Adult Day Health Care Programs and Managed Long Term Care

Effective date: 9/10/14

SUMMARY OF EXPRESS TERMS

The amendments make a number of changes to 10 NYCRR Part 425, governing the operation and payment of adult day health care (ADHC) programs in residential health care facilities. The purpose of the amendments is to enable such programs to contract and work effectively with managed long term care (MLTC) plans and care coordination models (CCMs) as more Medicaid recipients are required to enroll in MLTC plans and CCMs. The amendments also allow ADHC programs to offer an Unbundled Services/Payment Option, in which individuals requiring ADHC services and individuals requiring less than the full range of ADHC services can both receive services in the adult day health care program space.

Section 425.1

Amendments are made to the definitions of "Registrant," "Operating hours for an adult day health care program," and "Visit," and new definitions of "Care coordination model," "Comprehensive assessment," "Care plan," and "Unbundled Services/Payment Option" are added.

Section 425.3

Amended to allow operators of approved ADHC programs to elect the Unbundled Services/Payment Option.

Sections 425.4, 425.5, 425.6, 425.7, 425.8, 425.10, 425.12, 425.14, and 425.16

As part of their responsibility to manage and coordinate the health care needs of their enrollees, MLTC plans and CCMs provide certain services that ADHC programs are also required to provide for their registrants. Amendments are made to these regulatory sections to avoid duplication of services with respect to ADHC registrants who are referred to the ADHC program by an MLTC plan or CCM.

Section 425.23

A new section 425.23 is added, with respect to payments to ADHC programs, to allow a MLTC plan or CCM to order less than the full range of adult day health care services for a particular enrollee, based on an enrollee's individual medical needs as determined in the comprehensive assessment performed by the MLTC plan or CCM, and to enter into reimbursement arrangements with the ADHC program operator that take into account a registrant's receipt of less than the full range of adult day health care services.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Section 363-a(2) of the Social Services Law and Section 2803(2) of the Public Health Law, Part 425 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Part 425

Adult Day Health Care

(Statutory Authority: Public Health Law, section 2803(2); Social Services Law, section 363-a(2))

Sec.

425.15 Religious services and counseling

425.16 Dental services

425.17 Pharmaceutical services

425.18 Services for registrants with Acquired Immune Deficiency Syndrome (AIDS)

425.19 General records

425.20 Clinical records

425.21 Confidentiality of records

425.22 Program evaluation

425.23 Payment

425.1 Definitions. As used in this Part:

(a) *Adult day health care* is defined as the health care services and activities provided to a group of registrants with functional impairments to maintain their health status and enable them to remain in the community.

(b) *Registrant* is defined as a person:

(1) who is not a resident of a residential health care facility, is functionally impaired and not homebound, and requires supervision, monitoring, preventive, diagnostic, therapeutic, rehabilitative or palliative care or services but does not require continuous 24-hour-a-day inpatient care and services, except that where reference is made to the requirements of Part 415 of this Subchapter, the term resident as used in Part 415 shall mean registrant;

(2) whose assessed social and health care needs can satisfactorily be met in whole or in part by the delivery of appropriate services in the community setting; and

(3) who has been [admitted to] accepted by an adult day health care program based on an

authorized practitioner's order or a referral from a managed long term care plan or care coordination model and [the adult day health care program's interdisciplinary] a comprehensive assessment conducted by the adult day health care program or by the managed long term care plan or care coordination model.

(c) *Program* is defined as an approved adult day health care program, located at a licensed residential health care facility or an approved extension site.

(d) *Operating hours for an adult day health care program* are defined as the period of time that the program must be open, operational, and providing services to registrants in accordance with the approval granted by the Department. [(1)] Each approved adult day health care session must operate for a minimum of five hours duration, not including time spent in transportation, and must provide, at a minimum, nutritional services in the form of at least one meal and necessary supplemental nourishment, and planned activities[,]. In addition, an ongoing assessment must be made of each registrant's health status by the adult day health care program, or by the managed long term care plan or care coordination model that referred the registrant to the adult day health care program, in order to provide coordinated care planning, case management and other health care services as determined by the registrant's needs.

[(2) Unless otherwise permitted by the Department, each approved session will consist of the majority of registrants in attendance for at least five hours.]

(e) *Visit* is defined as an individual episode of attendance by a registrant at an adult day health care program during which the registrant receives adult day health care services in accordance with his/her care plan. A registrant's individual visit may be fewer than five hours or longer than five hours depending on the assessed needs of the registrant [but a program may only bill for one visit per registrant per day]. Registrants referred by a managed long term care plan or care

coordination model will receive services as ordered by those entities in conformance with those entities' comprehensive assessment after discussion and consultation with the adult day health care program.

(f*) Registrant capacity* is defined as the total number of registrants approved by the Department for each session in a 24 hour day.

(g) *Operator of an adult day health care program* is defined as the operator of a residential health care facility that is approved by the Department to be responsible for all aspects of the adult day health care program.

(h) *Practitioner* is defined as a physician, nurse practitioner or a physician's assistant with physician oversight.

(i) *Department* means the New York State Department of Health.

(j) *Commissioner* means the Commissioner of the New York State Department of Health.

(k) *Care coordination model* means a program model that meets guidelines specified by the Commissioner that support coordination and integration of services pursuant to Section 4403-f of the Public Health Law.

(l) *Comprehensive assessment* means an interdisciplinary comprehensive assessment of a registrant completed in accordance with Section 425.6 of this Part by the adult day health care program, or an interdisciplinary comprehensive assessment, approved by the Department, completed by the managed long term care plan or care coordination model that referred the registrant to the adult day health care program.

(m) *Care plan* means the care plan developed in accordance with section 425.7 of this Part by the adult day health care program.

(n) *Unbundled Services/Payment Option* means the ability of an adult day health care program to

provide less than the full range of adult day health care services to a functionally impaired individual referred by a managed long term care plan or care coordination model based on the registrant's comprehensive assessment. The full range of adult day health care services as described in Part 425 will be available to all registrants enrolled in the adult day health care program.

425.2 Application. (a) Prior to operation of an adult day health care program, the proposed operator must apply for and receive Department approval in accordance with Part 710 of this Chapter. Such application must include a description of the proposed program, including but not limited to:

(1) the need for the program, including a statement on the philosophy and objectives of the program;

(2) the range of services to be provided;

(3) the method(s) of delivery of services;

(4) physical space to be utilized and planned use thereof;

(5) number and expected characteristics of registrants to be served;

(6) a description of a typical registrant's program;

(7) personnel to be employed in the program, including qualifications;

(8) intended use of and coordination with existing community resources;

(9) financial policies and procedures;

(10) program budget;

(11) methods for program evaluation; and

(12) proximity to an identified number of potential registrants.

(b) A residential health care facility operator that has been approved by the Department to operate an adult day health care program at its primary site may provide adult day health care services at an extension site only when such use of an extension site has first been approved by the Department under the provisions of Part 710 of this Chapter.

(c) A residential health care facility operator that does not operate an adult day health care program at its primary site may provide such a program at an extension site approved by the Department for such use in accordance with section 710.1 of this Chapter if there is not sufficient suitable space within the residential health care facility to accommodate a full range of adult day health care program activities and services. The Department may conduct an on-site survey of the residential health care facility to determine whether the facility lacks suitable space for an adult day health care program.

425.3 Changes in existing program.

(a) Applications for approval of changes in the program, including but not limited to substantial changes in the physical plant, space and utilization thereof, the extent and type of services provided, and the program's registrant capacity, must be submitted to the Department in writing and must conform with the provisions of Part 710 of this Chapter.

(b) Written requests for additional program sessions must be based on the number and needs of registrants and be approved by the Department.

(c) An operator may not discontinue operation of services to registrants without:

(1) notifying each registrant and making suitable plans for alternate services for each registrant; and

(2) receiving written approval from the commissioner in accordance with Part 710 of this

Chapter. The application to discontinue services must set forth the specific intended date of discontinuance and the intended plans for alternate services to registrants.

(d) The operator of an approved adult day health care program must [apply in writing to the Department for approval to run a session in which the majority of the registrants are or will be attending for fewer than five hours] notify the Department of the program's election of the Unbundled Services/Payment Option in writing thirty days before commencement of this option.

425.4 General requirements for operation

(a) [A residential health care facility] An operator must:

(1) provide services to registrants consistent with the requirements of this Title and Part and other applicable statutes and regulations;

(2) provide appropriate staff, equipment, supplies and space as needed for the administration of the adult day health care program in accordance with the requirements of this Part; and

(3) provide each registrant with a copy of a Bill of Rights specific to operation of the adult day health care program.

These rights include, but are not limited to:

(i) confidentiality, including confidential treatment of all registrant records;

(ii) freedom to voice grievances about care or treatment without discrimination or reprisal;

(iii) protection from physical and psychological abuse;

(iv) participation in developing the care plan; [and]

(v) written notification by the program to the registrant at admission and following the continued-stay evaluation of the services the registrant shall receive while attending the adult day health care program: and

[(v)] (vi) freedom to decide whether or not to participate in any given activity.

(b) Administration. Without limiting its responsibility for the operation and management of the program, the operator must designate a person responsible for:

(1) coordinating services for registrants with services provided by community or other agency programs, including but not limited to certified home health agencies, social services agencies, clinics and hospital outpatient departments and services; provided, however, with respect to registrants referred to the adult day health care program by a managed long term care plan or care coordination model, the coordination of such services shall be the responsibility of the managed long term care plan or care coordination model; and

(2) day-to-day direction, management and administration of the adult day health care services, including but not limited to:

(i) assigning adequate and appropriately licensed personnel to be on-duty at all times when the program is in operation to ensure safe care of the registrants;

(ii) assigning and supervising activities of all personnel to ensure that registrants receive assistance in accordance with their plans of care;

(iii) ensuring supervision of direct care staff in accordance with state rules and regulation;

(iv) arranging for in-service orientation, training and staff development; and

(v) maintaining records in accordance with provisions of sections 400.2 and 415.3(d)(1) of this Subchapter.

(c) Policies and procedures for service delivery. The operator must:

(1) establish and implement written policies and procedures, consistent with the approved application for operation of the adult day health care program, concerning the rights and responsibilities of registrants, the program of services provided to registrants, use of physical

structures and equipment, and the number and qualifications of staff members and their job classifications and descriptions;

(2) ensure that written policies and procedures, consistent with current professional standards of practice, are developed and implemented for each service and are reviewed and revised as necessary;

(3) develop protocols for each involved professional discipline to indicate when the service of such discipline should be included in the registrant assessment;

(4) ensure that professional personnel are fully informed of, and encouraged to refer registrants to, other health and social community resources that may be needed to maintain the registrant in the community; provided, however, with respect to registrants referred to the adult day health care program by a managed long term care plan or care coordination model, such referrals shall be the responsibility of the managed long term care plan or care coordination model;

(5) establish and implement written policies for the storage, cleaning and disinfection of medical supplies, equipment and appliances;

(6) establish and implement written policies and procedures concerning refunds and prepayment for basic services in accordance with existing rules and regulations;

(7) establish and implement written policies and procedures concerning transfer and affiliation agreements covering registrants that are consistent with the standards specified in section 400.9 of this Subchapter; and

(8) provide in such agreement(s) reasonable assurance of assistance to each registrant in transferring to inpatient or resident status in a residential health care facility whenever the registrant is deemed by a practitioner to be medically appropriate for such care.

425.5 Adult day health care services.

(a) The operator must provide or arrange for services appropriate to each registrant in accordance with the [individual's interdisciplinary needs] comprehensive assessment conducted and [comprehensive] care plan [as] developed by the adult day health care program, or by the managed long term care plan or care coordination model that referred the registrant to the adult day health care program. At least the following program components must be available:

(1) case management[, including health education];

(2) health education;

[(2)] (3) interdisciplinary care planning;

[(3)] (4) nursing services;

[(4)] (5) nutrition;

[(5)] (6) social services;

[(6)] (7) assistance and supervision with the activities of daily living, such as toileting, feeding, ambulation, bathing including routine skin care, care of hair and nails; oral hygiene; and supervision and monitoring of personal safety, restorative rehabilitative and maintenance therapy services;

[(7)] (8) planned therapeutic or recreational activities that reflect the interests, cultural backgrounds and the communities of the registrants and provide the registrants with choices;

[(8)] (9) pharmaceutical services; and

[(9)] (10) referrals for necessary dental services and sub-specialty care.

(b) The following services may also be provided:

(1) specialized services for registrants with HIV or AIDS; and

(2) religious services and pastoral counseling.

425.6 Admission, continued stay and registrant assessment.

(a) The operator must:

(1) select, admit and retain in the adult day health care program only those persons for whom adequate care and needed services can be provided and who, according to [their] the [interdisciplinary needs] comprehensive [assessments] assessment conducted by the operator or by the managed long term care plan or care coordination model that referred the applicant to the adult day health care program, can benefit from the services and require a minimum of at least one (1) visit per week to the program;

(2) assess each applicant, unless the assessment was conducted by a managed long term care plan or care coordination model that referred the applicant to the adult day health care program, utilizing an assessment instrument designated by the Department, with such assessment addressing, at a minimum:

(i) medical needs, including the determination of whether the applicant is expected to need continued services for a period of 30 or more days from the date of the assessment. An operator may request approval by the appropriate Department regional office for an exemption, based on special circumstances, to the requirement for determining whether there is a need for continued services for 30 days or more.

(ii) use of medication and required treatment;

(iii) nursing care needs;

(iv) functional status;

(v) mental/behavioral status;

(vi) sensory impairments;

(vii) rehabilitation therapy needs, including a determination of the specific need for physical therapy, occupational therapy, speech language pathology services, and rehabilitative, restorative or maintenance care;

(viii) family and other informal supports;

(ix) home environment;

(x) psycho-social needs;

(xi) nutritional status;

(xii) ability to tolerate the duration and method of transportation to the program; and

(xiii) evidence of any substance abuse problem.

(3) register an applicant only upon appropriate recommendation from the applicant's practitioner after completion of a personal interview by appropriate program personnel;

(4) register an applicant only after determining that the applicant is not receiving the same services from another facility or agency.

(b) An individual may be registered in an adult day health care program only if his/her [admission] <u>comprehensive</u> assessment indicates that the program can adequately and appropriately care for the physical and emotional health needs of the individual.

(c) No individual suffering from a communicable disease that constitutes a danger to other registrants or staff may be registered or retained for services on the premises of the program.

(d) The operator may admit, on any given day, up to ten percent over the approved capacity for that program. The average annual capacity, however, may not exceed the approved capacity of the operator's program.

425.7 Registrant care plan.

(a) The operator must ensure that [: (a) a] an adult day health care program care plan based on the comprehensive [interdisciplinary] assessment required by this Part, and, when applicable, a transfer or discharge plan, is developed for each registrant and is in place within five visits [, not to exceed] or within 30 days [, from] after registration, whichever is earlier [;] . The adult day health care program and the referring managed long term care plan or care coordination model must be sure to coordinate with each other regarding the development of a registrant's care plan.

(b) [each] Each registrant's care plan must include:

(1) designation of a professional person to be responsible for coordinating the care plan;

(2) the registrant's pertinent diagnoses, including mental status, types of equipment and services required, case management, frequency of planned visits, prognosis, rehabilitation potential, functional limitations, planned activities, nutritional requirements, medications and treatments, necessary measures to protect against injury, instructions for discharge or referral if applicable, orders for therapy services, including the specific procedures and modalities to be used and the amount, frequency and duration of such services, and any other appropriate item.

(3) the medical and nursing goals and limitations anticipated for the registrant and, as appropriate, the nutritional, social, rehabilitative and leisure time goals and limitations;

(4) the registrant's potential for remaining in the community; and

(5) a description of all services to be provided to the registrant by the program, informal supports and other community resources pursuant to the care plan, and how such services will be coordinated.

(c) [development] Development and modification of the care plan is coordinated with other health care providers outside the program who are involved in the registrant's care[; and].

(d) [the] The responsible persons, with the appropriate participation of consultants in the medical, social, paramedical and related fields involved in the registrant's care, must:

(1) record in the clinical record changes in the registrant's status which require alterations in the registrant care plan;

(2) modify the care plan accordingly;

(3) review the care plan at least once every six months and whenever the registrant's condition warrants and document each such review in the clinical record; and

(4) promptly alert the registrant's authorized practitioner of any significant changes in the registrant's condition which indicate a need to revise the care plan.

425.8 Registrant continued-stay evaluation. The operator, directly or through the managed long term care plan or care coordination model that referred the registrant to the adult day health care program, must ensure that a written comprehensive assessment and evaluation is completed pursuant to section 425.6 of this Part at least once every six months for each registrant, addressing the appropriateness of the registrant's continued stay in the program, such assessment and evaluation to address, at a minimum:

(a) a reassessment of the registrant's needs, including an interdisciplinary evaluation of the resident's need for continued services;

(b) the appropriateness of the registrant's continued stay in the program;

(c) the necessity and suitability of services provided; and

(d) the potential for transferring responsibility for or the care of the registrant to other more appropriate agencies or service providers.

425.9 Medical services. The operator must, without limiting its responsibility for the operation and management of the program:

(a) assign to the operator's [residential health care facility's] medical board, medical advisory committee, medical director or consulting practitioner the following responsibilities regarding registrants of the program:

(1) developing and amending clinical policies;

(2) supervising medical services;

(3) advising the operator regarding medical and medically related problems;

(4) establishing procedures for emergency practitioner coverage, records and consultants; and

(5) establishing professional relationships with other institutions and agencies, such as general hospitals, rehabilitation centers, residential health care facilities, home health agencies, hospital outpatient departments, clinics and laboratories;

(b) ensure that medical services, including arranging for necessary consultation services, are provided to registrants of the program in accordance with sections 415.15(b)(1), (2)(ix), (3) and (4) of this Subchapter;

(c) provide or arrange for the personal, staff or other designated practitioner to obtain a medical history and a physical examination of each registrant, including diagnostic laboratory and x-ray services, as medically indicated, within six weeks before or seven days after admission to the program;

(d) ensure that the practitioner record, date and authenticate significant findings of the medical history, physical examination, diagnostic services, diagnoses and orders for treatment in the registrant's clinical records; and

(e) ensure that orders for treatment include orders for medication, diet, permitted level of

physical activity and, when indicated, special orders or recommendations for rehabilitative therapy services and other adult day health care services.

425.10 Nursing services. The operator, directly or through the managed long term care plan or care coordination model that referred the registrant to the adult day health care program, must:

(a) [provide nursing services to] evaluate the need of each registrant for nursing care on a periodic and continuing basis, but not less often than quarterly, and, when appropriate, provide [for] or authorize such care;

(b) ensure that a registered professional nurse is on-site and performs a nursing evaluation of each registrant at the time of admission to the program, unless such nursing evaluation has been performed by the managed long term care plan or care coordination model prior to referring the registrant to the adult day health care program;

(c) ensure that for each registrant the findings of the nursing evaluation, the nursing care plan, and recommendations for nursing follow-up are documented, dated and signed in the registrant's clinical record;

(d) ensure that nursing services are provided to registrants under the direction of a registered professional nurse who is on-site in the adult day health care program during all hours of the program operation. Based on the care needs of the registrants, for a program located at the sponsoring licensed residential health care facility, a licensed practical nurse may provide the on-site services when a registered professional nurse is available in the nursing home or on the campus to provide immediate direction or consultation; and

(e) ensure that appropriate health education is provided to registrants and family members to

provide support for the registrant and family in understanding and dealing with the registrant's health condition as it relates to his/her continued ability to reside in the community.
With respect to registrants referred to the adult day health care program by a managed long term care plan or care coordination model, the managed long term care plan or care coordination model shall be responsible for compliance with the requirements of this section.

425.11 Food and nutrition services. The operator must:
(a) provide nutritional services for each registrant;
(b) provide meals and nutritional supplements, including modified diets when medically prescribed, to registrants who are on the premises at scheduled meal times and, where appropriate, to registrants in their homes in accordance with the identified needs included in registrant care plans;
(c) ensure that the quality and quantity of food and nutrition services provided to registrants are in conformance with section 415.14 of this Subchapter, exclusive of the requirements specified in section 415.14(f);
(d) ensure that nutrition services are under the direction of a qualified dietitian, as defined in section 415.14 of this Subchapter; and
(e) ensure that dietary service records for the adult day health care service are maintained in conformance with sections 415.14(c)(1) and (2) of this Subchapter.

425.12 Social services. The operator must:
(a) provide social services in conformance with section 415.5(g) of this Subchapter except that the use of a full or part time social worker in an adult day health care program must be in

conformance with the approved application for operation and, with respect to section 415.5(g)(2)(ii) and (iii), regular access may be directly with a master's prepared or certified social worker or through a contract which meets the provisions of section 415.26(e);

(b) either directly or through the managed long term care plan or care coordination model that referred the registrant to the adult day health care program, ensure that psycho-social needs are assessed, evaluated and recorded, and that services are provided to meet the identified needs as part of the coordinated care plan; and

(c) ensure that staff members arrange for the use of and/or access to other community resources as needed and coordinate the needs of the registrants with services provided by the adult day health care program and other health care providers, community social agencies and other resources; provided, however, with respect to registrants referred to the adult day health care program by a managed long term care plan or care coordination model, this shall be the responsibility of the managed long term care plan or care coordination model.

425.13 Rehabilitation therapy services. The operator, either directly or through the managed long term care plan or care coordination model that referred the registrant to the adult day health care program, must:

(a) provide or arrange for rehabilitation therapy services to registrants determined through the [interdisciplinary assessments as needing] comprehensive assessment to need such services; and

(b) ensure that the rehabilitation therapy services provided are in conformance with section 415.16 of this Subchapter.

425.14 Activities. The operator, directly or through the managed long term care plan or care

coordination model that referred the registrant to the adult day health care program, must:

(a) ensure that activities are an integral part of the program, are age appropriate, and reflect the registrants' individual interests and cultural backgrounds;

(b) ensure that activities are designed to enhance registrant participation in the program, home life and the community;

(c) involve appropriate volunteers and volunteer groups in the program, unless prohibited by law;

(d) provide sufficient equipment and supplies for the operation of the activity program;

(e) provide or arrange for transportation to and from community events and outings; and

(f) ensure that activities are included as part of each [registrant's] care plan.

425.15 Religious services and counseling. If provided, religious services and counseling must be included in the registrant's care plan.

425.16 Dental services. The operator, directly or through the managed long term care plan or care coordination model that referred the registrant to the adult day health care program, must, as appropriate:

(a) provide or refer registrants for dental services; and

(b) ensure that dental services provided to registrants or for which they are referred are in conformance with the needs identified during [assessments of registrants] the comprehensive assessment.

425.17 Pharmaceutical services. The operator must:

(a) develop and implement written policies and procedures governing medications brought to the

program site by registrants;

(b) ensure that pharmaceutical services, when provided for registrants, are in conformance with section 415.18 of this Subchapter, exclusive of the requirements of section 415.18(c);

(c) ensure that each registrant's drug regimen is reviewed at least once every six months by a registered pharmacist in accordance with the registrant's care plan and otherwise modified as needed following consultation with the registrant's attending practitioner. Any modification to the drug regimen must be documented in the registrant's clinical record and included as a revision to the registrant's care plan; and

(d) ensure that written policies and procedures require the pharmacist to report any irregularity in a registrant's drug regimen and recommendations to the registrant's attending practitioner and to the program coordinator, with appropriate documentation in the registrant's clinical record and care plan.

425.18 Services for registrants with Acquired Immune Deficiency Syndrome (AIDS).

(a) Applicability.

(1) This section applies to an adult day health care program approved by the commissioner pursuant to Part 710 of this Chapter as a provider of specialized services for registrants with AIDS.

(2) For purposes of these regulations, AIDS means acquired immune deficiency syndrome and other human immunodeficiency virus (HIV) related illness.

(b) General requirements. The program shall provide comprehensive and coordinated health services in accordance with this Article and requirements set forth in sections 425.9 through 425.17 of this Part. In addition, the operator must provide or make arrangements for:

(1) case management services,

(2) substance abuse services, if appropriate,

(3) mental health services,

(4) HIV prevention and counseling services,

(5) pastoral counseling,

(6) TB screening and on-going follow up, and

(7) specialized medical services including gynecology, as needed.

(c) Staffing requirements. The operator must provide or make arrangements for:

(1) specialty oversight of the AIDS program by a practitioner who has experience in the care and clinical management of persons with AIDS; and

(2) nursing services for the AIDS program under the supervision of a registered professional nurse with experience in the care and management of persons with AIDS.

425.19 General records. The operator must:

(a) maintain on the premises of the program or facility the following written records, which must be easily retrievable and must include, but not be limited to, the following:

(1) a chronological admission register consisting of a daily chronological listing of registrants admitted by name with relevant clinical and social information about each, including as a minimum, name, address, next of kin, attending practitioner, principal diagnosis, and the place from which each registrant was admitted;

(2) a chronological discharge register consisting of a daily chronological listing of registrants discharged by name, the reason for discharge and the place to which the registrant was discharged;

(3) a daily census record consisting of a summary report of the daily registrant census with cumulative figures for each month and each year; and

(4) general records in conformance with sections 415.30(e) - (o) of this Subchapter.

(b) ensure that each record includes non-medical information consisting of:

(1) all details of the referral and registration;

(2) identification of next of kin, family and sponsor;

(3) the person or persons to be contacted in the event of emergency;

(4) accident and incident reports;

(5) non-medical correspondence and papers pertinent to the registrant's participation in the program; and

(6) a fiscal record including copies of all agreements or contracts.

(c) Maintain as public information, available for public inspection, records containing copies of all financial and inspection reports pertaining to the adult day health care services that have been filed with or issued by any governmental agency for six years from the date such reports are filed or issued.

425.20 Clinical records. The operator must:

(a) provide a clinical record for each registrant in accordance with the clinical records requirements of section 415.22 of this Subchapter;

(b) ensure that all reports and information pertaining to registrant care and planning are entered promptly;

(c) ensure that all entries are dated and authenticated by the person making the entry or ordering the services;

(d) ensure that all clinical records for registrants referred by a managed long term care plan or care coordination model are made available to the referring managed long term care plan or care coordination model;

[(d)] (e) ensure that the record is kept in a place convenient for use by authorized staff; and

[(e)] (f) retain intact clinical records and all other records of registrants and keep them readily accessible in a safe and secure place. Such records shall be retained safely and securely for a period of six years following discharge or cessation of operation of services. In the case of a minor, retention shall be for three years after reaching majority (18 years of age).

425.21 Confidentiality of records. The operator shall keep confidential and make available only to authorized persons all medical, social, personal and financial information relating to each registrant.

425.22 Program evaluation.

(a) Quality improvement. The operator must develop and implement a quality improvement process that provides for an annual or more frequent review of the operator's program. Such evaluation must include a profile of the characteristics of the registrants admitted to the program, the services and degree of services most utilized, the length of stay and use rate, registrant need for care and services, and disposition upon discharge. The process must:

(1) include an evaluation of all services in order to enhance the quality of care and to identify actual or potential problems concerning service coordination and clinical performance;

(2) review accident and incident reports, registrant complaints and grievances and the actions taken to address problems identified by the process;

(3) develop and implement revised policies and practices to address problems found and the immediate and systematic causes of those problems; and

(4) assess the impact of the revisions implemented to determine if they were successful in preventing recurrence of past problems.

(b) The results of the quality improvement process must be reported to the chief executive officer, nursing home administrator or governing body.

425.23 Payment

(a) Payments to adult day health care programs by State government agencies.

(1) A program may only bill for one visit per registrant per day.

(2) The majority of registrants for whom the program receives a payment made by a government agency must be in attendance for at least five hours.

(b) Payments to adult day health care programs by managed long term care plans or care coordination models:

(1) Payments shall be made in accordance with the negotiated agreement between the adult day health care program and the managed long term care plan or care coordination model.

(2) The full range of adult day health care services shall be available to registrants with a medical need for such services. Based on a registrant's individual medical needs, as determined in the comprehensive assessment, the managed long term care plan or care coordination model may order less than the full range of adult day health care services. Nothing shall prohibit adult day health care programs and managed long term care plans or care coordination models from agreeing to reimbursement terms that reflect a registrant's receipt of less than the full range of adult day health care services.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Section 2803(2)(a)(v) of the Public Health Law authorizes the Public Health and Health Planning Council to adopt and amend rules and regulations, subject to the approval of the Commissioner, that define standards and procedures relating to medical facilities, including nursing homes. Section 201(1)(v) of the Public Health Law and section 363-a of the Social Services Law provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program.

Legislative Objective:

Chapter 59 of the Laws of 2011 enacted a number of provisions of the Medicaid Redesign Team (MRT). One of these provisions calls for the mandatory enrollment of additional categories of Medicaid recipients into managed long term care (MLTC) plans or other care coordination models (CCMs). The amendments change a number of provisions in 10 NYCRR Part 425, governing the operation and payment of adult day health care (ADHC) programs in residential health care facilities, to remove regulatory obstacles to those programs transitioning from being primarily fee-for-service Medicaid providers to being providers that can contract and work effectively with MLTC plans and CCMs.

Needs and Benefits:

The amendments provide that the MLTC plan or CCM that refers an enrollee to an ADHC program will be responsible for meeting certain Part 425 requirements that are currently

the responsibility of the ADHC program operator, consistent with the MLTC plan's or CCM's responsibility to manage and coordinate the enrollee's health care needs. This will avoid having the ADHC program operator duplicate services that are required to be provided by MLTC plans and CCMs to their enrollees.

The amendments clarify that the full range of ADHC services are available to MLTC plan and CCM enrollees with a medical need for such services. This ensures that Medicaid-covered ADHC services provided through an MLTC plan or CCM remain equal in amount, duration, and scope to ADHC services available to recipients of fee-for-service Medicaid.

However, the regulations also allow an MLTC plan or CCM, based on an enrollee's individual medical needs, as determined in the comprehensive assessment performed by the MLTC plan or CCM, to order less than the full range of adult day health care services, and to enter into reimbursement arrangements with the ADHC program operator that take into account a program registrant's receipt of less than the full range of adult day health care services. The rule allows MLTC plans and CCMs to order, and ADHC programs to provide, only the needed individualized services identified in the registrant's comprehensive assessment and care plan, at a negotiated price that both the MLTC plan/CCM and the ADHC program can afford.

Finally, the amendments allow ADHC programs to elect the Unbundled Services/Payment Option, which permits a program to admit and serve functionally impaired individuals who may need less than the full range of adult day health care services. This gives these programs flexibility in their operations and permits them to more effectively contract with managed long term care (MLTC) plans.

Costs to the Department, the State, and Local Government:

The rule will not increase costs to the State or local governments.

Local Government Mandates:

The rule will not impose any program, service, duty, additional cost or responsibility on any county, city, town, village school district, fire district or other special district.

Paperwork:

The rule will not impose any additional paperwork for ADHC programs.

Duplication:

There are no duplicative or conflicting rules identified.

Alternative:

No alternatives were proposed to the Department or considered.

Federal Standards:

The regulations do not exceed any minimum federal standards.

Compliance Schedule:

ADHC programs should be able to comply with the regulations when they become effective.

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

The rule can potentially affect 165 adult day health care (ADHC) programs across the state. It will not affect any local government entities. The rule allows an ADHC program approved to operate by the State of New York to elect the Unbundled Services/Payment Option, thus permitting the program to admit and serve functionally impaired individuals who may need less than the full range of adult day health care services. It also allows these programs flexibility in their operations and permits them to more effectively contract with managed long term care (MLTC) plans. Since selecting the Unbundled Services/Payment Option is voluntary on the part of any ADHC program, it is impossible to know how many of the 165 programs will be affected. They may exercise this option as MLTC is expanded across the state and their decision to do so will be based on individual program experience, the location of the program and other community-based services available in their geographic area.

Compliance Requirements:

In order to exercise the Unbundled Services/Payment Option, the ADHC program will have to notify the Department in writing, thirty days in advance of implementation that they plan to exercise this option. ADHC programs are currently required by regulation to meet certain reporting and recordkeeping requirements, and these activities will not be increased for a program that elects this option.

Professional Services:

ADHC programs currently employ, either directly or through a contract, nurses; social workers; physical, occupational and speech therapists; certified nursing assistants; activities and dietary staff. These same types of individuals will continue to be employed since any ADHC program must have a full range of services available based on the needs of the population they serve. However, programs will be able to adjust their staffing based on the range of services needed on any given day.

Compliance Costs:

There are no direct or increased compliance costs as a result of this rule.

Economic and Technological Feasibility:

This rule will not change how ADHC providers serve or bill for registrants for whom they receive a fee-for-service Medicaid payment. Therefore, it will not have an impact on the program's technological needs for these registrants. The number of individuals for whom a fee-for-service payment is received is likely to decrease as individuals are enrolled in MLTC plans, and thus the number of direct billings attributable to ADHC to the State will also decrease. The decrease in the number of fee-for-service registrants will have a negative economic impact on ADHC providers. This rule will permit ADHC programs to address this by allowing them to offer less than the full range of adult day health care services and more effectively contract with MLTC plans. ADHC providers may have to improve their technology in order to bill and effectively communicate with the MLTC plans that they contract with, but these changes are not the result of this rule. Any need to increase their technology, in this instance, is the result of the changes in the long term care market in general and the expansion of MLTC plans.

Minimizing Adverse Impact:

There will be no adverse impact on local government. The rule is designed to allow ADHC program operations to be more flexible. Further, it will allow ADHC programs and the registrants they serve to more effectively adjust to the statutory mandate requiring the expansion of MLTC.

Small Business and Local Government Participation:

The rule reflects the Department's collaboration with the Adult Day Health Care Council, which is a trade association representing more than 90 percent of the ADHC programs operating in New York State. Members of the Council helped develop the concept of an Unbundled Services/Payment Option and had the opportunity to contribute to and comment on the concepts presented in this rule.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

All rural areas of the state in which adult day health care (ADHC) programs are located will be equally affected by this rule. There are approximately 41 programs operating in rural counties.

Reporting, Recordkeeping and Other Compliance Requirements; Professional Services:

For ADHC programs, no new reporting, recordkeeping or other compliance requirements are being imposed as a result of this rule. The only new requirement, should an ADHC program opt to utilize the Unbundled Services/Payment Option, will be to notify the Department of that decision in writing.

Costs:

No direct costs will be imposed as a result of this rule.

Minimizing Adverse Impact:

There will be no adverse impact on rural areas. Implementation of this rule will benefit managed long term care plans expanding to rural areas that will need to include medical and social model programs in the benefit package. By allowing ADHC programs to provide less than the full range of adult day health care services to functionally impaired individuals, the rule enables the programs to serve a larger population. This may prevent program closures and the displacement of registrants to nursing facilities, while providing continuity of care as registrants may receive different levels of treatment in one setting.

Rural Area Participation:

The Department participated in multiple meetings with the Adult Day Health Care Council which represents more than 90 percent of the ADHC programs in the state, including the 41 programs operating in rural areas.

JOB IMPACT STATEMENT

Nature of Impact:

The statutory mandate requiring the expansion of Managed Long Term Care (MLTC) will likely have a negative impact on adult day health care (ADHC) programs. As MLTC expands, enrollment in ADHC programs as currently structured may significantly decrease. This could result in the downsizing of programs and staff, closures and displacement of the registrants. The rule was designed to mitigate such an impact by providing ADHC programs flexibility in their operations and permitting them to more effectively contract with MLTC plans. The rule, therefore, could prevent job loss that might otherwise occur if it is not adopted.

Categories and Numbers Affected:

The staff affected by the proposal include: nurses; certified nursing assistants; physical, occupational and speech therapists; social workers; dietary/food service workers; housekeeping and activity professionals.

Regions of Adverse Impact:

Adoption of the rule will not result in an adverse impact on jobs or employment. The rule permits ADHC programs to select an Unbundled Services/Payment Option through which they deliver their services. Selection of this option is voluntary, and will be based on individual program experience and choice. Therefore, it is impossible to know how many programs or which regions of the state would be affected.

Minimizing Adverse Impact:

One of the reasons the Department wishes to adopt this rule is to minimize any adverse impact on ADHC registrants and programs which may result from the mandatory expansion of MLTC plans.

ASSESSMENT OF PUBLIC COMMENT

The revised rule making published in the *New York State Register* on June 11, 2014 revised the proposal by removing the definitions of "Hybrid Option" and "Social Adult Day Level Individual" and instead added a new definition of "Unbundled Services/Payment Option" to grant programs the ability to provide less than the full range of adult day health care services to functionally impaired individuals referred by a managed long term care plan or care coordination model. The Department must still be notified of a program's election of this option 30 days in advance. As was the case before, the full range of adult day health care services will remain available to all registrants. In addition, each registrant will be provided a written copy of the services they are to receive while attending the program at the time of admission and following the continued-stay evaluation.

Additional revisions included removing the allowance to admit up to 30% over the approved program capacity, and changing it back to 10%, and clarifying which entity is responsible for each service – either the adult day health care program and/or the managed long term care plan or care coordination model.

During the public comment period 131 comments were received. Of those, only 2 respondents shared concerns or suggestions for further revisions to the proposal. They are below.

1. COMMENT: While flexibility in the design and delivery of services in ADHC programs is key for clients enrolled in MLTC, it is just as crucial that the same flexibility also

encompass beneficiaries enrolled in mainstream Medicaid Managed Care and Special Needs Plans.

RESPONSE: We are evaluating this issue for possible action at a later time.

2. COMMENT: The ADHC will have to keep the same level of staffing even though the reimbursement/payment levels will be those of a social program for many registrants.

   RESPONSE: Yes. Adult Day Health Care programs must maintain the appropriate staffing levels and provide or arrange for the appropriate services for each registrant in accordance with their comprehensive assessment. Further, Adult Day Health Care operators must make available specific services regardless of how many recipients need them. For instance, nursing services must be available.

3. COMMENT: Logistically the ADHC will need to get authorization for each individual service that is included in the unbundled service package. ADHCs will have to hire more staff to obtain the authorizations.

   RESPONSE: This issue will be subject to discussion with the MLTC program.

4. COMMENT: There will be (as we have already seen) a shifting from patient centered care to MLTC paper requirements which the MLTCs are asking for. They are already regularly asking for documents that the DOH does not require.

RESPONSE: This will have to be evaluated after some experience under the new regulations.

5. COMMENT: Many of the services provided in the capitated ADHC are maintenance and not rehab. This way we have maintained the health and wellness of our registrants. In unbundled service model the MLTC plans will be reluctant to pay for maintenance therapy.

   RESPONSE: This will be evaluated over time.

6. COMMENT: Each MLTC has their own separate requirements therefore standardized tools cannot be used.

   RESPONSE: Each MLTC plan must use the UAS-NY.

7. COMMENT: MLTC plans are basing services on the UAS that they perform. Since the UAS relies on a 3-day time period and much of the assessment is anecdotal from the patient and the caregiver, services may be compromised.

   RESPONSE: This is an issue that is being evaluated.

8. COMMENT: The MLTCs are not yet required to pay for rehabilitation services, however, ADHC is required to provide those services. Who will be paying for the

services? The MLTC can rightfully say to bill Medicare for the services – which we cannot do.

RESPONSE: It is up to the MLTC plan to require the enrollee to receive the skilled services through an appropriate provider.

9. COMMENT: In the event FIDA does start, FIDA is an opt out-program. Who pays for the regulatory needed services for those patients who opt out?

RESPONSE: If a patient opts out of FIDA, other programs will still be available including MLTC.