September 29, 2023

Mr. Paul Pfeiffer
Office of Health Insurance Programs
DHPCO-One Commerce Plaza-1623
New York State Department of Health
Albany, NY 12237

Public Comment: HCBS Heightened Scrutiny Evidence Packets, Final Rule Implementation, and New Person-Centered Service Plan Requirements for Social Adult Day Care

Dear Mr. Pfeiffer:

We write to you on behalf of the New York State Adult Day Services Association (NYSADSA) and LeadingAge New York to express our concerns regarding the implementation of the Home and Community-Based Services (HCBS) Final Rule as it pertains to Social Adult Day Care (SADC) programs.

NYSADSA works to further the adult day services industry and its beneficial effects on New Yorkers. It is a statewide organization comprised of individuals, single-site programs, multiple-site programs, and professional organizations, and is primarily engaged in educating and supporting its members through advocacy, education, and compliance.

LeadingAge New York represents not-for-profit, mission-driven, and public continuing care providers, including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living, and community service providers, including SADC programs.

The true essence of the HCBS Final Rule lies not just in its formulation, but also in its meaningful implementation. For SADC programs to effectively realize the mandates of this rule, it is vital for the State to provide Managed Long Term Care (MLTC) plans with appropriate funding to support the requisite changes. Without the necessary financial backing, the entire premise of the HCBS Final Rule implementation becomes hollow. Additionally, MLTC plans must ensure a compliant Person-Centered Service Plan (PCSP) process that actively involves both providers and participants. It is imperative that detailed plans, inclusive of risk assessments, are transparently shared with providers to facilitate seamless and beneficial service delivery.

The New York State Department of Health's New Person-Centered Service Plan Template:

While we deeply appreciate and support the emphasis on a person-centered approach, which includes the New York State Department of Health's (DOH) new PCSP template for SADC programs, the template does not align with the New York State Office for the Aging (NYSOFA)

template requirements. Further, it demands medical information that exceeds the purview of SADC programs. While we are committed to the person-centered approach, it is concerning that some provisions seem to surpass the guidelines set by 9 NYCRR 6654.20 for SADC.

Per 9 NYCRR 6654.20 (d)(1)(iv)(a)(3), SADC programs are authorized to provide personal care which: (i) includes some assistance for the participant with toileting, mobility, transfer, and eating; (ii) may offer total assistance to the participant with the aforementioned needs; and (iii) may provide some or total assistance with dressing, bathing, grooming, self-administration of medication, routine skin care, changing simple dressings, and the use of supplies and adaptive and assistive equipment.

It is important to note that SADC programs do not operate with Registered Nurse (RN) supervision. Noting this fact and that several sections of the PCSP template require medical information and care planning around various diagnoses, we believe it is essential to clearly delineate the boundaries of services that SADC centers can plan for or offer without treading into nursing or medical practice areas. It is critical that the scope of services defined for SADC remains within the limits of the program's operational capacity and legal boundaries.

The template suggests that pertinent diagnoses should encompass all relevant physical, mental health, and behavioral health diagnoses, along with the impact of each diagnosis on the participant – for example, "Diabetes Mellitus Type II – insulin dependent at mealtimes." While this provides a holistic view of a participant's health, SADC staff, per their qualifications and scope of practice, are not equipped to diagnose participants or ascertain the potential implications of a particular diagnosis.

To address this issue and to ensure that the provided information is accurate, comprehensive, and adheres to medical standards, we recommend a modification to the template. The diagnoses section should explicitly indicate the source of this vital information. Given the expertise required to detail such diagnoses and their implications, we suggest this information be provided by the Medicaid MLTC plan, as delineated in 42 CFR § 441.301. This modification would ensure the accuracy of the medical information, adherence to regulatory standards, and, most importantly, the safety and proper care of our participants. Please see our highlighted revision of the SADC PCSP template attached, which offers this revision in several sections of the template.

Such a modification would align with the purpose of person-centered planning, ensuring that the information gathered is both accurate and relevant to designing an effective care plan. By clearly stipulating the source of this diagnostic information, we can avoid potential misinterpretations or gaps in understanding that might arise from non-medical personnel trying to decipher complex medical data.

We believe that this recommendation, if implemented, would further refine the PCSP template, making it a more effective tool for care providers and a more accurate reflection of participants' needs. Our suggestion is made with the utmost respect for the Department's intent and with a shared goal of ensuring the best possible care for our community's most vulnerable members.

We urge the Department to consider our concerns and revisit the new PCSP template requirements to ensure that they align with the scope and capabilities of SADC programs as defined under 9 CRR-NY 6654.20. This would not only safeguard the welfare of our participants, but would also ensure that the programs remain compliant with state laws and regulations.

Finally, we believe that sharing of the PCSPs by the MLTC with SADC programs and other Medicaid HCBS providers would help ensure coordination of Medicaid beneficiaries' PCSPs and keep both MLTC plans and providers on the same page. Currently, this is not being carried out.

Community Integration:

Our organizations are also concerned with the Department's communications to MLTC plans regarding SADC community integration as required by the HCBS Final Rule. The guidance states that off-site group activities without individual integration into the broader community are NOT community integration. The Department's Office of Health Insurance Programs should note that state guidance on community integration for other providers subject to the HCBS Final Rule, including adult day health care, does not exclude group outings from the definition of community integration. We question why the Department is implementing this requirement differently for this provider type.

There is a compelling argument to be made for the role of group outings in community integration. First, group outings can provide an essential bridge for individuals who may initially feel overwhelmed or anxious about integrating individually into the broader community. These outings can serve as a steppingstone, introducing them gently to new experiences and environments.

Furthermore, group outings do not inherently contradict the principle of 'meaningful engagement.' If the group outing is in line with the interests and goals set out in individuals' PCSPs, it holds value. For example, a group of individuals who share an interest in art visiting a local gallery is not just a group trip; it is a collective, meaningful engagement with the community based on shared passion.

Moreover, social interaction is a fundamental human need. Group outings can foster social bonds among participants, reducing feelings of isolation. Engaging with the community as a group can sometimes be more enriching than doing so individually, as it allows for shared experiences, mutual learning, and collective memory-making. Connecting with the community does not always mean being integrated as an individual constantly. Community also means being part of a group, sharing, and belonging. Thus, group outings, when executed thoughtfully and in alignment with individual interests, should indeed be considered a valuable aspect of community integration.

Significantly, SADC programs are required to adapt to meet the HCBS Final Rule by adjusting and expending resources like staffing and transportation to ensure community integration. However, the current interpretation of community integration for SADC programs makes compliance infeasible. The typical staffing ratio for SADC programs is one staff person for every

seven participants. The Department's individualized community integration requirement would call for a 1:1 staffing ratio. This requirement makes little sense considering SADC's current rates of reimbursement and its standard staffing model. Even if staff were prevalent and available, it would be challenging to carry out. We urge the Department to revisit the interpretation of this requirement and consider adequate reimbursement to address the extensive costs involved in SADC compliance with this Rule.

Freedom to Come and Go from Program:

The HCBS Final Rule requires Medicaid HCBS providers to allow individuals the freedom to come and go from program as they choose, at the time of their choosing. While SADC programs support honoring the preferences of participants, they are very cognizant as providers to deliver services in a responsible manner and in accordance with MLTC contracts and Medicaid reimbursement. Honoring the freedom to come and go, without reasonable expectation to attend program on scheduled days, has the potential to border on Medicaid fraud. SADC programs have a responsibility as a Medicaid service to provide authorized care and services and bill and be reimbursed for those services.

The practice to come and go from program also raises serious liability concerns for programs and compromises the safety of individuals who are supposed to be attending program, but who may choose to leave. Many of our SADC programs have a large number of participants with dementia or similar cognitive challenges who require supervision and cueing by staff. Participants could be put at serious risk if allowed to come and go as they please. Further, programs do not have the resources or staff, nor are they reimbursed at an appropriate level, to accompany participants on a 1:1 basis. We ask the Department to ensure reasonable implementation of this aspect of the Rule.

Job Search and Placement/Habilitation Services:

We also wish to highlight concerns regarding the MLTC PCSP template. It currently falls short in capturing individuals' employment goals, a significant aspect of person-centered planning as per 42 CFR § 441.301 (2). Despite its emphasis on person-centered care, the template's lack of provisions addressing employment goals shifts the responsibility onto SADC providers. However, many SADC providers lack expertise in habilitation services and employment supports, as well as resources for them. MLTC's current care plan practice results in a gap, given that SADC is expected to provide habilitation services and employment supports without these being incorporated in the overarching care plan from MLTC.

It is crucial that the MLTC PCSP template be revised to include a section on employment goals. This aligns with federal regulations and person-centered principles. Such a change would ensure a holistic approach, promoting the individual's independence, self-determination, and quality of life, and would also aid SADC providers in effectively allocating resources, ensuring tailored services for each member. Once the goal was documented in the MLTC PCSP, the MLTC could ensure that the member received habilitation services and the SADC program could assist with providing access to computers, assistance with instrumental activities of daily living (IADLs), and ADLs to access the community and experiential learning to prepare the person to enter the workforce.

SADC programs value the partnership they share with DOH in serving the community and are committed to providing the best possible care within their capacity and regulatory limits.

We look forward to an open dialogue and constructive solutions to address these concerns.

Sincerely,

Ann Marie Selfridge
President
New York State Adult Day Services Association

Meg Carr Everett
HCBS Policy Analyst
LeadingAge New York

cc: Karen Meier, OALTC
        Dianne Kiernan, OHIP
        Susan Montgomery, OHIP

Participant Name:
SADC Name :
SADC Location Address:
Authorization Period:
Date Issued:
If you have a question or a problem regarding your services, call your Program Director:
Program Director Name :
Program Director Phone   SName

Participant Name:	
SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Program Director:	
Program Director Name :	
Program Director Phone	

SName

Member Information			
Use this section to document the member's demographic and caregiver/insurance information.			
Participant Name		**Date of Birth**	
Address			
Phone Number		**Preferred Language**	
Email Address			
Gender		**Gender Identity**	
Legal Rep. / Guardian			
MLTC Care Manager		**Other Care Manager**	
Organization		**Organization**	
Contact Information		**Contact Information**	
Primary Care			
PCP Contact			
Emergency Contact			
Medicaid/CIN #			
Primary Insurance		**Secondary Insurance**	
Enrollee ID		**Enrollee ID**	

Participant Name:	
SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Program Director:	
Program Director Name :	
Program Director Phone	

SName

MEDICAL/NUTRITION/SENSORY/MEDICATION/PAIN STATUS

Relevant Physical / Mental / Behavioral Health Diagnoses **(Refer to MLTC Care Plan for full Medical Diagnoses)**	
Diagnosis	**Impact on Participant**
☐ **FALL RISK (Refer to MLTC RISK Management plan, safeguards)** ☐ **NO EVIDANCE OF FALL RISK PRESENTED**	**SADC Interventions (supervision, monitoring, transportation assistance, exercise class etc)**

Medical Information provided by:	
☐ **Participant**	☐ **Designated Representative**
☐ **MLTC Care Manager**	**MLTC Care Manager Name _____ RN License #_____)**
☐ **PCP Name : License #**	☐ **Other Name _____. Relationship if any _____**

Participant Name:	
SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Program Director:	
Program Director Name :	
Program Director Phone	

SName

* The definition of practice of medicine in New York State is defined as diagnosing, treating, operating or prescribing for any human disease, pain , injury , Deformity or physical condition. Social Adult Day Program is not authorized to diagnose, treat , operate or prescribe medical condition

Participant Name:
SADC Name :
SADC Location Address:
Authorization Period:
Date Issued:
If you have a question or a problem regarding your services, call your Program Director:
Program Director Name :
Program Director Phone

SName

COGNITIVE/PSYCHOSOCIAL/SPIRITUAL/COMMUNICATION STATUS (language preference, literacy level etc.)

Capacity for Self-esteem *(Interacts with others and seeks to establish, maintain, or improve the participant's sense of usefulness to self and others, the desire to use his or her physical and mental capabilities to the fullest extent, and his or her sense of self-respect):*

Capacity for independence and self-care (*Use of existing capacities, develops new capacities and interests and compensate for existing or developing impairments in capacity):*

Participant Name:
SADC Name :
SADC Location Address:
Authorization Period:
Date Issued:
If you have a question or a problem regarding your services, call your Program Director:
Program Director Name :
Program Director Phone

SName

Participant Name:	
SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Program Director:	
Program Director Name :	
Program Director Phone	

SName

Allergies (Refer to MLTC Care Plan for Medical Interventions)		
Allergy	**Severity**	**Required Interventions**

Medical Information provided by:	
☐ **Participant**	☐**Designated Representative**
☐ **MLTC Care Manager**	**MLTC Care Manager Name _____ RN License #_____)**
☐ **PCP**	☐ **Other Name _____Relationship if any _____**

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SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

Dietary Restrictions / Needs	
Restriction / Need	**Required Interventions**
Limitations on Access to Food (Refer to MLTC Risk Plan)	

MLTC RISK PLAN FOR MEALS / SNACKS YES ☐ NO☐
MLTC RISK PLAN FOR MEALS/SNACKS NOT RECEIVED BY MLTC ☐

MEAL PREFERENCES	
CONGREGATE MEALS ☐ **Notes:**	
EAT ALONE ☐ **Notes:**	
Notes :	

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

FUNCTIONAL ASSESSMENT/STAFF INTERVENTION	
ADLs	**Level of Care**
Mobility	Independent☐ Independent/w/device* ☐ limited Assist ☐ Supervision/Cueing ☐Complete Assist ☐Dependent☐
Transfers:	Independent☐ Independentw/device* ☐ limited Assist ☐ Supervision/Cueing☐ Complete Assis ☐ Dependent☐
Toileting:	Independent☐ Independent w/device*☐ limited Assist ☐ Supervision/Cueing☐ Complete Assist ☐ Dependent☐
Continence	Independent☐ Independent w/device* ☐ limited Assist ☐ Supervision/Cueing☐ Complete Assist ☐ Dependent☐
Eating	Independent☐ Independent w/device* ☐ limited Assist ☐ Supervision/Cueing☐ Complete Assist ☐ Dependent☐
Supervision Monitoring	Independent☐ Supervision/Cueing☐ Dependent☐ NOTES

Self administration of medication	Independent☐	

• **Current / Projected Need for Modifications and/or Assistive Devices**	
Modification / Device	**Description of Need**

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

Health and Safety Risks(Refer to MLTC Risk Plan)		
Risk	**Known Trigger(s)**	**Required Interventions**

MLTC Risk Plan in place: YES ☐ NO☐ NOT RECEIVED ☐

Competency Level	
Known Issue	**Required Intervention**

Medical Information provided by:	
☐ **Participant**	☐**Designated Representative**
☐ **MLTC Care Manager**	**MLTC Care Manager Name _____ RN License #_____)**
☐ **PCP**	☐ **Other Name _____Relationship if any _____**

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SADC Name :
SADC Location Address:
Authorization Period:
Date Issued:
If you have a question or a problem regarding your services, call your Care/Case Manager:
Case Manager Name :
Case Manager Phone

Likes	
Description	**Member Input**

Dislikes	
Description	**Member Input**

Strengths	
Description	**Member Input**

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

Weaknesses

Description	Member Input

SADC Program Goals / Objectives

Topic	Goal/Objective	Description	Necessary Actions / Steps

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

SADC Activity Preferences	
Activity Interested in	**Details**

SADC Staff Assistance Preferences	
Activity / Support	**Preferred SADC Staff Member**

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

INFORMAL SUPPORT STATUS is there a member of the client's family, a friend or neighbor who helps with care? YES ☐ NO ☐
Specify if more than one Informal Caregiver is providing help.
Describe help the informal Caregiver provides: Tasks, Supervision, Social/Emotional Support, Transportation, Other (specify).

NAME	PHONE	**How often does -this person help the client?**

Does the client appear to have a good relationship with his/her informal caregivers? Yes ☐ No ☐ NOTES:

Ask the person if they are interested in:			
Employment in the Community	☐ **YES**	☐ **Not Interested**	
Volunteering in the Community	☐ **YES**	☐ **Not Interested**	
Community Events	☐ **YES**	☐ **Not Interested**	**List Community Events below**

Transportation Assistance Required	☐**YES (provide details below)** ☐**NO**

Community Activities	
Activity Interested in	**Supports Needed**

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

Individualized Care Plan – Schedule

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

Person-Centered Service Planning Process Information			
Meeting Date		**Meeting Time**	
Meeting Location			
Was this meeting held at a place and time of the person's choosing?			Yes☐ No☐
Did the person lead the meeting to the best of their ability?			Yes☐ No☐
Did the person choose who was at the meeting?			Yes D No D
Name	**Title/Relationship**	**Agency**	**Date**
	[e.g., Care/Case Manager]		
	[e.g., Provider]		
	[e.g., Provider]		
	[e.g., Informal Support]		
	[e.g., Informal Support]		

SADC Name :	
SADC Location Address:	
Authorization Period:	
Date Issued:	
If you have a question or a problem regarding your services, call your Care/Case Manager:	
Case Manager Name :	
Case Manager Phone	

Acknowledgment:
I agree with what is written in this person-centered service plan and acknowledge that I, the recipient/enrollee, lead the person- centered planning process. I understand my rights and/or I have someone I trust who can help me with them. This includes the right to integrate with and be a part of my community, separate from the Social Adult Day Care service I am choosing to receive. I acknowledge that I was offered options to integrate with and be part of my community, and my decisions on goals or activities related to this are documented in this plan. I understand that my plan will be reviewed regularly, that I can ask for it to be reviewed sooner, and whom to speak to about having my plan reviewed and updated. I agree to this plan being shared with the people that need it to provide my services.
Enrollee/Recipient or Designated Representative Signature: _____ **Date:**
Program Staff Signature :   **Title :**   **Date:**