Adult Day
Health Care
Council

January 29, 2023

Ms. Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel, Reg. Affairs Unit, Room 2438
Empire State Plaza Tower Building
Albany, NY 12237

Re: I.D. No. HLT-48-22-00001-P – Part 425 Revised Regulation regarding Adult Day Health Care

Dear Ms. Ceroalo:

The Adult Day Health Care Council (ADHCC) appreciates the opportunity to comment on the proposed revision of Part 425 – Adult Day Health Care (ADHC). ADHCC represents 50 open and actively licensed medical model ADHC programs in the state and is working to bring the other 70 ADHC members back into membership and to reopened status. Typically, ADHCC represents more than 90 percent of ADHC programs operating across New York State. Before the pandemic, ADHCC members served over 10,000 New Yorkers annually – though significantly fewer now with current program closures. We are the only organization that speaks exclusively for ADHC providers; we are dedicated to the continuation and expansion of ADHC to meet the medical and social needs of older adults with chronic conditions and disabilities in the community and to offer support for their caregivers.

ADHCC and its members support the intention and goals of the Home and Community-Based Services (HCBS) Settings Rule, including person-centered planning, personal autonomy, and community integration of registrants, which comprise the majority of the revisions to this regulation. Please note our concerns, questions, and requests for clarification regarding the proposed regulation.

Elimination of Care Coordination Model Language

ADHCC questions the removal of the reference to “or care coordination model” from the definitions Section 425.1(b)(3) and other sections of regulation relating to referrals. Please provide the intent of the removal of this language. ADHC programs receive referrals, authorizations, and engage in care coordination with health homes, Nursing Home Transition and Diversion (NHTD)/Traumatic Brain Injury (TBI) programs, Office for People with Developmental Disabilities (OPWDD) providers, and other models that might fall under this category. There is concern that the removal of this language implies that the Department is relying on ADHC programs to perform the overarching person-centered care planning for the Medicaid beneficiary when this responsibility is carried out by these other care management entities.

The proposed regulations at Section 425.1(e) add “agency” as one of the referring entities of ADHC registrants. Please provide the definition and intention of adding this term and whether it refers to group homes, health homes, and other care management entities.

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Location of ADHC Programs

ADHCC supports revisions that will give sponsoring nursing homes more flexibility regarding where to establish an ADHC program. We support the new definition of "program" and the removal of "located at" in reference to ADHC program location at nursing homes. This will allow more flexibility in the location of ADHC programs, especially in the broader community. We also support 425.2 (c), which eliminates the requirement of allowing an off-site program only when there is no room on-site at a residential care facility. These changes will also allow future programs to comply more easily with the HCBS Settings Rule regarding colocation.

Unbundled Services/Payment Option

Section 425.1(n) of the proposed regulation removes managed long term care (MLTC) plans and care coordination agencies from the Unbundled Services/Payment Option provision. ADHCC lobbied for establishment of this provision, which permits programs to negotiate with MLTC plans for different levels of ADHC service and care at corresponding negotiated billing rates. Does elimination of MLTC from this provision imply that this payment structure is available to all or certain payor types? Please provide the revised language's intent.

ADHCC supports expanding the Unbundled Services/Payment Option model to include other payors of ADHC, including private pay, Veterans Administration, Medicaid managed care, and more. With that in mind, programs would require an increase in rates for mid-tier and high-level care if this structure were allowed. Current Medicaid rates set 15 years ago, in 2008, are well below the cost of care provided in this setting. As you may know, most closed ADHC programs are unwilling to reopen because of these low Medicaid rates. If this revision broadens the applicability of this tiered payment model, rates will have to increase. Allowing this model to merely provide a lower level of care at a lower ADHC Medicaid rate will only further chip away at the bottom line of these programs.

Include Telehealth Option for ADHC

ADHCC requests that the Department include language in the proposed regulation that authorizes telehealth as an option for ADHC providers. Telehealth is particularly effective when registrants are unable to attend program and require a check-in, case management, and services or support telephonically or by video. This is a service that would be optional if desired by the registrant or if there is immediate or urgent assessment or coordination that the ADHC program can provide.

ADHC programs appreciate the state and federal public health emergency flexibility of this mode of delivery and the recent statute that recognizes payment parity for in-person services with telehealth. We urge the Department to add language to this section recognizing the ability of programs to pivot to telehealth to provide an abbreviated menu of services when a registrant cannot attend program or immediate services are needed to facilitate additional care in the community. Billing codes would be developed to help implement this mode of care delivery.

ADHC programs, just like other primary and long-term care providers, are ready to adapt to new modes of care delivery. Most individuals expect and rely on this mode of delivery to be available. Telehealth check-ins are ideal for individuals who are more vulnerable, with chronic condition, who, when ill, may have difficulty accessing care. A telehealth visit with the ADHC program who knows and cares for a registrant on a daily or weekly basis is a practical and efficient way to determine the needs and status of an individual – whether it be a quick

assessment, delivered meals, case management, or more. There are appropriate options for telehealth, and ADHC programs and their registrants should be afforded these flexibilities.

General requirements for operation – Section 425.4

The proposed general requirements provide that registrants have the right to be integrated in and support full access to the greater community. While ADHC programs support the intent of registrants' rights and are available to assist in these goals, ADHC registrants live at home and have their own families, interests, and interactions with the community that ADHC programs are not privy to or have control over. ADHC programs support their registrants to the greatest extent possible, but also look forward to facilitating access to the community via other resources and avenues. ADHC programs should only be required to make reasonable efforts regarding this requirement.

The proposed regulation at Section 425.4(a)(7) expands on registrant freedom of choice by requiring ADHC operators to provide "freedom and support for individuals to control their own schedules and activities" and "activities at planned and at registrant desired time(s)" (Proposed Section 425.1(d)). While enhanced participant choice and autonomy is an important program goal, and mandated by the Final Rule, the proposed language suggests that all activities must be provided at any time desired by a participant. ADHCC believes that this is administratively and operationally unworkable and not required by the Final Rule. We suggest that this language be modified to require ADHCs to provide programming in a way that enhances resident choice, but allows ADHC programs to make "reasonable efforts" to do so.

Under Section 425.4(b) Administration, the proposed regulation gives the ADHC program the responsibility for coordination for registrants of specific services such as home health, social services, and hospital outpatient services, except when the registrant is in Medicaid managed care. We want to reiterate to the Department that while ADHC programs do provide these services, most ADHC registrants are provided care management in their health homes, Office of Mental Health (OMH) programs, OPWDD group homes, and other Medicaid programs. These programs should also be referenced in the regulation and considered the overarching care coordinators for the individuals under their care.

Under the same section, the proposed regulation inserts the term "consistent" to assigning staff to programs. We urge the Department to use the word "dedicated" to ensure that staff are assigned to that particular program. The use of the word consistent may interfere with staff having to assume various roles during the delivery of care when a program is short-staffed.

General requirements of ADHC settings – Section 425.5

While ADHC programs will support and engage registrants in aspects of individual autonomy and integration in the greater community, we reiterate the fact that ADHC registrants live at home and are already integrated in their greater communities as any non-Medicaid beneficiary lives. ADHC programs have the necessary responsibilities of providing skilled and other health care services during a registrant's five-hour day at program and must comply with providing those services to bill and receive Medicaid reimbursement.

This section includes access to employment opportunities, engagement in community life, control over personal resources, and access to services within the community to the same degree as non-Medicaid participants. This language goes beyond the requirements of the Final Rule (42 CFR 441.301[c][2]). We recommend that the language be modified to allow more flexibility to accommodate the potential geographic and other variations in

the availability, access to, and extent of community resources, including access to transportation. Language should be added requiring operators to "make reasonable efforts" to accomplish these objectives.

It should be noted that programs do not have access to their registrants' personal resources and therefore have no control over ensuring that registrants have access to controlling their personal resources, aside from mentioning a registrant's preferences to a caregiver/family during the person-centered planning process. This language appears to reflect the circumstances of a more OPWDD-oriented population.

This section and others would require ADHCs to (i) provide access to food and/or supplemental nourishment in the form of meals, snacks, and hydration of choice at planned and registrant-desired times and at any time; and (ii) obtain registrant feedback on foods of preference (Proposed Sections 425.12, 425.1(d), 425.5(a)(4), and 425.12(f)). It should be noted that while the Final Rule requires that individuals in a residential setting have access to food at all times, no similar requirement is imposed for community-based settings such as ADHCs. This language should be modified to limit the requirement to snacks and hydration, as it could be operationally impractical to require ADHCs to offer full meals at all operating hours. It should be noted that the Regulatory Impact Statement states that there is no cost to regulated entities to implement the regulations. This section alone requires significant expense.

The proposed section also states that visitors are not restricted from program. Again, we would suggest that this right be provided with a degree of reason. Local laws and guidance, including the local fire code, must be taken into consideration when allowing visitors. Outbreaks of illness requiring heightened infection control measures may also require a limitation on visitors that should be at the reasonable discretion of a program.

Admission, continued stay and registrant assessment – Section 425.7

We support the current language in the regulation that requires programs to ensure that a registrant is not receiving the same services from another facility or agency. ADHCC opposes the proposed language that a registrant cannot be enrolled in two different ADHC programs. We believe that it should be acceptable to have a registrant attend two different programs, as long as program attendance falls on different days and care is necessary and authorized. An example of this would be a registrant who attends one program a few days a week and then stays with family elsewhere and attends another day of the week at the second program. ADHC programs should only be required to ensure that attendance in two different ADHC programs does not occur on the same day.

Registrant person centered care plan – Section 425.8

ADHC programs are in full compliance with ensuring that their person-centered service plans (PCSPs) follow the federal rule. We support inclusion of the provisions proposed, with the following concerns in mind.

Current regulation requires a "designated professional person to be responsible for coordinating the care plan." We support continued inclusion of this provision rather than the proposed language which calls for someone designated responsible for "monitoring" the plan. The PCSP is the guidebook for each registrant and is tied to an assessment, reassessments, and the care and condition of the registrant. Staff should not merely monitor this plan, but ensure that person-centered service planning is scheduled often, efficiently, when requested and needed, and work with the registrant throughout their stay in program to tailor it to meet their needs and preferences.

ADHCC wholeheartedly supports implementation of person-centered care provisions. However, ADHC programs are not the gate at which Medicaid managed care and fee-for-service beneficiaries should be presented with the broad array of HCBS options. A patient's practitioner, the New York Independent Assessor, Medicaid managed care plans, and care managers typically explain the broad array of services available. ADHC providers will provide this service, but choice should happen far earlier in the process.

The new language also references that the PCSP must be understandable to the individual receiving the services. While most of our programs utilize their own PCSP templates and have incorporated some of the Department provisions referenced in its template, the Department's own template does not follow the regulation's requirement of simplicity. Plans must be written and organized in plain language and be understandable to all parties.

In addition, ADHC programs are concerned that the DOH template expands the scope of the PCSP expected of ADHC programs. ADHC programs conduct PCSPs within their care planning process, but their PCSP pertains to the services delivered by the ADHC such as food preferences, therapy goals, preferred activities, outings and recreation, and personal care needs. The template, however, appears to assume that ADHC programs are responsible for all services and supports that registrants may need, including those delivered or coordinated by other programs such as MLTC plans or waiver programs. Again, many, if not most ADHC registrants already have care managers or coordinators through OPWDD, waiver programs, MLTC plans, or health homes.

We appreciate receiving the tool, and we assume that it was provided to ADHC programs for coordination purposes with the overarching care managers. This would be appropriate so that all plans and goals are coordinated for registrants. We would appreciate clarification regarding the Department's intentions regarding this template and the care planning process.

Nursing services – Section 425.11

The proposed regulations eliminate language allowing ADHC programs to share a nurse with their sponsoring nursing home. Many ADHC programs hire and retain their own registered nurse, including all off-site programs. However, current staffing shortages make current regulation a flexible option for programs that are not able to hire a registered nurse, but may arrange to use an ADHC dedicated supervising registered nurse from the nursing home to carry out necessary assessments, provide supervision, and other services in the ADHC program. This flexibility might also be necessary when a program's registered nurse calls in sick. Otherwise, if unable to find a replacement for the day, the entire ADHC program might have to close. Considering the substantial nursing and staff shortages already affecting the entire health care continuum, this change will have significant negative consequences for ADHC staffing. We urge the Department to keep the current regulation in place.

Conclusion

In conclusion, the proposed regulations implementing the HCBS Settings Rule are supported by and currently in practice by programs. ADHC programs will continue to educate staff on various aspects of person-centered care planning and care, prioritizing the registrant's autonomy to guide the process. Implementation of the HCBS Rule is a culture shift, but one that is welcomed by this provide type. ADHCC continues to be concerned that many aspects of the HCBS Rule language are tailored to individuals with developmental disabilities and their lived experience in group homes. Therefore, we feel that ADHC programs should be afforded a degree of reasonable compliance with several aspects of the rule so that they can provide the health care services they are being reimbursed for and which are necessary to enable their registrants to stay healthy and living at home.

Further, contrary to the Regulatory Impact Statement which states that there is no additional expense for regulated entities to comply with this rule, several of the HCBS Rule requirements do require financial expense. Additional costs are being incurred by programs to pay for staff necessary for care and supervision of registrants both off-site and on-site during outings into the community. Transportation costs for registrants to and from program and for outings are expensive and in some instances are being refused by transportation vendors due to the low ADHC Medicaid transportation rate.

ADHCC appreciates the chance to comment on the proposed rule, and we look forward to receiving clarification on the several questions set forth in our letter.

Sincerely,

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