

NYS DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

Division of Health Plan Contracting and Oversight

Guidelines for the Transition of Adult Day Health Care and AIDS Adult Day Health Care Services in Medicaid Managed Care

Overview

Effective August 1, 2013, the provision of Adult Day Health Care (ADHC) and the AIDS Adult Day Health Care Program (AIDS ADHC) services to enrollees in Medicaid Managed Care Organizations (MCOs) will become the responsibility of the MCO. As required by federal regulations, ADHC and AIDS ADHC services provided to MCO enrollees must be identical in the amount, duration, and scope to the same service when furnished to Medicaid fee-for-service consumers. [42 CFR §438.210]. The following guidelines identify the roles and responsibilities of MCOs, ADHC and AIDS ADHC providers.

I. Scope of the Adult Day Health Care Benefit

- a) Adult Day Health Care, as defined by 10 NYCRR §425.1 and the Medicaid Managed Care/HIV Special Needs Plan Model Contract (MMC Model Contract), includes the health care services and activities provided to individuals who are not residents of a residential health care facility, are functionally impaired and not homebound, and require supervision, monitoring preventive, diagnostic, therapeutic, rehabilitative or palliative care or services but do not require continuous 24 hour per day inpatient care and services.
- b) The registrant is defined as a person who has:
 - i. Assessed social and health care needs that can satisfactorily be met in whole or in part by the delivery of appropriate services in the community setting; and
 - ii. Been admitted to an adult day health care program based on an authorized practitioner's order and the ADHC program's interdisciplinary comprehensive assessment.
- c) The program defined as an adult day health care is a DOH approved program located at a licensed residential health care facility or an approved extension site.
- d) An 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, planned activities, ongoing assessment of each registrant's health status in order to provide coordinated care planning, case management and other health care services as determined by the registrant's needs.

- e) Unless otherwise permitted by the Department, each approved session will consist of the majority of registrants in attendance for at least five hours.
- f) The operator of an ADHC program is the operator of a residential health care facility that is approved by the Department to be responsible for all aspects of the adult day health care program.
- g) The operator must provide or arrange for services appropriate to each registrant in accordance with the individual's interdisciplinary needs assessment and comprehensive care plan. At least the following program components must be available:
 - i. case management, including health education;
 - ii. interdisciplinary care planning;
 - iii. nursing services;
 - iv. nutrition;
 - v. social services;
 - vi. assistance and supervision with the activities of daily living, such as toileting, feeding, ambulation, bathing including routine skin care, care of hair and nails; oral hygiene; and supervision and monitoring of personal safety, restorative rehabilitative and maintenance therapy services;
 - vii. planned therapeutic or recreational activities that reflect the interests, cultural backgrounds and the communities of the registrants and provide the registrants with choices;
 - viii. pharmaceutical services;
 - ix. referrals for necessary dental services and sub-specialty care;
 - x. the following may also be provided:
 - (1) specialized services for registrants with HIV or AIDS; and
 - (2) religious services and pastoral counseling
- h) Reassessment Requirement
 - i. The operator must complete a written comprehensive assessment and evaluation at least once every six months to include:
 - 1) Appropriateness of the registrant's continued stay in the program,
 - 2) The registrant's needs,
 - 3) The necessity and suitability of services provided, and
 - 4) The potential for transferring responsibility for or the care of the registrant to other more appropriate agencies or service providers.

II. Scope of the AIDS Adult Day Health Care Program benefit

- a. AIDS Adult Day Health Care Programs are designed to assist individuals with AIDS or HIV disease to live more independently in the community or to eliminate the need for residential health care services. AIDS ADHCs are defined in regulations found

in 10 NYCRR Part 759, and 10 NYCRR Part 425. The program targets services to high need individuals with HIV and co-morbidities such as substance abuse and mental illness, and to those who may need assistance with managing other chronic conditions such as diabetes and hypertension. Health care services and activities are provided to registrants who are not residents of a residential health care facility, are functionally impaired and not homebound, and who require additional services (but not continuous inpatient care) to maintain or improve their health status and enable them to remain in the community.

- b. The registrant is defined as a person who has:
 - i. Assessed and health care needs that can satisfactorily be met in whole or in part by the delivery of appropriate services in the community setting; and
 - ii. Been admitted to an AIDS adult day health care program based on an authorized practitioner's order and the AIDS ADHC program's interdisciplinary comprehensive assessment.
- c. AIDS adult day health care includes care and services provided to a registrant in a diagnostic and treatment center, a residential health care facility, or approved extension site under the medical direction of a physician by personnel of the AIDS adult day health care program in accordance with a comprehensive assessment of care needs and development of an individualized health care plan, ongoing implementation and coordination of the health care plan, and transportation.
- d. The AIDS ADHC program provides or arranges for services appropriate to each individual, according to the individual's interdisciplinary needs assessment and comprehensive care plan.
- e. Services must include:
 - i. HIV general medical services, including gynecologic services (as agreed upon/authorized by the MCO);
 - ii. Sick call visits for registrants presenting with a new problem, which may result in coordination with the primary care physician and/or MCO to address conditions that require immediate or further medical intervention;
 - iii. Case management services;
 - iv. Food and nutrition services;
 - v. Social services;
 - vi. Assistance with and/or supervision of, activities of daily living, such as toileting, feeding, ambulation, bathing including routine skin care, care of hair and nails, and oral hygiene;
 - vii. Rehabilitation therapy services as the registrant's needs indicate;

- viii. An activities program involving 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;
- ix. Nursing services;
- x. Pastoral counseling;
- xi. Counseling for HIV risk reduction;
- xii. Pharmaceutical services;
- xiii. Substance abuse services;
- xiv. Mental health and psychiatric services;
- xv. Ancillary services, commensurate with the level of medical care delivered on-site; and
- xvi. Referrals for dental services and sub-specialty care.

III. ADHC and AIDS ADHC Transitional Care

- a) Members currently receiving these services will receive 90 days of transitional care with the current care plan, or until the MCO authorizes an alternate care plan, whichever is later.
 - i. For individuals currently in care, MCOs are required to use the most recent assessment completed by the ADHC or AIDS ADHC, unless there are changes to the individual's condition, to authorize the care plan after the 90 day period. The ADHC or AIDS ADHC provider must share the assessment and care plan with the MCO.
 - ii. If a member changes MCOs within the 90 day benefit transitional care period, or anytime thereafter, the member will receive transitional care coverage as per the SDOH standard transitional care policy entitled "New Managed Care Enrollees in Receipt of an On-going Course of Treatment," which provides for up to 60 days transitional care coverage or until the new MCO authorizes an alternate care plan, whichever is sooner.
- b) The MCO will allow members currently receiving these services to continue with their current provider for one year, unless the member elects to change providers. The MCO may not initiate provider changes during the transition year.
- c) For one year beginning August 1, 2013, contracted ADHCs and AIDS ADHCs may conduct the assessment (Registrant Assessment Instrument – RAI or Uniform Assessment System – UAS, when implemented) for members newly referred for these services. The providers will be allowed up to two visits to complete the assessment, to be reimbursed at the per diem rate. MCOs must cover the two visits even if they do not authorize the member for placement.

- d) For one year beginning August 1, 2013, MCOs will pay the Medicaid FFS rate for their members (new and existing enrollees) receiving ADHC and AIDS ADHC services during the transition year.
- e) This means if MCOs have contracts with providers for a rate other than the Medicaid fee for service (FFS) rate, the MCO is required to pay the Medicaid FFS rate during the transition year.
- f) After completion of one year since the August 1, 2013 transition of ADHC and AIDS ADHC, plans may negotiate a different payment rate with the provider.

IV. MCO Responsibilities: Accessing the Benefit and Authorization of Services

- a) Enrollees must have an order from a physician for ADHC or AIDS ADHC to be assessed for participation in these programs. There is no standard form for this order.
- b) As per the transitional care policy in section III above, during the transition year, MCOs notified by a provider or member of an order for ADHC or AIDS ADHC services must arrange for the member to attend a participating ADHC or AIDS ADHC for up to two visits for initial assessment. Alternately, a participating ADHC or AIDS ADHC may notify the MCO of a member that presented with a medical order for assessment, so the MCO may appropriately arrange for coverage of up to two visits for completion of the assessment.
- c) Upon completion of the assessment, if the ADHC/AIDS ADHC agrees the member is in need of these services, the ADHC/AIDS ADHC must request authorization of services from the MCO, following MCO procedures.
 - i. If a person centered care plan has been developed, the MCO will review the request and make a determination for ongoing services (number of visits per week, duration, and types of service).
 - ii. If more visits are needed to complete a comprehensive assessment, MCO may authorize up to a total of 5 visits within 30 days to complete the assessment and develop a person centered comprehensive care plan, which must then be submitted to the MCO for authorization of ongoing services (including number of visits per week, duration, and types of service).
- d) The MCO must reassess for ADHC/AIDS ADHC services at least once every six months.
 - i. A new physician order is not required to continue ADHC/AIDS ADHC services.
 - ii. Reassessments are conducted by the ADHC/AIDS ADHC provider.
 - iii. If the ADHC/AIDS ADHC provider believes services need to continue, a new assessment and person centered care plan must be submitted to the MCO for authorization of services for the new period.

- iv. The ADHC/AIDS ADHC must notify the MCO if it is recommending the member be discharged from the program.
- e) For the purposes of service authorization, the timeframe for review and determination of a request for ADHC/AIDS ADHC services begins with the MCOs receipt of the completed assessment.
 - i. All new service authorization requests will be reviewed on an expedited basis as provided by Appendix F of the model contract: within three business days of the request (receipt of the assessment), with a possible extension for more information, if in member's best interest, for up to 14 calendar days.
 - ii. All reassessments for continued services will be reviewed within concurrent time frame as provided by Appendix F of the model contract for a new authorization time period: within one business day of the request (receipt of the assessment), with a possible extension for more information, if in member's best interest, for up to 14 calendar days.
- f) The MCO must ensure that its denial or reduction of ADHC or AIDS ADHC services does not result in a member losing access to services that maintain the safety of the member in the home or that their identified medical needs are not met. That is, other needed services such as home health, personal care, outpatient PT, etc. have been authorized according to the member's needs.

V. ADHC/AIDS ADHC Provider Responsibilities

- a) For existing registrants, the ADHC/AIDS ADHC must:
 - i. Verify eligibility on the 1st and 15th of every month to ensure the member's health plan has not changed.
 - ii. Notify the MCO as soon as possible that their member is receiving services.
 - iii. Share the most recent assessment and care plan to secure authorization for services beyond the applicable transitional care period.
 - iv. Work with the PCP and/or MCO when a member needs a referral for off-site services with participating providers.
 - v. Follow the MCO provider contract and/or the provider manual for prior authorization and billing requirements.
 - vi. If there is disagreement with the MCO determination, the provider may appeal on behalf of the member. The member will also have right to a state fair hearing and may be eligible for external appeal. The Provider has appeal rights on their own behalf.
- b) For new registrants, the ADHC/AIDS ADHC must:
 - i. Check eligibility prior to performing the admission or assessment.

- ii. During the transition year, notify the MCO if the member presents at the facility with a physician order for services and:
 - 1) if participating in the MCO's network, arrange for coverage of assessment visits (within two visits); or
 - 2) if not participating in the MCO's network, have the MCO arrange for member to be seen at participating ADHC/AIDS ADHC for assessment.
- iii. If participating with the MCO's network, coordinate with the MCO to develop a person centered comprehensive care plan within five visits and 30 days.
- vii. Obtain authorization from the MCO for the number of visits per week and duration of authorization, according to approved care plan.
- viii. If there is disagreement with the MCO determination, the provider may appeal on behalf of the member. Member will also have right to state fair hearing and may be eligible for external appeal. The Provider has appeal rights on their own behalf.

VI. ADHC and AIDS ADHC Network Requirements

- a) MCOs in the Metropolitan Region (NYC, Nassau, Suffolk, and Westchester Counties) must contract with
 - i. ADHC – minimum of three providers per county,
 - ii. AIDS ADHC – two providers, where available, per county.
- b) MCOs for Rest of State must contract with:
 - i. ADHC – minimum of two providers per county,
 - ii. AIDS ADHC – one provider, where available, per county.
- c) MCO's ADHC and AIDS ADHC networks must be submitted to Bureau of Managed Care Certification and Surveillance Project Managers on an Excel spread sheet no later than June 14, 2013. MCOs must provide the network information to the counties and the contracted providers in each county.
- d) MCOS will be able to submit the inclusion of these providers via the Provider Network Data System using codes 664 for ADHC, and 355 for AIDS ADHC, with the 3rd quarter network submission due July 22, 2013.
- e) MCOs must ensure that members may remain with same provider. MCOs may enter into single case agreements with providers providing services to less than five members of an ADHC/AIDS ADHC.

VII. Transportation and Claims Coding

- a) ADHC rates exclude transportation, which will continue to be paid through FFS.

- b) The FFS rate for AIDS ADHC includes transportation. Plans are required to pay the rate inclusive of transportation for the transition period. After the transition year, plans and providers will negotiate rates exclusive of transportation, and transportation will be covered through FFS Medicaid.

Optional / Suggested Claims Coding:

Service	HCPCS/ ICD-9	HCPCS/ICD-9 Description	Modifier	Units	Provider Specialty Code	MEDS COS	FFS Rate Codes
Adult Day Health Care	S5102	Day care services, adult; per diem	NA	1	664	12 or 15	2800, 3800
AIDS Adult Day Health Care	S5102	Day care services, adult; per diem	U1	1	355	12 or 15	1850