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New Jersey Association of Mental
Health and Addiction Agencies, Inc.



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Re: Comments on the Proposed New Rule of New Jersey Administrative Code
(N.J.A.C.) 10:36 – Behavioral Health Program Service Standards

On behalf of the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA), its members and those they serve, I thank you for the opportunity to comment in response to the New Jersey Department of Human Services Division of Mental Health and Addiction Services' proposed new chapter N.J.A.C 10:36, Behavioral Health Program Service Standards, along with repeals of 10:37E and 10:37F.

NJAMHAA has long supported the value of integrated care. Behavioral health providers have a long history of providing whole person care and look forward to advancing comprehensive care under the new program standards. Below are concerns, inquiries and recommendations we wish to share regarding the proposed new rule.

GENERAL COMMENTS

A relevant fact that I wish to note is that N.J.A.C. 8:43K has not been finalized, which leaves stakeholders in the dark on aspects of the program service standards, as many program rules are included in 8:43K and several provisions in 10:36 simply refer back to 8:43K. It was anticipated that N.J.A.C. 10:36 would fill in gaps for issues not addressed in N.J.A.C. 8:43K, and that has not been the case for all topics. In instances where provisions in 10:36 refer the reader to 8:43K or where a program aspect has not been addressed in either but seems appropriate for 8:43K, comments herein may be directed at 8:43K.

Inspections

One example of a topic that is not addressed in either new rule is the frequency of inspections. Currently, inspections for mental health programs occur every three years and at substance use disorder (SUD) programs every two years. NJAMHAA recommends aligning inspection frequency for both mental health

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and SUD programs at a consistent interval (i.e., every 3 years), unless program-specific factors warrant otherwise, to reduce administrative burden and provide parity between mental health and SUD services.

Mental Health Intensive Outpatient

It must also be noted that 8:43K-6.11(a) which specifies eligibility criteria for intensive outpatient (IOP) services shows clear intent to establish a Mental Health (MH) IOP by the inclusion of “mental health” in the section heading. However, the final eligibility criteria in 8:43K-6.11(a)4. specifies that “the patient is willing to participate in intensive outpatient SUD and/or addiction treatment services.” NJAMHAA and its members greatly appreciate the intent to develop a MH IOP to address the gap in service options for individuals with serious mental illness who require structured group therapy but do not need the rehabilitative or vocational services of Adult Partial Care. NJAMHAA recommends establishing MH IOP standards within N.J.A.C. 10:36 that permit providers to deliver structured, group-based mental health treatment with a flexible billing structure (i.e., one to three hours per day) as soon as possible. This would create a critical “step-down” option between partial care and traditional outpatient, aligning with modern care models and improving client access to the right level of service.

Billing Alignment and Guidance

Throughout these comments there is mention of increased staffing, services and administrative burdens that specific requirements demand. It is important that all mandated staffing, services and administrative tasks be aligned with and supported by billing options, with clear guidance. Examples include, but are not limited to, additional medical staff in substance use partial care programs and new assessment and discharge planning obligations, all of which impose costs without identified reimbursement mechanisms. It is also unclear whether family psychoeducation is a Medicaid billable service. Explicit billing guidance is recommended.

SUBCHAPTER 2. DEFINITIONS

10:36-2.1 Definitions

A handful of terms used in 10:36 are only found defined in 8:43K-1.3, e.g., “counseling and therapy services” and “medication monitoring”. Many more terms that are used in 8:43K only have definitions listed in 10:36. These include: “addictive disorder”, “admission’ or ‘admitted”, (8:43K does define “admit”), “evidence-based practices”, “family members and/or other supportive persons”, “FDA”, “mental illness”, “regularly scheduled” and “treatment record”.



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Even more terms are defined in both 10:36 and 8:43K, with differences inconsequential in most cases, though more substantial in some, such as for “document,” “documented,” or “documentation,” “opioid use disorder” and “patient”. (Other terms found in both, several with inconsequential differences, are: “biopsychosocial assessment”, “DEA”, “DMHAS”, “dosage”, “DSM” or “DSM-5-TR”, “medication”, “psychoeducation services”, “progress note” and “opioid treatment program” (in 10:36, this is defined in subchapter 9)). There are also a couple of similar terms defined in both sets of regulation. “Behavior Health” and “Psychiatric advance directive” are defined in 10:36-2.1 and “Behavioral health care and behavioral health services” and “advance directive for mental health care” are defined in 8:43K.

We recommend a full review of definitions. Such review should determine if a definition should be in one or both regulations, ensure any terms defined in both are accurate and the same, and that all terms used in 8:43K are defined there. We also wish to emphasize the exclusion of children and youth services in the definition of “patient” as an individual 18 years or older in 10:36. Action is needed to retain 10:37E for those services or develop a new rule for them. This definition is also problematic for Certified Community Behavioral Health Clinics that serve both populations.

SUBCHAPTER 3. GENERAL BH PROGRAM OPERATIONAL REQUIREMENTS

10:36-3.3 Submission of documents and data to the DHS and/or DMHAS

10:36-3.3(a) specifies the New Jersey Substance Abuse Monitoring System as an example of the systems BH programs shall submit data to. For clarity, it is recommended that the language say “including for substance use programs,...” as the text otherwise implies it applies to all BH programs, including MH programs.

10:36-3.4 Waiver

The clearly documented process for submitting waiver requests to the Assistant Commissioner of DMHAS, or their designee, is greatly appreciated.

SUBCHAPTER 4. BH PROGRAM STAFFING REQUIREMENTS

10:36-4.1 General Staffing Requirements

This provision requires compliance with staffing requirements in 8:43K and federal standards. In 8:43K-6.2, all behavioral health programs are required to employ a Program Director, Clinical Supervisor and counseling and/or therapy staff. Current staffing requirements for MH outpatient (OP) programs (10:37E) state that the Program Director “shall manage OP operations and provide OP staff clinical supervision”. Substance use (SU) OP programs are required in 10:161B to have a



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Facility Administrator and Director of Substance Abuse Counseling Services. While 8:43K allows a Program Director to also serve as Facility Administrator, it does not state that a Program Director may serve as Clinical Supervisor, as is currently allowed in MH OP programs. In SU OP, the Director of Substance Abuse Counseling Services may provide clinical supervision or may have another qualified staff do so. 10:36 Subchapter 6, Program Standards for Outpatient Addictive Disorder and/or Mental Health Services should specify that the Program Director may serve as the Clinical Supervisor or may designate a qualified staff member to do so. Without such flexibility, 8:43K would require MH and SU OP programs to hire a Clinical Supervisor, a position that is not accounted for in current rates and which, given the ongoing workforce shortage, would not be easy for all programs to fill.

The same additional requirement for a Clinical Supervisor would apply to both MH and SU partial care (PC) programs where current regulations require only a Program Director in MH PC and a Director of SU Counseling in SU PC. 10:36 Subchapter 8 Program Standards for Partial Care (PC) Mental Health or Addictive Disorder Services should also specify that the Program Director may serve as the Clinical Supervisor or may designate a qualified staff member to do so.

Additional required staff for both MH and SU partial care (PC) programs are specified in 8:43K-6.12(a) and include a Medical Services Supervisor, Medical staff, and, for SU PC, Primary Case Coordinator. In 10:37F, MH PC program staffing requirements include a Program Director, Medical Director, Direct Care On-site Staff Supervisor, Primary Case Coordinator and MH Services worker. For these programs, the new regulations require additional medical staff and do not include the Direct Care On-site Staff Supervisor position, which is critical to efficient, successful operation in MH PC programs and should be retained. We would not want to see the Program Director take on the supervision responsibilities of this position. We recommend including this position in 10:36 Subchapter 8, Program Standards for Partial Care Mental Health or Addictive Disorder Services in lieu of a Clinical Supervisor, and providing flexibility as to the requirement for additional medical staff.

Current SU PC regulations (10:161B-7.1) do not require medical services “to be provided either in the facility or through written agreement”, only that “The program shall have written protocols to ensure ready access to psychiatric and medical services.” The requirements in 8:43K for a Medical Services Supervisor, Medical staff, and Primary Case Coordinator would be all newly required staff positions. The existing flexibilities regarding medical staffing in SU PC should be retained and specified in Subchapter 8, Program Standards for Partial Care Mental Health or Addictive Disorder Services. At a minimum, the regulations should clearly allow the Medical Services Supervisor to also be the designated “Medical staff” and rates should be adjusted for the addition of this position as well as the addition of a Primary Case Coordinator.



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SUBCHAPTER 5. BH PROGRAM CORE SERVICE STANDARDS

10:36-5.1 Admission intake process

10:36-5.1(a)7 Requires “screening for physical health and substance withdrawal to identify physical health and/or withdrawal issues that require immediate medical intervention precluding admission to the BH program.” Only a nurse, APN or Psychiatrist would be qualified to fully assess for both physical health and/or withdrawal issues – something that is outside of clinicians’ purview. While MH PC currently requires a psychiatric assessment, MH OP and SUD OP, IOP and SU PC do not, and neither do they require nursing services. As was noted in preceding comments on staffing (Subchapter 4), many programs would need to add medical staff to meet the proposed staffing requirements and to be able to meet this particular requirement for the admission intake process. Not only would there be a significant financial cost to do so that is not covered by current rates, but the ability to hire the necessary staff amidst the current and projected workforce shortages would make it difficult for programs to meet these requirements.

10:36-5.2 Screening and assessment services and tools

10:36-5.2(a) requires programs to “use evidence-based, nationally recognized, and peer-reviewed screening and assessment tools.” More clarity is requested regarding which listed items this applies to as tools to meet this requirement may not exist for all the listed/required screenings.

10:36-5.2(d) requires a biopsychosocial assessment at intake, then quarterly in the first year and every six months thereafter for MH and SU OP. 10:36-8.3 sets a different biopsychosocial assessment requirement for MH and SU PC which is at intake, then every six months in the first year and annually thereafter. This is far beyond what is currently required in any program covered by the proposed rule, requires additional staff time, and may duplicate ongoing treatment planning and clinical review processes.

Currently, all mental health and substance use outpatient and partial care programs conduct a biopsychosocial assessment at intake. Then care/service/treatment/recovery (care) plans are developed and regularly reviewed at least every three months in the first year and every six months thereafter in most programs, with 10:37E requiring review only “at significant decision points in each client’s course of treatment”. In all cases, progress notes and updates to plans must be submitted regularly for extension of services.

Given the additional administrative burden and costs associated with increased requirements to conduct biopsychosocial assessments as well as other requirements for reevaluating care plans at regular intervals, NJAMHAA recommends that the biopsychosocial assessment requirement remain for intake only and the proposed subsequent quarterly and six-month timeframes be removed.



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5.2(e) specifies requirements regarding an immediate needs assessment. Such assessments are currently captured within the biopsychosocial assessments done in OP and PC programs. We ask that DMHAS comment on whether there will be a separate document required/specified for the immediate needs assessment and the current biopsychosocial assessments will be amended or if the immediate needs assessments will continue to be incorporated in the biopsychosocial assessments.

10:36-5.3 BH care plan and planning

10:36-5.3(d) requires updates to the care plan at the time of discharge. While discharge planning begins at admission and is updated periodically, the requirement to update at the time of discharge when the separate discharge plan will be final is redundant. We recommend removing 10:36-5.3(d).

10:36-5.6 Medication services

10:36-5.6(a) allows BH programs to provide or arrange for the provision of medication services, specifying in (a)2. that those programs not providing services directly “must facilitate the provision of medication services”. 10:36-5.6(b) goes on to specify the “medication education, management and monitoring” that “patients prescribed medication as part of their treatment services” must receive. Once again, this will require medical staffing that many programs do not currently employ. Beyond that, it is not clear whether programs not directly providing medication services should be responsible for the education, management and monitoring, or if that would appropriately fall to the prescriber. In any case, these would not fall within a clinician’s therapeutic duties and billing options, subsequently requiring not only additional staffing, but new billing codes. This would be especially difficult to implement in OP, PC and IOP programs. While MH PC programs are currently required to provide medication management, they do not require medication education or monitoring. Beyond the aforementioned staffing and billing eligibility challenges all programs would have, the large number of individuals who receive services via telehealth in OP and the current billing structure and hourly requirements for both PC and IOP programs add more difficulty to complying with these provisions. We recommend clarifying that: medication management continue to be only required of MH PC programs; the prescriber entity is responsible for medication management for OP, IOP and SU PC patients; the prescribing entity is responsible for medication education and monitoring; medication services be provided according to the prescriber based on clinical indications; and that billing guidance be issued for those services.

10:36-5.7 Psychoeducational and patient education services

10:37-5.7(b) requires BH programs to offer psychoeducation services to family members and other supportive persons identified by the patient. This is a new requirement and may add unreimbursed costs as service formats and billing eligibility are unclear. There are no known billing options for this in OP unless it is expected to be billed as Family Therapy, and that option does not exist for PC or



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IOP programs, with IOP not allowing any billing over the daily rate. Clarity on expectations as well as billing codes and guidance are needed.

In 10:37-5.7(c), psychoeducation topics are listed. Normally, specific topics are not documented, however, some inspectors have wanted to see such documentation. The expectations for documentation should be stated.

10:36-5.10 Involuntary discharge from the BH program

10:36-5.10(a) lists the reasons for which a BH program may involuntarily discharge a patient. Among them, at 5.10(a)2 is “The patient is refusing to participate in their treatment”. Clarity is needed as to whether “patient is refusing to participate in their treatment” covers chronically missed appointments. There is concern that the proposal may not adequately provide for the ability to discharge a patient for chronic missed appointments or excessive tardiness. This section must also be reconciled with 10:36-7.4(b) and 8:43K-6.11(b) regarding IOP programs which are discussed in the comments on Subchapter 7 below.

Multiple NJAMHAA members have shared their support for 5.10(b) that prohibits involuntarily discharging “a patient who is experiencing, or has experienced, a relapse related to an addictive disorder.” This is seen as a positive change, though it is expected to take some education and supervision.

SUBCHAPTER 7. PROGRAM STANDARDS FOR INTENSIVE OUTPATIENT (IOP) ADDICTIVE DISORDER SERVICES

10:36-7.4 IOP addictive disorders services description of services and hours

10:36-7.4(b) states that an IOP program shall review with the patient the “level of care that supports the patient’s needs and continued engagement with treatment services” when the patient’s attendance is “frequently or consistently unreliable or sporadic without reasonable cause or excuse.” The only example given is when “the patient does not attend their nine hours of IOP services for two consecutive weeks during a four-week period.” More clarity should be given to when the level of care should be reviewed; for instance, would two weeks within a four-week period that are not consecutive also require such review?

Furthermore, it is difficult to reconcile this requirement with the flexibility provided by 8:43K-6.11(b) which states that “A facility may, on a weekly basis, transition a patient who does not attend the minimum number of treatment hours established by the DMHAS program standards for intensive outpatient services to the outpatient behavioral health level of care and retain the patient for treatment.”



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It is also difficult to understand how this would work operationally. Would discharge and readmission need to be processed in NJSAMS? Would new assessments be required? Since only five units can be billed each week in outpatient programs, this would still result in many hours of services being provided that are not billable whenever more than five hours were provided.

It is recommended that a more flexible billing structure be developed for IOP programs. Flexibility to unbundle IOP services is all that is needed, not necessarily changing the level of care. This would allow for a range of hours to be provided on a given day, such as the two to five hours that are billable for PC programs on any day. Such flexibility would also increase the number of patients able to meet the nine hours per week minimum. If such flexibility is not afforded, much greater detail is needed on how the transitions to and from OP and IOP would work operationally for programs to be able to bill for at least some of the services they have provided when the three-days per week, nine-hour minimum is not met.

In Closing

In summary, and with great appreciation for the immense undertaking that a re-orientation of regulations to drive integrated licensing, oversight and care delivery approaches is and has been, NJAMHAA and the provider community it represents do have significant concerns about the increased staffing, service and documentation requirements that have been proposed. Without comparable significant increases to funding and billing options, providers will not be able to meet the proposed requirements. Billing options simply must be aligned with the staffing and service provisions.

Another significant concern that is reflected throughout our comments is that greater clarity is needed in many areas so that provisions are not left open to interpretation. This is especially important given the dual accountability to DMHAS and DOH, where conflicting corrective actions and duplicative audits could be problematic.

Thank you in advance for your consideration of these comments and recommendations for the proposed new rule 10:36 Behavioral Health Program Service Standards. We look forward to the refinement of both 8:43K and 10:36 to meet our shared goal of developing a framework for quality integrated care service delivery.

Sincerely,

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