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Bureau of Managed Long Term Care (MLTC)
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Krista Nolin
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New York State Office for the Aging (NYSOFA)
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Re: Clarification Request – Distinction Between Supervision of Activities of Daily Living (ADLs) and Community Integration Supervision in Social Adult Day Care (SADC) Programs

Dear Mses. Kiernan and Nolin:

The New York State Adult Day Services Association (NYSADSA) respectfully submits this correspondence to clarify our understanding—and request formal guidance—on the differentiation between two critical supervision roles provided within SADC programs: supervision of ADLs and supervision related to community integration for individuals with cognitive impairments.

Supervision of ADLs Within SADC Programs

As stipulated in 9 New York Codes, Rules, and Regulations (NYCRR) §6654.20, SADC programs are mandated to provide supervision and hands-on assistance with ADLs including toileting, mobility, transferring, and eating. This supervision ensures participants' safety and dignity within the protective environment of the program and is a core component of daily service delivery.

Supervision Related to Community Integration

Conversely, under the Home and Community-Based Services (HCBS) Final Rule (42 Code of Federal Regulations (CFR) §441.301(c)(4)), all participants receiving Medicaid HCBS must be supported to fully access the greater community, consistent with their MLTC Person-Centered

Service Plan (PCSP). Supervision decisions relating to a participant's ability to engage in community activities must be individualized, based on a current assessment of cognitive and functional status, and documented in the PCSP.

Our intent is to reaffirm that the need for ADL-related supervision does not inherently restrict a participant from independently accessing their community unless a clear, person-specific health or safety concern is present and appropriately documented.

Conflict-Free Case Management and Decision Authority

In accordance with 42 CFR §441.301(c)(1)(vi), SADC providers may not serve as case managers or develop PCSPs for participants receiving HCBS services, as this presents a conflict of interest. This responsibility lies with the MLTC plan care manager or another conflict-free entity designated by the state.

While SADC providers may observe and report on participant behavior or safety risks, they are not authorized to unilaterally impose or determine community access restrictions. All determinations regarding the necessity for supervision in the community must be made within the context of the PCSP process, led by a conflict-free care coordinator, and with full participant involvement and consent.

SADC Program Role and the Corporate Practice of Medicine Rule

It is important to highlight that SADC programs are non-medical, non-clinical providers. They do not employ licensed medical professionals to deliver health care services, nor are they permitted to diagnose, treat, or make clinical determinations about participants. SADC services are structured under New York's non-clinical regulations (e.g., 9 NYCRR §6654.20) and are primarily designed to provide supervision, socialization, nutrition, and assistance with ADLs in a community-based setting.

Under the Corporate Practice of Medicine (CPOM) rule in New York, non-physician entities—including general business corporations like most SADC providers—are strictly prohibited from owning, controlling, or influencing medical decisions or clinical judgment. This doctrine ensures that only licensed clinicians may make medical assessments and decisions, safeguarding participants from the inappropriate use of clinical authority by non-medical entities.

Consequently, SADC programs are not legally authorized to make determinations regarding an individual's cognitive capacity or medical ability to be left alone, or to assess risk for independent community access. Such decisions fall under the purview of a participant's MLTC plan, through a conflict-free PCSP process led by a qualified care manager or licensed clinician.

Any remediation process that compels a non-medical provider to make or override clinical decisions—such as whether a participant can be left alone or navigate the community unsupervised—raises significant concerns under the CPOM rule. Doing so may exceed the legal scope of a SADC provider's authority and blur the boundary between non-clinical supervision and clinical evaluation, potentially exposing providers to regulatory risk.

Remediation Issue and Regulatory Inconsistency

NYSADSA wishes to raise a growing concern: SADC programs are increasingly being cited for non-compliance during audits when there is a perceived conflict between the MLTC PCSP and the SADC PCSP. Specifically, when the MLTC care manager has assessed and documented that a participant may access the community independently, auditors are questioning why the SADC program's internal documentation indicates that supervision is required for ADLs during program hours.

This logic implies that a participant deemed cognitively capable of leaving the building alone must also be capable of performing all ADLs without support—a conclusion that conflicts with both regulatory definitions and the clinical reality of many SADC participants.

As per 9 NYCRR §6654.20, participants may be eligible for SADC based on needing assistance with ADLs or due to cognitive/psychosocial impairments requiring supervision. These needs can—and often do—exist simultaneously and in different environments (e.g., a participant may require prompting or assistance for incontinence or mobility within the structured program environment, yet be oriented and safe to navigate familiar community routines independently).

Due to these remediation findings, programs are increasingly forced to choose between removing all supervision supports within the program—including those tied to functional ADL impairments—or revoking the participant's ability to go out into the community independently and documenting this change at the SADC provider level within the PCSP. Both choices risk compromising either person-centered care or regulatory compliance and present significant ethical and clinical concerns.

Moreover, the DOH PCSP guidance itself clarifies that the question "Can the participant be left alone and unsupervised?" is intended to assess cognitive or communication-based safety concerns, such as those posed by dementia or impaired judgment. It is not designed to assess a participant's need for support with ADLs such as toileting, mobility, or eating. Despite this clarification, current remediation practices appear to misinterpret the intention of this field, conflating cognitive supervision with ADL-related support needs. As a result, providers are placed in a contradictory position where documenting in-program ADL supervision is perceived as inconsistent with the participant's ability to function independently in other contexts.

The Role of the SADC PCSP

SADC-specific PCSPs are critical tools used to train staff and ensure they are aware of each participant's individualized needs and supports during their time in the program. These documents help guide staff interactions, promote safety, and reinforce consistency in care delivery.

Requiring programs to remove all references to ADL-related supervision from the SADC provider-level PCSP simply because a participant is permitted to access the community independently can be concerning. It risks creating a misleading clinical picture that downplays

functional impairments, may result in staff being unprepared to support participants' actual needs, and undermines the integrity of documentation used to guide care and protect participant well-being. Conversely, revoking or limiting a participant's ability to be left alone or go into the community independently solely because they require assistance with ADLs within the structured day program environment may unnecessarily restrict their autonomy, contradict HCBS Final Rule principles, and fail to recognize the contextual nature of support needs.

We believe this issue reflects a need for clearer alignment between the HCBS Final Rule's intent, state-level documentation requirements, and remediation protocols. Recognizing that an individual's supervision needs may vary based on setting, time of day, and task, we request the opportunity to affirm that documentation of ADL supervision in the SADC setting is not inherently contradictory to a participant's community integration rights under HCBS—when those rights are evaluated and approved through a conflict-free planning process.

Request for Confirmation

NYSADSA respectfully requests formal clarification as to whether:

1. A participant may be deemed appropriate for supervision with ADLs during SADC attendance while simultaneously being considered safe to access the community alone under the HCBS (MLTC 42 CFR §441.301(c)(1)) PCSP process; and
2. SADC documentation indicating ADL-related supervision should be considered in conflict with the HCBS community access rights, even when that access is determined by a conflict-free MLTC care manager.

We request confirmation from your offices that:

- The interpretation presented above aligns with state and federal regulations.
- Documentation in the SADC PCSP indicating supervision needs related to ADLs within the day program context does not, by itself, constitute a violation of HCBS requirements if the participant has been assessed by the MLTC plan as safe to engage in community activities independently.

We deeply appreciate your guidance on this matter as we work diligently to uphold compliance standards while protecting the autonomy, safety, and dignity of our participants.

Sincerely,

Ann Selfridge

Ann Marie Selfridge
President
NYSADSA

cc: Susan Montgomery, DOH
Paul Pfeiffer, DOH
Michael Gunn, NYSOFA
Deana Prest, NYSOFA