Policy Clarification

AIDS Adult Day Health Care Programs
AIDS Institute
New York State Department of Health
March 5, 2007

The purpose of this March 2007 Policy Statement is to provide further clarification to the policy statement issued in June of 2006 regarding core health services and allowable billing in the AIDS Adult Day Health Care Program. A Medicaid claim can only be generated as a result of services that are provided in the Medicaid benefit package. The June 2006 policy statement clarified that clients must receive a "core service" each day of attendance in order for the program to legitimately submit a bill. These core services are listed below. Additionally, as indicated in regulations/guidelines, a "**minimum**" of three hours of ***health*** care services per week must be provided, and the client must be in attendance at the program for a minimum of three hours on any day where a Medicaid bill is generated. In order to meet billing requirements, these pre-requisites must be met regardless of the client's frequency of attendance in the program.

Services that may be counted towards the minimum three-hour threshold of ***health*** services for the week include the "core" services listed below as well as health ***related*** services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive are plan. These "indirect" services **cannot** be the primary reason for the day care visit and the generation of the bill, but can be included for the minimum three-hour threshold.

All the client's needed services must be listed in the client's comprehensive care plan, except that there is no need for the care plan to include required routine program interventions that are specified in regulations (e.g. monthly medical assessment, quarterly reassessments). The care plan should reflect the frequency with which the client attends the program. Planned interventions that exceed the frequency of the minimal regulatory requirements should be included on the client's comprehensive care plan. Under **no** circumstances can the indirect supplementary service(s) be the primary reason for the generation of the ADHC Medicaid claim, or the rationale for the client's enrollment in the program.

Core Services

Each day a client is in program, they must receive at least one of the following "core" services:

- ❑ Medical visits (MD, NP, PA)
- ❑ Nursing visits (RN)
- ❑ 1:1 Mental health (MSW, LCSW, LCAT)
- ❑ 1:1 Nutrition (RD)
- ❑ 1:1 Substance Abuse (CASAC, MSW)
- ❑ Medication groups (MD, RN, NP, PA)
- ❑ Medical groups (MD, NP, PA, RN)
- ❑ Substance abuse groups (CASAC, MSW, LCSW)
- ❑ Mental health support groups (MSW, NPP, LCSW, Masters in Divinity, LCAT (must be closed group))
- ❑ Nutrition groups (RD)
- ❑ ADL
- ❑ PT/OT
- ❑ Case management
- ❑ Prevention/Risk reduction (LCSW, RN, MD, PA, NP or CASAC)
- ❑ Any routine assessment performed by a credentialed staff person

Services that are solely social or recreational in nature can only be counted towards time in program (Social/recreational services are listed below). Social/recreational services cannot be counted toward fulfilling the requirements for health care services, and as is the case with the indirect supplementary services, cannot be the primary reason for the generation of the Medicaid claim.

Social/Recreational Services

- ❑ Community meeting/morning meeting
- ❑ Open Art
- ❑ Games
- ❑ Field Trips
- ❑ Current events
- ❑ Vocational education
- ❑ Computer skills
- ❑ Peer support
- ❑ NA/AA meetings on site
- ❑ Recreational activities (softball, baseball, movies, etc)
- ❑ Stipend/peer led activities
- ❑ Exercise that is not medically indicated by clinical staff