

SUMMARY OF EXPRESS TERMS

These proposed amendments concern those sections of Title 10 that apply to adult day health care services for registrants with acquired immune deficiency syndrome. First, the amendments are intended to expand the population that may be served by adult day health care programs that are approved as providers of specialized services for registrants with AIDS (“AIDS ADHCPs”). Second, the amendments would conform the standards applicable to AIDS ADHCPs operated by residential health care facilities with those operated by diagnostic and treatment centers. Lastly, the amendments would conform the regulations governing AIDS ADHCPs to the regulations governing non-specialized adult day health care programs, thereby similarly allowing for AIDS ADHCPs to more effectively contract with managed care plans.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by sections 201(1)(v) and 2803(2) of the Public Health Law, subdivision (g) of section 86-2.9, section 86-4.41, section 425.18 and Part 759 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivision (g) of section 86-2.9 is amended to read as follows:

(g) Effective April 1, 1994 and thereafter, reimbursement for adult day health care services[,] that are provided to registrants with acquired [immunodeficiency] immune deficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses and, effective April 1, 2017, that are provided to registrants who are otherwise considered at the discretion of the commissioner to be part of a high-need population that, regardless of their HIV status, would benefit from receiving these adult day health care services shall be established pursuant to this subdivision. The services to be provided to such registrants shall be the same as those listed in Part [427] 759 of this Title.

Reimbursement to a residential health care facility shall be established as follows:

(1) The rate of payment shall consist of a single price per visit to include the operating component, transportation, and the capital cost component of the rate. Payment shall be based upon a per visit rate of \$160 with not more than one reimbursable visit per 24-hour period per registrant.

(2) To be eligible to receive reimbursement pursuant to this section, a residential health care facility must be certified by the department pursuant to Part 710 of this Title to

provide adult day health care services for AIDS/HIV registrants and, effective April 1, 2017, other high-need registrants.

* * *

Section 86-4.41 is amended to read as follows:

86-4.41 Computation of basic rates for day health care services provided by freestanding ambulatory care facilities to patients with acquired immune deficiency syndrome (AIDS), [and] other human immunodeficiency virus (HIV) related illnesses [by free-standing ambulatory care facilities] and other high-need populations that, regardless of their HIV status and in the discretion of the commissioner, would benefit from receiving adult day health care services.

Effective April 1, 1994 and thereafter, reimbursement for adult day health care services that are provided to registrants with acquired immune deficiency syndrome (AIDS), other human immunodeficiency virus (HIV) related illnesses and, effective April 1, 2017, that are provided to registrants who are otherwise considered at the discretion of the commissioner to be part of a high-need population that, regardless of their HIV status, would benefit from receiving these adult day health care services shall be established pursuant to this section.

(a) For payments made pursuant to this section for day health care services rendered to patients who have AIDS or HIV-related illness and other high-need registrants, reimbursement shall be a single price per visit, with not more than one reimbursable visit per day per patient. For 1993 an initial price shall be determined taking into consideration reasonable projections of necessary costs, and the costs and statistics contained in proposed annual budgets for this service as defined in section 759.1([c]d) of this Title, including, but not limited to, utilization, staffing and salaries. For subsequent rate periods

the price established pursuant to this section shall be adjusted by the trend factor described in subdivision (e) of this section after considering the actual allowable expenditures and statistics for the year which ended 15 months prior to the rate period.

(b) To be eligible to receive reimbursement pursuant to this section, a free-standing ambulatory care facility must be certified to provide general medical services and day health care services for AIDS/HIV patients and, effective April 1, 2017, to other high-need registrants.

(c) The price established pursuant to this section shall be full reimbursement for the following:

(1) physician services, nursing services, and other related professional expenses directly incurred by the licensed facility, including the provision of triage or sick call services;

(2) space occupancy and plant overhead costs;

(3) administrative personnel, business office, data processing, recordkeeping, housekeeping, food services, transportation, and other related facility overhead expenses;

(4) all ancillary services described in section [759.6] 759.8 of this Title and laboratory tests and diagnostic X-ray services appropriate to the level of primary medical care required by the patient;

(5) all medical supplies, immunizations, and drugs directly related to the provision of services [except for those drugs used to treat AIDS patients for which fee-for-service reimbursement is available as determined by the Department of Social Services (see section 7.0 of the Medicaid Ordered Ambulatory Services Fee Schedule as contained in the Medicaid Management Information Systems (MMIS) Clinic Services Provider Manual (revised October, 1992)). Copies of the schedule may be obtained from the

Department of Social Services and are available for inspection and copying at the Department of Health, Records Access Office, 22nd Fl., Corning Tower, Empire State Plaza, Albany, New York 12237-0042)].

(d) Components of the price may be adjusted for service capacity, urban or rural location, and for regional differences in wage levels, space occupancy, and facility overhead costs, by comparing anticipated utilization and costs with actual experiences. The downstate region shall be defined as the counties of Putnam, Rockland, Westchester, Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk and the upstate region shall be defined as all remaining counties in the State.

(e) The commissioner shall establish trend factors to project increases in prices for the effective period of the reimbursement rates. The trend factors shall be developed using available price indices including elements of the United States Department of Labor consumer and producer price indices and special price indices developed by the Commissioner for this purpose. The projected trend factors shall be updated on an annual basis, based upon current and available data.

Section 425.18 is amended to read as follows:

425.18 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 [sections 425.9 through 425.17 of this] Part 759 of this Title and shall receive payment for such services in accordance with section 759.14 of this Title. [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.]

Part 759 is amended to read as follows:

PART 759

ADULT DAY HEALTH CARE SERVICES FOR REGISTRANTS WITH AIDS AND
OTHER HIGH-NEED POPULATIONS

(Statutory authority: Public Health Law, Sec. 2803)

Sec.

759.1 Definitions

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759.[5]6 Comprehensive care planning

759.7 Registrant continued stay evaluation

759.[6]8 Registrant services

759.[7]9 Medical record system

759.10 General records system

759.11 Confidentiality of records

759.[8]12 [Utilization control and quality assurance] Quality assessment and assurance

759.[9]13 Program [E]evaluation

759.14 Payment

Section 759.1 Definitions. As used in this Part, unless the context otherwise requires:

(a) For purposes of this Part, AIDS shall mean acquired immune deficiency syndrome and other human immunodeficiency virus (HIV) related illnesses.

(b) *Registrant* means a person who either has AIDS or HIV-related illness or is otherwise considered to be part of a high-need population that, regardless of HIV status and in the discretion of the Commissioner, would benefit from receiving adult day health care services and:

(1) who is not a resident of a residential health care facility, is functionally impaired and not homebound, and requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative [items] care or services but does not require the continuous 24-hour-a-day inpatient care and services provided by a general hospital, or residential health care facility; [and]

(2) whose assessed social and health care needs[, in the professional judgment of the physician of record, nursing staff, and social services and other professional personnel of the adult day health care program can be met satisfactorily in whole or in part by delivery of appropriate services in such program] 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 care organization or care coordination model and a comprehensive assessment conducted by the adult day health care program or by the managed care organization or care coordination model.

(c) *Adult day health care program, or program,* means an approved adult day health care program that is provided in a licensed diagnostic and treatment center, a residential health care facility or an approved extension site of either.

(d) Adult day health care services, or services, means care and services provided to a registrant [in a diagnostic and treatment center or approved extension site] under the medical direction of a physician by personnel of the adult day health care program. Such care and services are required to be in accordance with a comprehensive assessment of care needs and individualized health care plan to maintain or improve a registrant's health status and enable the registrant to remain in the community[, ongoing implementation and coordination of the health care plan, and transportation].

(e) Managed care organization means a managed care plan or a managed long-term care plan.

(f) Operating hours for an adult day health care program means 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 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 care organization 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.

(g) Visit means 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 or her comprehensive care plan. Registrants referred by a managed

care organization 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.

(h) Registrant capacity means the total number of registrants approved by the Department for each session in a 24-hour day.

(i) Operator of an adult day health care program, or operator, means the operator of a diagnostic and treatment center or a residential health care facility that is approved by the Department to be responsible for all aspects of the adult day health care program.

(j) Practitioner means a physician, nurse practitioner, or a physician's assistant with physician oversight.

(k) Department means the New York State Department of Health.

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

(m) 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.

(n) Comprehensive assessment means an interdisciplinary comprehensive assessment of a registrant completed in accordance with section 759.5 of this Part by the adult day health care program or an interdisciplinary comprehensive assessment, approved by the Department, completed by the managed care organization or care coordination model that referred the registrant to the adult day health care program.

(o) Care plan means the comprehensive care plan developed in accordance with section 759.6 of this Part by the adult day health care program.

(p) 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 care organization or care coordination model based on the registrant's comprehensive assessment. The full range of adult day health care services as described in Part 759 shall be available to all registrants enrolled in the adult day health care program.

759.2 Applicability.

(a)(1) The operator of a diagnostic and treatment center or a residential health care facility may provide adult day health care services to registrants when approved pursuant to Part 710 of this Title.

(2) A diagnostic and treatment center or a residential health care facility which has been approved by the [department] Department to operate an adult day health care program at its primary site may provide adult day health care services at an extension site approved by the [department] Department under the provisions of section 710.1 of this [Chapter]Title.

(3) A diagnostic and treatment center or a residential health care facility which 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] Department in accordance with section 710.1 of this Title if there is not sufficient suitable space within the center or residential health care facility to accommodate a full range of adult day health care program activities and services. The [department] Department may conduct an onsite survey of the [center] extension clinic or offsite location of the residential health care facility to

determine whether the facility space and/or location is suitable for an adult day health care program.

(b) Prior to operation of the facility's adult day health care [services] program, the operator shall apply to the [department] Department for approval in accordance with Part 710 of this Title and shall submit a description of the proposed program, including but not limited to:

- (1) need for the program, including statements on philosophy and objectives of the program;
- (2) range of services provided;
- (3) methods of delivery of services;
- (4) transportation arrangements for registrants;
- (5) physical space and use thereof;
- (6) number and expected characteristics of registrants to be served;
- (7) personnel participating in the program, including qualifications;
- (8) case management services and use of and coordination with existing community resources, including designated AIDS centers, health homes and other licensed health facilities, alcohol and substance abuse programs and rehabilitation facilities as appropriate;
- (9) financial policies and procedures;
- (10) program budget;
- (11) methods for program evaluation; and
- (12) proximity to an identified number of potential registrants.

795.3 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 to the provisions of Part 710 of this Title.

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

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

(1) receiving written approval from the Commissioner in accordance with Part 710 of this Title. The application to discontinue services must set forth the specific intended date of discontinuance and the intended plans for alternate services to registrants;

(2) notifying each registrant and coordinating with the registrant's managed care organization, care coordination model, or primary care physician regarding the development of suitable plans for alternate services for each registrant; and

(d) The operator must notify the Department of the program's election of the Unbundled Services/Payment Option in writing thirty days before commencement of this option.

759.[3]4 General requirements.

[The operator shall have and implement written policies and procedures which shall provide for:

(a) a written affiliation agreement with a designated AIDS center or other hospital for the transfer of registrants requiring emergency care, acute inpatient care services and clinical, sub-specialty clinical, and ancillary services;

(b) the appropriate transfer of registrants when applicable, to the care or supervision of other health facilities in accordance with the provisions for transfer and affiliation under section 400.9 of this Title;

(c) staff experienced in the care and management of persons with AIDS or HIV-related illness, equipment and space sufficient to meet the assessed needs of registrants, including sufficient bath and toilet facilities pursuant to Section 713-2.12 of this Title; and

(d) the development and implementation of in-service and continuing educational programs, staff counseling and supportive services, and infection control specific to AIDS and HIV illness.]

(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. Such staff are to be experienced in the care and management of persons with AIDS or HIV-related illness as well as in the care and management of other high-need populations that may be registrants of the program. Equipment and space are to be sufficient to meet the assessed needs of registrants, including sufficient bath and toilet facilities, pursuant to Part 714 of this Title;

(3) provide each registrant with a copy of a bill of rights specific to the 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 comprehensive care plan;

(v) receiving written notification by the program 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) 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 other community-based agency programs, including but not limited to, certified home health agencies, social service 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 care organization or care coordination model, the coordination of such services shall be the responsibility of the managed care organization or care coordination model; and

(2) day-to-day direction, management and administration of the adult day health care services; such person must be a practitioner who has experience in the care and clinical management of persons with AIDS or HIV-related illness and other high-need populations that enroll as registrants, 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 comprehensive care plans, including nursing services under the supervision of a registered professional nurse with experience in the care and management of persons with AIDS or HIV-related illness and other high-need populations that enroll as registrants;

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

(iv) developing and implementing or arranging for in-service orientation, training and staff development, staff counseling and supportive services, and infection control specific to AIDS and HIV-related illness and other high-need populations that enroll as registrants; and

(v) maintaining records in accordance with provisions of sections 400.2, 415.3(d)(1), 425.20 and 751.9(m)–(o) of this Title.

(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 care organization or care coordination model, such referrals shall be the responsibility of the managed care organization 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 governing medications brought to the program site by registrants;
- (7) establish and implement written policies and procedures concerning refunds and prepayment for basic services in accordance with existing rules and regulations;
- (8) 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 Title;
- (9) 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; and
- (10) establish and implement a written affiliation agreement with a designated AIDS center or other hospital for the transfer of registrants requiring emergency care, acute inpatient care services and clinical, sub-specialty clinical, and ancillary services.

759.[4]5 Admission, continued stay, and [patient] registrant assessment.

(a) The operator shall:

(1) select and admit to 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 [needs] comprehensive assessment, can benefit from the services [and require a minimum of three hours of health care services] provided on the basis of at least one visit per week to the program;

(2) assess each applicant, unless the assessment was conducted by a managed care organization or care coordination model that referred the applicant to the adult day health care program, utilizing an assessment instrument provided by the [department] Department as part of the admission review process, which assessment shall include at a minimum the following:

(i) medical needs, including the determination that the applicant is expected to need continued service for a period of [60] 30 or more days from the date of the completion of the comprehensive assessment;

(ii) use of medication and required treatment;

(iii) nursing care needs;

(iv) functional status;

(v) mental/behavioral health status;

(vi) sensory impairments;

(vii) rehabilitation therapy needs, including a determination regarding the specific need for physical therapy, occupational therapy, and speech language pathology services;

(viii) family and other informal supports;

(ix) home environment;

- (x) psycho-social needs;
 - (xi) financial status;
 - (xii) nutritional status;
 - (xiii) ability to tolerate the duration and method of transportation to the program;
 - (xiv) evidence of any substance abuse problem; and
 - (xv) need for HIV risk reduction counseling.
- (3) register each applicant only upon recommendation from the applicant's physician and after completion of a personal interview by qualified personnel with the applicant, next of kin and/or sponsor;
- (4) register each applicant only after determining that the applicant is not receiving the same services from any other facility or agency;
- (5) [notify the applicant of the availability of general medical care services at the day health care program and] determine whether the applicant is receiving primary medical care and, if so, where the care is provided;
- (6) admit an applicant to the service only after execution of a written agreement which shall include but not be limited to a requirement that:
- (i) the applicant agrees to a medical examination at a physician's office, the facility or other appropriate site, within six weeks prior to or seven days after admission [and as indicated in the physician's plan of care, HIV comprehensive care protocols or by medical necessity]; and
 - (ii) the operator provides to the applicant, next of kin and/or sponsor a written list of basic services furnished by the facility to registrants and paid for as part of the registrant visit at daily, weekly or monthly rates;

- (7) record all financial arrangements with the applicant or designated representative, with copies executed by and furnished to each party;
- (8) make no arrangement for prepayment for basic services exceeding one month; and
- (9) comply with the provision of financial policies as set forth in the applicable section of this Title[; and
- (10) register applicants in an adult day health care program only if the pre-registration evaluation determines that the program can adequately and appropriately care for the applicants].

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

(c) No applicant suffering from [active tuberculosis] a communicable disease that constitutes a danger to other registrants or staff may be registered or retained for services on the premises unless a physician certifies that the registrant presents no significant risk to any person.

(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.

759.[5]6 Comprehensive care planning[s].

(a) The operator shall:

(1) develop a comprehensive care plan based on the comprehensive assessment required by this Part and, when applicable, a transfer or discharge plan, for each registrant 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 care organization or care coordination model must be sure to coordinate with each other regarding the development of a registrant's comprehensive care plan;

(2) designate staff members to ensure the completion of the comprehensive care plan with the participation of consultants in the medical, social, paramedical and related fields as appropriate;

(3) ensure that the comprehensive registrant care plan includes for each registrant:

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

(ii) the registrant's pertinent diagnoses, including mental health 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;

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

([ii]iv) the registrant's potential for remaining in the community; [and]

([iii]v) transportation arrangements; and

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

(4) ensure that development and modification of the comprehensive care plan is coordinated with other health care providers outside the program who are involved in the registrant's care.

(b) Designated staff members, with the participation of consultants in the medical, social, paramedical and related fields, as appropriate, shall:

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

(2) modify the comprehensive care plan accordingly; [and]

(3) review the comprehensive care plan at least [quarterly] 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 comprehensive care plan.

759.7 Registrant continued stay evaluation. The operator, directly or through the managed care organization 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 759.5 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 is 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.

759.[6]8 Registrant services. The operator must provide or arrange for services appropriate to each registrant in accordance with the comprehensive assessment conducted and comprehensive care plan developed by the adult day health care program or by the managed care organization or care coordination model that referred the registrant to the adult day health care program. The following registrant services shall be provided on-site, as appropriate, to each registrant in accordance with the individual's multidisciplinary assessment of needs and comprehensive care plan[.];

(a) [HIV general medical services including gynecologic services;] medical services provided by the operator, which, without limiting its responsibility for the operation and management of the program, must:

(1) assign to the operator's medical board, medical advisory committee, medical director or consulting practitioner the following responsibilities regarding registrants of the program:

(i) developing and amending clinical policies;

(ii) supervising medical services;

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

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

(v) 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;

(2) ensure that medical services, including arranging for necessary consultation services, are provided to registrants of the program in accordance with the registrant's managed care organization or care coordination model;

(3) provide or arrange for the personnel, 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;

(4) 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;

(5) 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;

(b) [sick call visits occurring in addition to regularly scheduled visits for registrants presenting with a new problem which either results in a referral to a hospital outpatient department or clinic, or a referral to a sub-specialist off-site or which requires immediate attention of the physician on-site;

(c)] case management services;

[(d)] (c) food and nutrition services provided by the operator, which must:

(1) 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 comprehensive care plans;

(2) ensure that nutrition services are under the direction of a qualified dietitian;

(i) A qualified dietitian is one who is qualified based on:

(a) registration by the Commission on Dietetic Registration of the American Diabetes Association;

(b) education, training, and experience in identification of dietary needs, planning, and implementation of dietary program; or

(c) certification as a certified dietician or certified nutritionist in accordance with Article 157 of the Education Law;

(3) ensure that dietary service records for the adult day health care service are maintained;

[(e)] (d) social services[;] provided by the operator must:

(1) be under the supervision and direction of a licensed clinical social worker;

(2) be provided through the use of a full or part-time licensed mental health professional in conformance with the approved application for operation and regular access may be directly with a master's prepared or licensed mental health professional;

(3) either directly or through the managed care organization or care coordination model that referred the registrant to the adult day health care program, ensure that psychosocial

needs are assessed, evaluated and recorded, and that services are provided to meet the identified needs of the registrant as part of the comprehensive care plan; and

(4) 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 care organization or care coordination model, this shall be the responsibility of the managed care organization or care coordination model.

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

[(g)] (f) rehabilitation therapy services provided or arranged by the operator, either directly or through the managed care organization or care coordination model that referred the registrant to the adult day health care program, in conformance with the registrant's needs identified during the comprehensive assessment;

[(h)] (g) an activities program, provided by the operator either directly or through the managed care organization or care coordination model that referred the registrant to the adult day health care program, which must [involving] involve community, interpersonal and self-care functions appropriate and sufficient in scope to the needs and interests of each registrant to sustain physical and psychosocial functioning and must:

- (1) ensure that activities are an integral part of the program and reflect the registrants' individual interests and cultural backgrounds;
- (2) ensure that activities are designed to enhance registrant participation in the program, home life and the community;
- (3) involve appropriate volunteers and volunteer groups in the program, unless prohibited by law;
- (4) provide sufficient equipment and supplies for the operation of the activity program;
- (5) provide or arrange for transportation to and from community events and outings; and
- (6) ensure that activities are included as part of each registrant's comprehensive care plan;
- [(i)] (h) nursing services, provided by the operator, directly or through the managed care organization or care coordination model that referred the registrant to the adult day health care program, must be based on the care needs of the registrant as specified in the comprehensive care plan and be provided by a registered professional nurse. A licensed practical nurse, acting within his or her lawful scope of practice under Title VIII of the Education Law, may provide the on-site services when a registered professional nurse is available at the sponsoring licensed facility to provide immediate direction or consultation;
- (1) in addition to providing nursing services as specified in the registrant comprehensive care plan, the operator must ensure that a registered professional nurse is available to conduct sick call triage assessments to registrants presenting with new problems or symptoms that result in consultation with the registrant's primary care physician or the managed care organization in which the registrant is enrolled or, as necessary, immediate transfer to an emergency department;

- [j)] (i) pastoral counseling, either provided directly or arranged for by the operator;
- [(k)] (j) counseling for HIV risk reduction;
- [(l)] (k) pharmaceutical services;
- [(m)] (l) substance abuse services;
- [(n)] (m) mental health and psychiatric services;
- [(o)] (n) ancillary services commensurate with the level of [medical] care delivered on-site; and
- [(p)] (o) referrals for dental services and sub-specialty care that are in conformance with the needs identified during the comprehensive assessment.

759.[7]9 Medical record system. The operator [shall ensure that] must:

(a) [the facility maintains] maintain a medical record system that contains a record, including a current comprehensive care plan for each registrant, in accordance with accepted professional standards of practice and the medical records system section of this Title. Each registrant's medical record shall contain, as a minimum:

(1) identification and admission information, including:

(i) all details of the referral and registration;

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

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

(iv) accident and incident reports;

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

(vi) a fiscal record including copies of all agreements or contracts;

(2) documentation of medical examinations, progress notes and discharge summaries;
and

(3) all other pertinent information related to the resident's care including record of attendance;

(b) [the facility shall] develop and implement policies and procedures to ensure the confidentiality of all medical records.

759.10 General records system. 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; and

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

(b) 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.

759.11 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.

[759.8 Utilization control and quality assurance. The operator shall ensure that the utilization control and quality assurance program of the facility conforms to the regulations set forth in Section 751.8 of this Title.]

759.12 Quality assessment and assurance. The facility shall establish and maintain a coordinated quality assessment and assurance program that integrates the review activities of facility services to enhance the quality of life and registrant care and treatment.

(a) Facility-wide quality assurance. Quality assurance shall be the responsibility of all staff, at every level, at all times. Supervisory personnel alone cannot ensure quality of care and services. Such quality must be a part of each individual's approach to his or her daily responsibilities.

(b) Quality assessment and assurance committee. The facility shall maintain a quality assessment and assurance committee consisting of at least the following:

(1) the program director;

(2) the licensed master social worker;

(3) a registered nurse designated by the facility;

(4) at least three other members of facility staff.

(c) Committee functions. The quality assessment and assurance committee shall:

(1) meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary;

(2) have a written plan for the quality assessment and assurance program which describes the program's objectives, organization, responsibilities of all participants, scope of the program, procedures for overseeing the effectiveness of monitoring, assessing and problem-solving activities. Such plan shall also provide for the development and implementation of quality improvement initiatives designed to advance the quality of life, care and services in the facility;

(3) define methods for identification and selection of clinical and administrative problems to be reviewed. The process shall include but not be limited to:

(i) the establishment of review criteria developed in accordance with current standards of professional practice for monitoring and assessing registrant care and clinical performance;

(ii) regularly scheduled reviews of clinical records, resident complaints and suggestions, reported incidents and other documents pertinent to problem identification;

(iii) consultation, on at least a quarterly basis with the Consumer Advisory Board, to seek recommendations on quality improvements;

(iv) documentation of all quality assessment and assurance activities, including but not limited to, the findings, recommendations and actions taken to resolve identified problems; and

(v) the timely implementation of corrective actions and periodic assessments of the results of such actions;

(4) ensure that the outcomes of quality assurance reviews are shared with appropriate

staff to be used for the revision or development of facility policies and practices and in granting or renewing staff privileges, as appropriate; and

(5) facilitate participation in the program by administrative staff and health-care professionals representing each professional service provided; and

(6) report its activities, findings and recommendations to the governing body as often as necessary, but no less than 4 times a year.

759.[9]13 Program [E]evaluation. [The operator shall develop and implement procedures which provide for at least an annual written evaluation of the adult day health care program to include, at a minimum, 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 evaluation shall also include such data items as are available to the operator and are identified and set forth on forms provided by the department.]

(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, program director, or governing body.

759.14 Payment

- (a) Payments to adult day health care programs by State government agencies. A program may only bill for one visit per registrant per day.
 - (b) Payments to adult day health care programs by managed care organizations 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 care organization or care coordination model.
 - (2) The full range of adult day health care services shall be available to registrants with a documented need for such services. Based on a registrant's individual needs, as determined in the comprehensive assessment, the managed care organization 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 care organizations 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. 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:

Under the above authority, the Department of Health as the single state agency responsible for the Medicaid program has the authority to implement programs beneficial to Medicaid recipients, including those with HIV disease. AIDS adult day health care programs (AIDS ADHCPs) were established as part of the continuum of care for persons with HIV disease and are designed to assist those individuals to live more independently in the community and to delay or eliminate the need for residential health care services. With these proposed regulations, the Department seeks to assure the continued viability of these valued programs by permitting them to offer their services to other high-risk populations and to effectively contract with managed care organizations.

Needs and Benefits:

The proposed amendments expand the population that may be served by AIDS ADHCPs in order to provide these programs with an opportunity to serve other high-risk populations. Under managed care, these programs have experienced decreases in utilization per client and the proposed expansion would permit the programs to regain some or all of that lost capacity by serving other populations that may be in need of and can benefit from the services the programs offer.

The proposed amendments also will conform the standards applicable to AIDS ADHCPs operated by residential health care facilities with those operated by diagnostic and treatment centers. Currently, programs in each setting are subject to different regulatory requirements, and these amendments would create consistent requirements regardless of site of service.

Lastly, these proposed regulations conform the regulations governing AIDS ADHCPs to the recently amended regulations governing non-specialized adult day health care programs, thereby allowing for AIDS ADHCPs to more effectively contract with managed care plans.

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

The rule will not increase costs to State or local governments. The proposal to expand the populations that these programs can serve is a response to the inclusion of the adult day health care service into the managed care benefit package, which the programs anticipated would result in a decline in utilization among its clients. The programs have experienced such a decline, and the anticipated increase in the volume of high-need HIV-negative clients served is expected to offset that decline in utilization. In addition, programs have recently closed, and the remaining programs are operating at an average

of 54% capacity. Lastly, the majority of these programs' clients, who are HIV-infected, are enrolled in HIV Special Needs Plans and we expect it will take some time for ADHC programs to attract high-need HIV-negative clients from other Medicaid ("mainstream") managed care plans. For these reasons, we project the fiscal impact from implementing these proposed amendments to be cost-neutral to the Department, the State, and local governments.

Local Government Mandates:

This 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:

This rule will not impose any additional paperwork for these AIDS ADHC programs. The process for admitting a client without HIV disease, evaluating that client and deriving a treatment plan appropriate to meet that client's needs and that client's participation in program activities following the client's treatment plan is no different from what is currently the case for a person with HIV disease.

Duplication:

There are no duplicative or conflicting rules identified.

Alternative:

The only alternative considered was not to propose these amendments to the regulations. However, with the input of the regulated community, we decided to go forward with these proposed amendments in order to allow programs to expand the populations they serve and to achieve the consistency between programs based in

residential health care facilities and diagnostic treatment facilities that will result from implementing these proposed amendments.

Federal Standards:

The regulations do not exceed any minimum federal standards.

Compliance Schedule:

This proposed amendment will become effective upon publication of a Notice of Adoption in the *New York 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 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 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 for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.