Summary of Express Terms

The proposed amendments concern sections of 10 NYCRR Part 425, that apply to adult day health care services for registrants in a non-residential health care facility with medical needs. The purpose of the amendments is to come into compliance with the Centers for Medicare and Medicaid Services (CMS) home and community-based services (HCBS) Final Rule.

The amendments also ensure Medicaid's HCBS program in a non-residential setting, provide full access to the benefits of community living and offer services in the most integrated settings. This also establishes requirements that are eligible for reimbursement for the Medicaid home and community-based services (HCBS) provided under sections 1915 of the Medicaid statute.

The amendments are made to the setting requirements, where in the setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life and events, control personal resources, and receive desired services in the community, to the same degree of access as individuals not receiving Medicaid.

Amendments are in the following areas:

The setting should be selected by the individual from among setting options including non-disability specific settings.

The settings options must be identified and documented in the person-centered plan and are based on the individual’s needs, preferences.

The setting should ensure an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.

The setting should optimize, but does not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact

The setting should facilitate individual choice regarding services and supports, and who provides them.

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))

Section 425.1 - Definitions

425.1 Definitions. As used in this Part:

(a) *Adult day health care* is a community-based model. It is defined as the health care services and activities provided in a non-residential group setting 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 services 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 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 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 listed on the operating certificate [located at] of 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. 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 in the form of snacks and hydration of choice, and [planned]activities at planned and at registrant desired times(s). 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 person-centered care planning, case management and other health care services as determined by the registrant's needs.

(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 person-centered 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. Registrants referred by an agency, physician or 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 the [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 supports coordination and integration of services pursuant to Section 4403-f of the Public Health Law.]

(k) [(l)] *Comprehensive assessment* means an interdisciplinary comprehensive assessment of a registrant completed in accordance with Section 425.[6]7 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.

(l) [(m)] *Person-centered [C]care plan* means identifying goals and developing care plans [the care plan developed] in accordance with section 425.[7]8 of this Part by the

adult day health care program. *Person-centered care planning* is a process driven by the registrant that reflects the services and supports that are important to the registrant to meet their needs identified through an assessment of functional need, as well as what is important to the registrant with regard to the preference for the delivery of such services and supports 42 CFR 441.301(c)(2). Assists registrants in achieving their personally defined outcomes by integrating the registrant in, and supporting full access to, the community while providing registrant dignity and privacy.

(m [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.

Section 425.2 - Application

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.]

Section 425.3 - Changes in existing 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 notify the Department of the program’s election of the Unbundled Services/Payment Option in writing thirty days before commencement of this option.

Section 425.4 - General requirements for operation

425.4 General requirements for operation.

(a) 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) rights of privacy, dignity, respect, and confidentiality, including confidential treatment of all registrant records;

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

(iii) protection and freedom from physical and psychological abuse, coercion and restraint;

(iv)participation in developing the person-centered care plan;

(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

(vi) right to individual initiative, autonomy, and independence in making life choices, including freedom to decide whether or not to participate in any given activity.

(4) be selected from among options by the individual and be physically accessible to the individuals supported;

(5) be integrated in and support full access to the greater community;

(6) facilitate an individual's informed choice about their services and who provides them;

(7) provide freedom and support for individuals to control their own schedules and activities;

(8) provide individuals access to food (meals and/or snacks) and visitors at any time;

(9) offer individuals participation in developing the person-centered care plan; and

(10) provide 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.

(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, consistent 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] person-centered care plan;

(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 assuring that staff possess the competencies and skill sets necessary to meet the needs safely and in a manner that promotes each registrant's rights, and physical, mental and psychosocial

well-being; 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 annually 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.

Section 425.5 – General requirements for Adult day health care settings

425.5 General requirements for Adult day health care settings.

(a) the operator must assure that the adult day health care program has all the qualities of a Home and Community-Based Service (HCBS) setting:

(1) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(2) The setting is selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered care plan and are based on the individual's needs and preferences.

(3) The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(4) The setting optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, access to meals and snacks as desired at any time, and decisions concerning individuals with whom to interact. Visitors are not restricted.

(5) The setting facilitates individual choice regarding services and supports, and who provides them.

Section 425.6 - Adult day health care services

425.6 Adult day health care services.

(a) The operator must provide or arrange for services appropriate to each registrant in accordance with the comprehensive assessment conducted and person-centered care plan 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;

(2) health education;

(3) interdisciplinary care planning;

(4) nursing services;

(5) nutrition;

(6) social services;

(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[,];

(8) restorative rehabilitative and maintenance therapy services;

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

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

[(10)] (11) 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 other high-need populations; and

(2) religious services and pastoral counseling.

Section 425.[6]7 - Admission, continued stay and registrant assessment

425.[6]7 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 the comprehensive 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, social history, preferences and interests;

(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 or operator's medical director 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.] enrolled in another adult day health care program.

(b) An individual may be registered in an adult day health care program only if his/her comprehensive 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 10% over the approved capacity for that program. The average annual capacity, however, may not exceed the approved capacity of the operator's program.

Section 425.[7]8 - Registrant person-centered care plan

425.[7]8 Registrant person-centered care plan.

The operator must ensure that: (a) [An adult day health care program] A person-centered care plan based on the comprehensive 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 or within 30 days 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 person-centered care plan.

(b) Each registrant's person-centered care plan process must be commensurate with the level of need of the registrant, and the scope of services and supports available and must[include]:

(1) [designation of a professional person to be responsible for coordinating the care plan]include registrant led input and include people chosen by the registrant;

(2) provide necessary information and support to ensure the registrant directs the process to the maximum extent possible and is enabled to make informed choices and decisions, with the registrant's representative having a participatory role, as needed and as defined by the registrant, unless State law confers decision-making authority to the legal representative;

(3) be timely and occur at times and locations of convenience to the registrant;

(4) reflect cultural considerations of the registrant and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;

(5) include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants;

(6) offer choices to the registrant regarding the services and supports the registrant receives and from whom;

(7) include a method for the registrant to request updates to the care plan, as needed; and

(8) record the alternative home and community-based settings that were considered by the registrant.

(c) The person-centered care plan must reflect the services and supports that are important for the registrant to meet the clinical and support needs as identified through an assessment of functional need, as well as what is important to the registrant with regard to preferences for the delivery of such services and supports. The written plan must also:

(1) reflect [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](2) reflect the registrant's strengths and preferences, 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](3) set forth the registrant's potential for remaining in the community; [and]

[5](4) include a description of all services to be provided to the registrant by the program, informal supports and other community resources pursuant to the person-centered care plan, and how such services will be coordinated;

(5) reflect that the setting in which the registrant receives services is chosen by the registrant;

(6) reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed;

(7) be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities or with limited proficiency in English;

(8) identify the individual and/or entity responsible for monitoring the plan;

(9) be finalized and agreed to, with the informed consent of the registrant (and/or persons identified by the registrant) in writing and signed by all individuals and providers responsible for its implementation;

(10) be distributed to the registrant and other people involved in the plan;

(11) include those services, the purchase or control of which the registrant elects to self-direct; and

(12) prevent the provision of unnecessary or inappropriate services.

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

([d]e) 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 person-centered care plan;

(2) modify the person-centered care plan to reflect registrant physical and social changes accordingly;

(3) review the person-centered 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 person-centered care plan.

Section 425.[8]9 - Registrant continued-stay evaluation

425.[8]9 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]7 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.

Section 425.[9]10 - Medical services

425.[9]10 Medical services. The operator must, without limiting its responsibility for the operation and management of the program:

(a) assign to the operator'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.

Section 425.[10]11 - Nursing services

425.[10]11 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) 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 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, a licensed practical nurse may provide the on-site services under the supervision of a registered nurse;

[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 and people chosen by the registrant 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 mode] shall be responsible for compliance with the requirements of this section.

Section 425.[11]12 - Food and nutrition services

425.[11]12 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 and registrant desired meal/snack times and, where appropriate, to registrants in their homes in accordance with the identified needs included in registrant person-centered 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.

(f) Provide individuals with access to snacks and meals at any time and obtain registrant

feedback on foods of preference.

Section 425.[12]13 - Social services

425.[12]13 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].

Section 425.[13]14 - Rehabilitation therapy services

425.[13]14 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 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.

Section 425.[14]15 - Activities

425.[14]15 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 in coordination with the registrant's person-centered care plan;

(b) ensure that activities involve integration in and full access of individuals to the greater community, control personal resources and ability to engage in community life to the same degree of access as individuals not receiving home and community-based services;

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

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

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

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

([f]g) ensure that activities are included as part of each person-centered care plan.

Section 425.[15]16 - Religious services and counseling

425.[15]16 Religious services and counseling.

If provided, religious services and counseling must be included in the registrant's person-centered care plan.

Section 425.[16]17 - Dental services

425.[16]17 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 the comprehensive assessment.

Section 425.[17]18 - Pharmaceutical services

425.[17]18 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 person-centered 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 person-centered 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 person-centered care plan.

Section 425.[18]19 - Services for registrants with Acquired Immune Deficiency Syndrome (AIDS) and other high-need populations

[425.18] 425.19 Services for registrants with Acquired Immune Deficiency Syndrome (AIDS) and other high-need populations.

(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 and other high-need populations that in the discretion of the Commissioner would benefit from receiving adult day health care services.

(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 Part 759 of this Title and shall receive payment for such services in accordance with section 759.14 of this Title.

Section 425.[19]20 - General records

425.[19]20 General records. The operator must:

(a) maintain on the premises of the program or facility the following registrant written records including the person-centered care plan, 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.

Section 425.[20]21 - Clinical records

425.[20]21 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];

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

(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).

Section 425.[21]22 - Confidentiality of records

425.[21]22 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.

Section 425.[22]23 - Program evaluation

425.[22]23 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.

Section 425.[23]24 - Payment

425.[23]24 Payment

(a) Payments to adult day health care program 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) 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. 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:

To implement programs beneficial to Medicaid recipients, including those persons who require health care services and activities in a non-residential group setting.

Needs and Benefits:

The legislature has determined that oversight of adult care facilities is in the interests of the state, as Adult Day Health Care (ADHC) programs provide medically supervised services, as well as personal care and socialization to individuals with physical and mental impairments or chronic illnesses who otherwise would require nursing home admission.

The proposed rule provides clear guidance to the operators of ADHC facilities, reflecting Centers for Medicare & Medicaid Services' (CMS) intent to ensure that individuals receiving services and supports through Medicaid's home and community-based services

(HCBS) programs have full access to the benefits of community living and are able to receive services in the most integrated setting.

With these proposed regulations, the Department seeks to assure the continued viability of these valued programs by permitting them to offer their services to elderly and disabled populations with functional impairments to maintain their health status and enable these persons to remain in the community.

CMS announced new rules that will potentially have a far-reaching and positive impact on the nature of day service settings funded through Medicaid as part of HCBS. The proposed regulations are needed as they can contribute to better quality services and more opportunities for individuals with disabilities who require less than institutional level of care, but still have a significant need to have access to greater number of services in the community which they might not otherwise qualify. The purpose of the amendments is to come into compliance with CMS' HCBS Final Rule. The proposed amendments provided will refer an enrollee to an ADHC program who will be responsible for meeting Part 425 Adult day health care requirements. It is the responsibility of the ADHC program operator to manage and coordinate the enrollee's health care needs and be guided by the requirements outlined in the HCBS rule.

The proposed amendments will ensure that all ADHC programs in a non-residential setting provide full access to the benefits of community living and offer services in the most integrated settings.

Lastly the proposed amendments aim to ensure that enrollees have a free choice of setting options, who provides services to them, and that individual rights and freedoms are not restricted, among other provisions.

Costs:

Costs to Regulated Entities:

There will be no costs incurred by regulated entities.

Costs to State Government:

There will be no costs incurred by state government.

Costs to Local Governments:

There will be no costs incurred by local governments.

Local Government Mandates:

There is no local government program, service, duty or responsibility imposed by the rule.

Paperwork:

There are no new reporting requirements imposed by the rule.

Duplication:

There are no other rules or other legal requirements of the state and federal governments that may duplicate, overlap or conflict with the rule.

Alternatives:

This rule is a necessary update to maintain the Department's oversight of the adult care facility program in compliance with federal Medicaid HCBS requirements. There were no significant alternatives to this rule.

Federal Standards:

CMS published a final rule that established new standards for approved settings for the provision of Medicaid-funded home and community-based services. Also established were new person-centered planning and conflict-of-interest requirements. The proposed change is to align with the Medicaid HCBS under Section 1915(c), 1915(i), and 1915(k) of the Social Security Act.

Small Business Guide:

A small business guide as required by section 102-a of the State Administrative Procedure Act is unnecessary at this time. The Department will provide educational webinars for all adult care facilities prior to promulgation.

Compliance Schedule:

Adult care facilities will be able to comply with this regulation upon publication of the Notice of Adoption in the State Register.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment that applies to adult day health care services for registrants does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202 bb(4)(a), of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas.

STATEMENT IN LIEU OF

JOB IMPACT STATEMENT

A job impact statement is not being submitted with this rule because it is evident from the nature and purpose of these amendments that the regulation will not have a substantial adverse impact on jobs and/or employment opportunities.