apply to CSS services upon adoption of the proposed amendments. N.J.A.C. 10:190-1.1 requires that all mental health programs be licensed by the Department of Human Services and have "a purchase of service contract or an affiliation agreement with the Division of Mental Health and Addiction Services" or be licensed by the Department of Health. In contrast, participation in the Medicaid/NJ Family Care program for CSS is limited to licensed providers of CSS that are under contract with DMHAS pursuant to the proposed new rules at N.J.A.C. 10:79B-1.2(c) and 2.2(b). The commenter requested that N.J.A.C. 10:79B-1.2(c) and 2.2(b) be changed to also allow licensed CSS providers with an affiliation agreement with DMHAS to provide CSS to participate as Medicaid providers.

RESPONSE: The Department declines to make the requested changes. Although a provider with an affiliation agreement rather than a contract can be licensed to provide CSS, the Department believes that only the licensed providers under contract with DMHAS should be eligible to receive State and Federal Medicaid funding for those services.

4. COMMENT: NJAMHAA commented that its member providers believe the proposed rules would not be beneficial for consumers or providers because they are restrictive,

complicated, inefficient, and cost-prohibitive. NJAMHAA asked the Department to consider amending the rules to add some flexibility.

RESPONSE: This comment is too general to provide a specific response. As a general matter, however, the Department does not believe that the proposed new rules will be overly restrictive or cost-prohibitive. To a significant extent, the requirements are dictated by the approved Medicaid State Plan Amendment for Community Support Services. The Department also believes that the rules are necessary to ensure that consumers receive appropriate, high quality, and clinically necessary services and that claims for reimbursement are accurate. In an effort to help providers prepare to implement the rules, the Department has sponsored informational presentations and training sessions for providers over the past several years. In addition, DMHAS is creating a tool that will help providers to assess and monitor compliance with the CSS regulations.

5. COMMENT: NJAMHAA requested that the CSS regulations include rates to avoid misunderstandings and disputes about reimbursement that providers should expect to receive.

RESPONSE: The Department believes that the existing approach will provide any necessary flexibility that will be needed as the Community Support Services program is implemented. For this reason, no change will be made in response to the comment. The Department further notes that it has extensively engaged the provider community throughout the process of developing the rates for CSS services.

6. COMMENT: NJAMHAA asked whether the new rates for “hospital-based CSS providers” will be subject to Medicaid "cost-to-charge ratios" applicable to hospital outpatient services. The commenter expressed concern that there will be a disincentive against hospital participation if the cost-to-charge ratio is applied because it could result in a reduction in the provider’s charge.

RESPONSE: The cost-to-charge ratio does not apply. Community support services are a mental health rehabilitation service provided by mental health rehabilitation providers. Although a CSS provider might be affiliated with a hospital, it is not considered a hospital provider for the purposes of billing.

Comments Regarding N.J.A.C. 10:79B-2.3, Services

7. COMMENT: NJAMHAA commented that providing 24/7 access to crisis services, as required by proposed N.J.A.C. 10:79B-2.3(d) is unrealistic because it would be cost prohibitive for providers to acquire the appropriate staff. NJAMHAA requested that the rule be amended to provide flexibility; for example, by allowing affiliations with established 24/7 crisis service providers as an alternative for CSS providers who do not have this staffing capacity.

RESPONSE: The Department declines to make the requested change for the following reasons. Once a consumer selects an agency that will provide and coordinate community support services, those services must be provided by that agency and cannot be provided from another community support service provider agency. Community support services are a comprehensive package of behavioral health services. Because of the nature of the interaction between the client and the CSS provider, the CSS provider

has increased familiarity with the client, giving them a unique advantage in addressing a situation where a client experiences increased distress or is in an active state of crisis. A requirement of the CSS program is to develop a crisis contingency plan that can be implemented as needed, see proposed N.J.A.C. 10:37B-1.2 (definition of crisis intervention) and 4.4(a)24.

Further, this generally will not be a new requirement for CSS providers. Although CSS is a new Medicaid service, many of the providers that will be providing CSS currently are providing supportive housing services. Under the existing regulatory framework, supportive housing services are within the scope of N.J.A.C. 10:37A and are required to have on-call staff available 24/7 for times of stress and crisis as set forth in the existing rules at N.J.A.C. 10:37A-4.3(c)7. Supportive housing services now fall within the ambit of the recently approved Medicaid State Plan Amendment for CSS and will be governed by the new CSS rules at N.J.A.C. 10:37B and 10:79B. As such, the inclusion of the on-call requirement in N.J.A.C. 10:79B-2.3(d) is consistent with long-standing requirements. For all of these reasons, no change will be made in response to the comment.

8. COMMENT: Nora Barrett commented that the reference to an “individualized recovery plan” at proposed N.J.A.C. 10:79B-2.3(e) is inconsistent with proposed community support services rules at N.J.A.C. 10:37B, which use the terminology “Individualized Rehabilitation Plan” (IRP).

RESPONSE: The Department agrees that the appropriate terminology is “individualized rehabilitation plan” rather than “individualized recovery plan” and, in response to the

comment, it is revising the original definition at N.J.A.C. 10:79B-1.1 and additionally unifying the rule text via the use of "IRP" throughout the rest of the chapter.

9. COMMENT: Nora Barrett commented that proposed N.J.A.C. 10:79B-2.3(e) is too narrow regarding the identification of staff that may participate in development of the IRP. The commenter noted that the proposed DMHAS CSS regulations allow most members of the treatment team to contribute to the development of the IRP. The commenter recommended that a sentence be added to subsection (e) to clarify that other qualified members of the treatment team are allowed to contribute to the development of the IRP.

RESPONSE: The Department agrees that the State Plan Amendment for CSS and the DMHAS proposed new rule at N.J.A.C. 10:37B-2.4(b) permit a wide range of staff to contribute to the development of the IRP, but are more specific with respect to staff that must authorize or sign the IRP. Proposed N.J.A.C. 10:79B-2.3(e) identifies the staff that must "complete" the IRP and that term might be misinterpreted as limiting the staff able to participate in the process of developing the IRP. Proposed N.J.A.C. 10:79B-2.3(e) would be clearer if, rather than restating the requirements for development of the IRP, it referenced the rules governing IRP development at N.J.A.C. 10:37B-2.4. Similarly, N.J.A.C. 10:79B-2.3(e) also identifies staff that must complete the comprehensive rehabilitative needs assessment (CRNA) and would be further clarified by referencing the DMHAS rules regarding development of the CRNA at N.J.A.C. 10:37B-2.3. That approach is consistent with proposed N.J.A.C. 10:79B-2.3(a), which references the proposed DMHAS rules at N.J.A.C. 10:37B with respect to the services that are included

in CSS. Consequently, for the purpose of clarity and consistency with the applicable DMHAS rules, the Department is making the above-described changes upon adoption.

Comment Regarding N.J.A.C. 10:79B-2.4, Conditions on Claims for Reimbursement for Services

10. COMMENT: NJAMHAA expressed concern that some of the requirements in proposed N.J.A.C.10:79B-2.4 are too burdensome and requested that the provisions be changed to permit flexibility. The commenter expressed a belief that: the prohibition against span billing and the requirement that claims be reported on a separate line for each day and by each type of staff in subsection (c) will require additional administrative support and costly system changes; subsection (e) requires that non-consecutive complete units rendered on the same day shall be totaled and paid, but these types of services are currently bundled and not allowing that practice to continue will impose an additional administrative burden; and, the limits on total billable units per day by types of staff in subsection (f) is overly complicated and will be difficult to track and properly bill, which will cause delays in payment and cause additional associated administrative and fiscal burdens.

RESPONSE: CSS allows billing under bands of credentialed staff to afford the provider some flexibility in the way they deliver services. However, each service must be billed daily and must relate to the individualized rehabilitation plan (IRP). Daily billing provides clarity on what service was provided and allows the Department to ensure that documentation supports that billing. Billing should not be complicated if the provider bills for each individual service provided and only for services indicated in the IRP. Providers

can utilize any credentialed staff type that is accounted for within the band, providing flexibility for assignment of services.

Comment Regarding N.J.A.C. 10:79B-2.7, Prior Authorization

11. COMMENT: NJAMHAA commented that the requirement in proposed N.J.A.C. 10:79B-2.7(c) that a copy of the consumer's individualized rehabilitation plan accompany a request for prior authorization will result in an increased administrative burden and inefficiencies by virtue of having to send paper. The commenter added that the process of obtaining prior authorizations has historically been inefficient and ineffective, leading to delays in providing services, causing additional administrative burden and delaying payments to providers.

RESPONSE: The Department disagrees that the prior authorization process is unduly burdensome. First, the prior authorization process serves several important functions by ensuring that the services listed in the IRP are clinically appropriate and helping to ensure proper billing. Second, prior authorization is not required for the first 60 days of service as set forth in proposed N.J.A.C. 10:79B-2.7(a). Third, prior authorization for services may be approved for up to six months consistent with N.J.A.C. 10:79B-2.7(d). Further, prior authorization requests and supporting IRPs that are submitted timely should not result in any delay of services. Finally, the Department is exploring mechanisms for further streamlining the process, such as by facilitating electronic prior authorization.

Federal Standards Statement

The Department has reviewed the applicable Federal laws and regulations and that review indicates that the adopted new rules do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

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

10:79B-1.1 Definitions

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

...

"*[Individual]* ***Individualized*** rehabilitation plan (IRP)" shall have the same definition as that provided at N.J.A.C. 10:37B.

...

10:79B-2.3 Services

(a) – (b) (No change from proposal.)

(c) CSS to be provided shall be identified in the *[Individual Rehabilitation Plan (]*IRP*[)]* and provided by the level of clinician identified. CSS shall be provided by the level of clinician most appropriate to provide the service requested and shall not be determined by the availability of staff at the time of the intervention.

(d) (No change from proposal.)

(e) The comprehensive rehabilitation needs assessment (CRNA) and *[individualized recovery plan (]*IRP*[)]* must be *[completed by a licensed clinician whose license allows them to assess a client for the purposes of completing a treatment plan]* ***developed consistent with the requirements at N.J.A.C. 10:37B-2.3 and 2.4, respectively** *.

(f) (No change from proposal.)

10:79B-2.4 Conditions on claims for reimbursement for services

(a) - (i) (No change from proposal.)

(j) Transportation of a client is not reimbursable as a service. Any provision of services provided to a CSS client during travel shall be indicated in the *[individual rehabilitation plan]* ***IRP*** prior to the travel and shall have corresponding documentation supporting what service was provided, by whom, to whom, and the expected outcome of the intervention.

(k) (No change from proposal.)

10:79B-2.5 Recordkeeping

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

(c) The *[individual rehabilitation plan (]*IRP*[)]* shall identify those services to be provided, the credential of the practitioner providing the service, the amount of time that will be devoted to the provision of the service, and the location of services to be provided. Only those services provided as described in the IRP are reimbursable. The IRP must be amended as required if services not previously documented in the IRP are

determined necessary for the beneficiary's treatment in order to ensure proper billing.

(d) – (f) (No change from proposal.)