July 31, 2014

Mark Kissinger, Director
Division of Long Term Care
NYS Department of Health
Corning Tower
Empire State Plaza Albany, NY 12237

RE: State's Transition Plan for Implementing Federal HCBS Settings Rule

Dear Mr. Kissinger:

On behalf of LeadingAge New York, I am pleased to provide comments on New York's Transition Plan to implement the federal final rule on Home and Community Based Services (HBCS) Settings for Medicaid-funded long term services and supports provided in non-institutional residential settings. LeadingAge NY represents over 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout the State.

We believe that this rule has broad implications that are likely to impact nearly every Medicaid-eligible individual in the State, as well as a vast array of service providers, including those that are *not* Medicaid providers. We appreciate the spirit of the rule, which is designed to promote independence, autonomy and choice for individuals receiving services under home and community based waivers covered by Medicaid. New York has a highly developed, long-standing system of home and community based services and waiver programs, which ironically poses greater challenges to the State than perhaps other states. We must determine how to implement the requirements in ways that are least disruptive to systems of care and the people who rely on them.

As we have noted in our comments to the Centers for Medicare and Medicaid Services (CMS) on earlier drafts of the rule, the population in New York receiving Medicaid HCBS waiver services is extremely diverse and different groups may need to be treated differently. While the rule is designed to ensure choice for Medicaid beneficiaries, the implementation could, in fact, result in narrowing options for some. Consumers should have the ability to waive certain aspects of the regulation if they desire to live in a setting that does not meet all of the regulatory criteria.

Below are comments regarding the State's implementation plan from the perspectives of the different aspects of our LeadingAge NY membership, and different focus areas; but first some general comments:

General Comments Regarding the Transition Plan

This is an extremely complex rule, made even more so with many reform efforts underway in the State. The five-year transition period is crucial to thoughtfully implement—perhaps even too short of a time

period. It is concerning that while the clock is already ticking on New York's five-year transition period; it may be well into the five-year period before service providers fully understand the implications of the implementation. It is *critical* that we develop more detailed transition plans soon, so that all parties will understand what is or will be required in the near future. Failing to do so could mean that investments are made to develop services that ultimately do not meet the criteria, and consumers moving into to settings that would ultimately prohibit them from being able to access needed services.

Additionally, while the State technically has five years to transition the HCBS settings requirements in, and the rule does not yet apply to 1115 waivers, these requirements are already being imposed through the Special Terms and Conditions (STCs) of the State's 1115 waiver agreement with CMS. **We respectfully request that: 1) CMS clarify when the rule will apply to 1115 waivers, presumably through the regulatory promulgation process; 2) the 1115 waiver be subject to the same five-year transition period as the other HCBS waivers, and 3) the STCs be revised to omit these requirements until the transition period concludes.**

Below is a summary of perspectives from different LeadingAge NY member types on the transition plan:

1. **Adult Care Facilities**

LeadingAge NY asserts that adult care facilities (ACFs) are already doing much of what these new federal regulations require. We would recommend that the State identify those areas where ACFs clearly already meet the requirements in regulation, to avoid facility-by-facility documentation requirements. CMS has stated that any modification must be supported by a specific assessed need and justified in the person-centered service plan. We believe, however, that there are some modifications that we can proactively identify that would be justified and should be accepted. For example, the regulation discusses facilitating access to work opportunities; however it is rare that residents of adult homes and enriched housing programs desire to seek employment. It seems unnecessary, then, for each ACF to have to address that issue and document, if not appropriate.

To aid the State in considering how ACFs already meet the federal requirements, we comment on the concepts of the rule outlined in *The Summary of Key Provisions of the HCBS Settings Final Rule* issued by CMS, with reference to adult home regulations. Enriched housing programs, which are also ACFs, generally provide a more independent apartment-like setting, and thus we have selected the adult home regulations as a reference. However, enriched housing regulations mirror adult home regulations in most areas. This is not an exhaustive list, but rather a few examples from regulations that demonstrate meeting the general regulatory concepts.

The setting:

- **is integrated in and supports full access to the greater community:**

Access to and integration with the community is specifically addressed in Title 18 NYCRR Part 487.5(a)(3). In addition, key responsibilities of the case manager include assisting each resident to maintain family and community ties and to develop new ones; encouraging resident participation in facility and community activities, and assisting them access service providers in the community (487.7(g)). Community providers as well as visitors and other professionals are allowed to come to the facility to serve or visit residents. Activities (487.7(h)) also should bring members of the community into the facility, and vice versa.

- **is selected by the individual from among setting options;**

Residing in any ACF is always at the option of the resident, no one would ever be forced to live in that setting. Sometimes choices are limited by factors such as the specialized needs of an individual, or service/bed availability. For example, in New York City, alternative housing options simply do not exist. In addition, the State has limited the number of Medicaid-assisted living (the assisted living program or ALP) slots in the State, which inherently limits access. That being said, an individual is able to both select where they live, and to terminate their admission agreement if they no longer want to remain in the facility. If an ACF resident wants to live in another setting, the facility must assist them in transferring. This is specifically addressed in Title 18 NYCRR Part 487.5(f).

- **ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;**

Resident rights, which include dignity, privacy, respect and freedom from coercion are specifically addressed in Title 18 NYCRR Part 487.5(a)(3). In addition, restraints are expressly prohibited, per Title 18 NYCRR Part 487.7 (e)(7).

- **optimizes autonomy and independence in making life choices; and,**

The concepts of autonomy and independence are woven throughout the regulations, and specifically addressed in Title 18 NYCRR Part 487.5(a). There are also specific examples where these principles are stressed. For example, individuals are permitted to self-manage and administer their own medication regime (Title 18 NYCRR, Part 487.7(f)(1)). Case management regulations (487.7(g)(2)) include the provision that each resident shall be provided such case management services as are necessary to support the resident in maintaining independence of function and personal choice. Residents also have other choices; for example they may choose to provide their own housekeeping or laundry.

- **facilitates choice regarding services and who provides them.**

CMS has clarified that the selection of a particular provider, if a ‘package of services’ (as is the case in an ACF or assisted living setting), is in and of itself choice of service provider. That being said, case management regulations state that the resident has their choice of medical services providers (487.7(g). In addition, residents have choice of home care services providers, if they require more skilled services than the facility can provide, for example.

Provider-owned or controlled HCBS

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings, which we presume apply to ACFs. These requirements include:

- **The individual has a lease or other legally enforceable agreement providing similar protections.** All ACFs have an admission or residency agreement, which is a very specific, legally enforceable document that is reviewed and approved by DOH. This is specifically addressed in adult home regulations, Title 18 NYCRR Part 487.5(a)(3).

- **The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;** Generally speaking, no more than two residents are permitted to share a bedroom per Title 18 NYCRR Part 487. 11(x). There were some facilities in the late 1970s that were permitted to have more than 2 persons to a room; however this a rare occurrence, if at all. ACFs do their best to honor choice of roommate, within the context of the limitations of availability. That being said, if roommates fail to be compatible, facilities will intervene and attempt to find a solution.

  It was clarified in the CMS webinar regarding the rule that the freedom to furnish and decorate individual's rooms does have limits. Adult home regulations actually require that a facility provide furnishing; however residents can certainly bring in personal items and decorate. It should be noted that there are circumstances where it is inadvisable to bring in furniture, as it can provide a threat to the cleanliness of the facility and the health of the residents. This regulation must be applied in a reasonable fashion.

  Lastly, some ACFs have lockable doors, and some do not. In some cases, having lockable doors may present a safety hazard. For example, dementia units probably should not have lockable doors and in this case a general waiver should be granted, while the provider strives to ensure the resident still has privacy.

  • **The individual controls his/her own schedule including access to food at any time;** During a webinar that CMS provided on this issue, it was suggested that this requirement meant that residents should have access to food outside of scheduled meal times; that individuals could access food when they wished. CMS acknowledged that this is not without limits, and it must be acknowledged that ACF providers must also encourage residents to comply with special diets and physician's orders. That being said, many ACFs have refrigerators and microwaves in resident rooms, and residents have the ability to store food in their rooms to the degree that they are able to do so in a way that maintains a clean and safe environment. Guidance should be provided to ACF providers that reflect an understanding that the ACF is fundamentally responsible for the resident's overall well-being-including encouragement to special diets, for example.

- **The individual can have visitors at any time;** ACF regulations require that individuals be able to have visitors. At the same time, ACFs are responsible to ensure a safe environment for all of their residents. Thus, facilities may need to put parameters around visiting time (i.e., it's not appropriate to come at 2:00 a.m. if the resident or their roommate is sleeping), or where they can visit if the visit itself might be disruptive. Guidance should be provided to ACF providers that reflect an understanding that the ACF is fundamentally responsible for all residents' well-being and safety.

- **The setting is physically accessible.** ACF environmental regulations (Title 18 NYCRR Part 487.11) require that the setting is accessible to the resident. In addition, the retention standards limitations are such that residents go to a more appropriate level of care if the setting is no longer appropriate to their abilities.

CMS notes that any modification to these above additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan. We suggest that some of these issues can be addressed in more general way, perhaps though a waiver process. This is meant not to diminish the effect of the rule, but rather to minimize time spent on issues and documentation that may not be relevant to the population.

It will be important for the State to determine how these requirements will apply to ACFs, as not all serve Medicaid-eligible individuals, and some serve only a few. We want to ensure that we do not set up requirements that ultimately discourage ACFs from serving the low-income population; doing so could actually result in promoting nursing home care. At the same time, this rule does not apply to an ACF that serves the private pay population.

It would also be important for DOH to consider this direction and determine how their survey practices support or hinder the implementation of this rule. There has always been a tension in this level of care between resident choice and freedom, and provider responsibility for the overall safety and well-being of a resident *at all times*. These requirements heighten that tension. The survey process does not allow room for residents to take risks and make choices that may ultimately be detrimental to their well-being.

2. Assisted Living Program

As noted above, we are particularly concerned that the transition plan seems to push the planning process for ACFs and ALPs to September 2017-August 2018. This is concerning given that the ALP population will have been mandatorily enrolled into managed long term care (MLTC) by that time, and thus may already be held to the requirements. In addition, there are current efforts to expand ALP beds, and those developing new providers should have clear guidance about these parameters before investing time and money. We urge that the planning process begin earlier, so that all will be ready for implementation. LeadingAge NY is eager to participate.

We suggest that the ALP should be examined differently in relation to this rule, as it is a unique hybrid of services in the State. The ALP is neither institutional nor home and community based, but rather something in between. We think that New York's ALP should not be characterized as an HCBS setting, and yet object to the default conclusion that it would thus be an institution. We urge the State and CMS to consider a third category, for which neither institutional nor home and community based standards, rules and policies fit entirely. To aid in understanding this perspective, we provide the following as background.

The ALP was established in 1991 in NY to serve individuals who are medically eligible for skilled nursing facility placement, yet whose needs can be safely met in a less restrictive and lower cost residential setting. The ALP program was created at a time when New York's burgeoning elderly population, coupled with a shortage of affordable low-income housing options, was causing many frail elderly individuals to seek premature placement in nursing homes. Appropriate and cost effective alternatives were explored by DOH and the Department of Social Services, which led to the ALP's creation. ALPs are regulated by DOH, and participating providers are selected to participate in the program by competing for eligible "ALP beds" under a competitive application process.

The ALP meets the needs of nursing home-eligible individuals by combining the residential services of an ACF with health care services provided through a home care agency. The health care services provided by an ALP are essential to independent living as, but for the ALP, those residents would be confined to a higher level of care. Moreover, ALP providers are responsible for providing or arranging for the full spectrum of residential services that an individual needs, including room, board, meals, personal care, supervision, case management, and housekeeping. Services in the ALP are determined by initial and periodic reassessments, and providers are required to maintain sufficient staff at all times and to submit staffing plans to the Department for review.

At present, the Medicaid reimbursement for ALP services is funded through the State Medicaid plan. ALP providers receive a daily capitation rate that is determined by an individual medical need and level of care assessment based on the Resource Utilization Group (RUGs III) case-mix classification system. State law has set the ALP Medicaid rate at approximately 50 percent of what the reimbursement would be if that particular individual was actually receiving services in the nursing home; providing the State and Federal government an immediate, tangible cost savings while avoiding unnecessary institutionalization. It is planned that the ALP population will be enrolled into mainstream Medicaid managed care and managed long term care within the next two years, and it is at this point that such services would be provided under an 1115 waiver, thus presumably triggering the HCBS settings requirements.

The ALP population consists of approximately 5,000 individuals, with the overwhelming majority of the population being Medicaid and SSI eligible, as well as dually eligible (i.e., eligible for both Medicare and Medicaid). Since 1993, the ALP program has more than doubled in size, and the 2012 State Budget called for an even greater expansion, authorizing the Commissioner of Health to approve an additional

6,000 beds. Yet, despite these efforts, New York continues to find itself fighting to keep pace with its ever- growing numbers of frail elderly Medicaid beneficiaries and its mandate to provide these individuals with care in the most inclusive setting possible. According to July 2012 RUGS III assessment data compiled from nursing homes in New York, more than 15,000 current nursing home residents could be receiving services in the ALP.

Despite its limited enrollment, the ALP is an essential provider that plays an integral part in allowing Medicaid eligible individuals to remain in their communities and avoid unnecessary institutionalization. Its unique attributes are necessary to its continued success. Given these features, and the acuity of the population served, it is inappropriate to hold the ALP to the HCBS standards that have been developed to create a baseline of community integration across general settings. The ALP plays a dual role in New York's long term care continuum in that it provides vital health care services to residents in the least restrictive setting, while at the same time providing an effective cost savings mechanism for the State in avoiding the placement of residents in a higher, and more costly, environment. CMS should recognize the ALP as the unique provider that it is; a critical "intermediary level of care" residential provider between the independent setting of an HCBS and a nursing home. Such a designation is consistent with the underlying theme of the ALP: allowing for the provision of health care in a less restrictive and more cost effective setting for residents who are in need of higher level of care than provided at a traditional HCBS.

3. Adult Day Health Care

Assuming that the HCBS settings rule will apply to adult day health care (ADHC) at some point, please note that the rule identifies settings that are NOT HCBS as well as those that are presumed to have institutional qualities and, therefore, do not meet the rule's requirements for HCBS settings. Those that are NOT HCBS are: nursing homes, institutions for the mental disease, intermediate care facilities and hospitals. ADHC programs in New York are not approved to operate as any of these entities.
In terms of settings that are presumed to have institutional qualities, including those in a publicly or privately-owned facility that provide inpatient treatment or settings on the grounds of, or immediately adjacent to a public institution there are ADHC programs that are located in these settings, but they would meet the higher level of scrutiny standard:

- **Is integrated in and supports access to the greater community**.
- **Does not have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS**

Since inception, ADHC programs have been sponsored by nursing homes, but individuals attending them are "not occupants" (Chapter 855 of the Laws of 1969) of the nursing home and thus a recipient of community-based services. Given the professional level of staff required to operate ADHC programs in NY, the services required and the environmental costs associated with ADHC construction, it makes sense that ADHC programs would be sponsored/operated by a nursing home or a hospital affiliated

with a nursing home. This is particularly true of ADHC programs in rural areas. If they were not "housed in" or sponsored by health care facilities, it is unlikely that they could survive financially at all.

While ADHC programs are sponsored by nursing homes and often are located within them or on the same campus, those who attend are fully integrated into the community. By definition, individuals must be functionally impaired, but not a resident of an inpatient facility or in need of twenty-four hour care. In addition, the individual must be assessed as being able to remain in the community and must be referred by the community physician who continues the relationship with the individual throughout their time in the ADHC program. The individual's time in an ADHC is referred to as a "visit" and is a portion of a day (5 hours). This visit, while longer in length and made up of various components, is no different on its face than a "visit" to a doctor's office or neighborhood clinic, which clearly are community-based settings. Finally, individuals are transported to/from programs by private transporters, family members or in some rare instances utilize public transportation [10 NYCRR Section 425.1 (a) and (b)].

In terms of the ADHC population, it is very much a reflection of the community in which the program is located. Functional impairment and a need for health care services are the common denominators among registrants in ADHC programs in New York. While some programs may have developed a "niche" such as serving those with a visual impairment or a secondary behavioral health diagnosis, the population is diverse in terms of registrant conditions addressed. In virtually every program you will find a mix of individuals with dementia, those being assisted for stroke/cardio vascular problems, diabetes and older persons with medical conditions who are also persons with developmental disabilities, to name a few. New York has one Alzheimer's-specific ADHC program, one MS-specific ADHC program and one pediatric ADHC program.

In urban areas, you may find a high concentration of ethnic groups in certain programs, but this ethnic concentration is a reflection of the neighborhood/community in which the ADHC program is located. Urban ADHC centers in New York, in particular, tend to be racially and ethnically diverse reflecting The National Center for Health Statistics' *2013 Study of Long-Term Care Services in the United States* finding that "Adult day service center participants were the most racially and ethnically diverse among the five sectors."

- **Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.**
- **Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services.**

ADHC regulations are intentional throughout with respect to individuals remaining in the community. However, ADHC registrants are older (average age 74) often frail, have chronic illnesses and disabilities and are not seeking work. Individuals must be assessed with an eye toward their potential to remain in the community [10 NYCRR Section 425.7(b) (4)]. Their care plan must be developed outlining and utilizing community resources and supports and coordinated with health care providers in the

community outside the ADHC program [Section 425.7(b) (4) and (5)]. Activities must reflect *"the registrant's interests and cultural backgrounds"* and must, by design, *"ensure the individual's participation in the program, home life and the community."* An ADHC activities program must also, *"provide or arrange for transportation to and from community events and outings"* [Section 425.14 (a), (b) and (e)].

- **Person-centered service plans document the options based on the individual's needs and preferences; and for residential settings, the individual's resources.**

Section 425.7 establishes that a care plan must be developed using an interdisciplinary assessment, which requires the program to establish an individualized plan that addresses a complete array of medical and psycho-social needs. The care plan must also establish *"the medical and nursing goals and limitations anticipated for the registrant and, as appropriate, the nutritional, social, rehabilitative and leisure time goals and limitations; (4) the registrant's potential for remaining in the community; and (5) a description of all services to be provided to the registrant by the program, informal supports and other community resources pursuant to the care plan, and how such services will be coordinated… (c) development and modification of the care plan is coordinated with other health care providers outside the program who are involved in the registrant's care.*

Registrants and family members/caregivers are routinely invited to care planning meetings, which are held twice per year at a minimum.

- **Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting.**

If an individual otherwise meets the eligibility requirements and is referred by a physician, a registrant in fee-for-service Medicaid may choose among home and community-based providers and/or among ADHC programs in their geographic area. Individuals enrolled in a managed care program may choose between a minimum of two ADHC programs in their geographic area if approved by the managed care plan for services. The only limitation on this ability to choose would be in a rural area where there may only be one ADHC and/or other community-based provider offering services.

- **Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.**

ADHC programs must ***"****provide each registrant with a copy of a Bill of Rights specific to operation of the adult day health care program.*

> *These rights include, but are not limited to:*
> *(i) confidentiality, including confidential treatment of all registrant records;*
> *(ii) freedom to voice grievances about care or treatment without discrimination or reprisal;*
> *(iii) protection from physical and psychological abuse;*
> *(iv) participation in developing the care plan; and*
> *(v) freedom to decide whether or not to participate in any given activity [Section 425.4(3)].*

In addition, Section 425. 21 guarantees the confidentiality of all registrant records and that these will only be made available to authorized individuals. Registrant councils are a significant part of ADHC program operations and provide an additional avenue for registrants to voice their concerns, advocate for their specific interests and direct their own care.

- **Optimizes individual initiative, autonomy, and independence in making life choices.**
- **Facilitates individual choice regarding services and supports, and who provides them.**

Individual autonomy and independence are supported in ADHC since these two characteristics are essential to any individual who intends to remain in the community. Goals established through the care planning process are designed to support autonomy and independence. Autonomy and independence are further supported by the health education an individual receives, any rehabilitation services received, by the therapeutic activities designed for them and through social work services/groups offered to the individual through the ADHC program.

To summarize, despite the ADHC program's relationship to nursing homes in New York, it is clearly a home and community based service. The outlined points above further demonstrate how these settings meet the heightened scrutiny standard.

4. Home Care, Waivers and Other Home and Community-based Service (HCBS) Providers

Consistent with comments elsewhere in this document, the fundamental concerns of home care providers relate to when and how the requirements apply, which entities are responsible for implementation and enforcement of Person Centered Planning (PCP) and the settings requirements, and ensuring that needed services are not disrupted for the people they serve.

Many LeadingAge NY members are long-standing HCBS providers of 1915(c) waivers such as the Long Term Home Health Care Program (LTHHCP), the Traumatic Brain Injury (TBI), and the Nursing Home Transition and Diversion (NHTD) waivers. PCP has been a cornerstone in developing plans of care (PoC) or service plans for these waivers. The DOH application to CMS for any of these 1915(c) waivers requires, Appendix D, Participant-Centered Planning and Service Delivery which includes several components: (a) who develops the plan of care, who participates in the process, and the timing of the plan; (b) the types of assessments that are used to support the plan development; (c) how the participant is informed of the range of services; (d) how the plan development process ensures the plan addresses the participant goals, needs , and preferences; (e) how services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) and how and when the plan is updated. This includes risk assessment and mitigation.

Given this history and experience with PCP, and the current efforts to infuse PCP concepts into a variety of services, we ask that there be consistency among the HCBS Final Rule, the 1115 Partnership Plan, Affordable Care Act, Section 2402 (a), 1915(c) waivers, and Title 42 Part 441.730 in regard to

person-centered planning. There should be consistency regarding defining what should be in the PCP, the process, the qualifications of the individual developing the plan with the participant, conflict of interest standards and statements, training with the assessment instrument to development the PCP, knowledge of what might lead to the need for HCBS, and on-going training on best practices to uphold the principles of the *Olmstead* decision.

Given that the federal rule updates the approach to HCBS waivers, we also recommend that the LTHHCP be updated to further support individuals living in the most integrated setting possible. Presuming that DOH plans to submit a renewal LTHHCP application to CMS for 2015, we recommend that the State also repeal the requirement for undergoing a certificate of need (CON) process to approve specific counties of operation for existing LTHHCPs when under contract with a managed care plan. There would be greater choice for consumers and greater efficiencies for LTHHCPs who are under contract with managed care plans to operate in the same counties as the plan.

5. Managed Long Term Care

As we noted in our introduction, we need greater clarity on the actual impact on managed long term care. We request that the 1115 waiver have the same benefit as the other waivers in terms of a public vetting process, and a subsequent five-year transition period. The Special Terms and Conditions (STCs) of the 1115 waiver should be revised to omit requirements regarding HCBS settings until this process is finalized. Given the scope of the 1115 waiver's reach, this is vital. Below are just some of the considerations that need to be thought through.

The MLTC plans depend upon the ability to be flexible in how they meet enrollee needs in a variety of possible settings. The federal rule creates several concerns as to how that flexibility can be maintained; both in terms of care planning enrollee needs, and housing options. Although the rule is geared towards creating options for enrollees, by proscribing too restrictive a set of rules, the ultimate impact could actually be the opposite. Protections need to be put in place to allow plans to step outside the narrow confines of the rule when the enrollee needs or desires dictate that this would be in his or her best interests. Protections also need to be in place to ensure that if an enrollee's current situation is meeting his or her needs and preferences that some exception is allowed.

The need for flexibility is highlighted with the experience of long-standing Program for All-inclusive Care for the Elderly (PACE) programs in the State. Many of the regulated housing options tend not to work because the rules did not contemplate such collaboration. ACFs, for example, pose difficulty because the retentions standards for an ACF are at odds with the eligibility requirements for PACE. While consumers could be well-served by this combination of DOH-regulated programs, the rules get in the way. The goal of PACE is to keep high needs people well and in the community; to do so requires some degree of flexibility and creativity. Again, we should thoughtfully consider how to implement this rule in a way that doesn't limit choice for PACE participants, nor limit the success of PACE. In addition, we should review state regulations to eliminate unnecessary barriers to maintaining a consumer in the least restrictive setting-whether being served by PACE or MLTC.

In addition, it is unclear how the PCP requirements will be applied to MLTCs, which of the entities providing services to the consumer is responsible, and how that works with the other planning, assessment and coordination functions of all. Given that such issues are central to the work of MLTC plans, we urge that LeadingAge NY and our member plans be active participants in the development of such standards.

The rule also needs to clarify what the duty of the plan is relative to waiver programs being used as subcontractors. The MLTC plans should *not* have to bear any responsibility to ensure that subcontractors are meeting the requirements of the rule.

6. **Senior Housing**

In general, senior housing settings are likely to meet the HCBS settings characteristics, with the exception of those located on the campus of institutions, which would be subject to "heightened scrutiny". Senior housing is typically an independent apartment, some with amenities to support the elderly to remain independent as long as possible. It is in no way institutional, and in some cases the proximity to an institution facilitates access to needed services to remain living independently, or access to a loved one residing in a higher level of care on the campus.

As noted elsewhere in the document, there is a large number of housing options for seniors, both market rate and subsidized, that are on the same campus as a nursing home or hospital. In New York City where land to develop is scarce and expensive, such settings may be some of the only land available to develop housing. State and city policy are pushing senior housing development on unused institutional grounds as a way to lower costs for senior housing development.

We urge the State to clarify that senior housing is indeed home and community based, regardless of its proximity to an institution and/or location within a community that has different levels of care. New York is wisely encouraging the development of new affordable models of housing for the Medicaid eligible population, and this regulation should not be a barrier when the setting itself affords independence and autonomy.

Overarching Issues

Heightened Scrutiny

In the guidance, Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community, issued by CMS, were pleased to see it noted that most Continuing Care Retirement Communities (CCRCs), which are designed to allow aging couples with different levels of need to remain together or close by, do not raise the same concerns around isolation as other settings. In New York, CCRC-*like* settings are at issue.

In the State, many providers have developed campus settings in response to consumer preferences, which may include services such as assisted living, adult day health care, and/or senior housing on the same campus as a nursing home. This scenario has been particularly supportive of couples, whose needs rarely progress at the same pace—enabling a spouse to easily visit their frailer spouse who requires a higher level of care, and making it easier for family to visit their loved ones.

The State has promoted these models by encouraging the rightsizing of nursing home beds to develop assisted living and other HCBS either on the campus, adjacent to or *in the same building as* the nursing home. HEAL grants—funded by both State and Federal dollars, supported the development of these services. The non-nursing home services and settings on these campuses are non-institutional in nature are generally provided by established providers experienced in serving the needs of the elderly.

We point this out to note that such settings have been designed, not to inhibit choice; but to *increase* choice, access and ease for the elderly. We urge the State to work with CMS to clarify that CCRCs and CCRC-like settings do not require the type of heightened scrutiny that CMS contemplates for other settings.

Person Centered Planning

As noted earlier in this document, providers are striving to learn and incorporate the variety of different requirements inherent in the numerous reforms underway. A common element is the infusion of PCP, and we again ask that there be consistency among the HCBS Final Rule, New York's 1115 waiver special terms and conditions, and the Affordable Care Act, Section 2402 (a). There should be consistency regarding defining what should be in the PCP, the process, the qualifications of the individual developing the plan with the participant, conflict of interest standards and statements, training with the assessment instrument to development the PCP, knowledge of what might lead to the need for HCBS and on-going training on best practices to uphold the principles of the *Olmstead* decision.

The assessment process, a key aspect of PCP, should be designed in way that the consumer is indeed at the center, and does not have to undergo multiple, duplicative assessments. Rather, the assessment process should be developed in a way that assessments have interoperability, or the ability to share information. We understand that DOH has consolidated several assessment tools into the UAS-NY; however LeadingAge NY supports more work on aligning assessment tools to enhance the PCP process to be more comprehensive, maximize efficient use of resources, and be considerate of the experience of the person at the center of the service.

In addition to our above comments, there remain specific questions we hope DOH can answer:

Questions

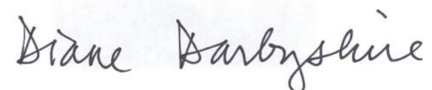
1. What will happen to consumers that, at the time of implementation, are receiving Medicaid-covered HCBS under a waiver and live in a setting that does not meet the criteria? Will CMS or the State force that individual to move? Will their services be discontinued, even if they need them? Will the person be required to move into a nursing home?
2. In certain parts of the State, Medicaid beneficiaries may not be living in a setting that meets the HCBS standards, but there may not be suitable alternatives. This is the case in rural areas and even more so in New York City where five-year wait lists for affordable housing are the norm. This begs the question—what then happens to the consumer? Where will they go?
3. CMS has said repeatedly that these requirements will apply to 1115 waivers. When will that happen and why were these waivers treated differently? Please clarify how this currently impacts managed long term care and managed care providers and the people they serve.
4. Please provide more guidance about the Person Centered Planning requirements in the event that a person is enrolled in managed care or managed long term care. Which entity is responsible for what aspects of Person Centered Planning?
5. How must the State implement the process of "heightened scrutiny"? Must they do individual site visits? What will be required of providers?
6. Based on the State's transition plan, it would appear that the HCBS regulations do not as yet apply to ADHC since some ADHC services are currently being delivered as optional services under the Medicaid State Plan, or through the 1115 waiver. Is this an accurate read of the State's transition plan?
7. If these rules are to apply to ADHC at different times as a result of an affirmative answer to #4 above, how would this implementation be carried out?

Conclusion

While we understand that this is an opportunity to comment on the State's transition plan, as opposed to the rule itself; it is critical to bear in mind the context in which these requirements are being implemented. In New York, there is an unprecedented amount of change in long term care and health care. Fundamental reforms to service delivery and payment are afoot. Providers are being challenged to work with new partners, in new ways. There is *tremendous* pressure to do more with less, to save money, to improve outcomes. It seems incongruous to implement new standards at this time that will ultimately increase cost and require more documentation that ultimately takes away from patient care. Greater flexibility and time to implement the rule would be ideal; and certain populations should be exempt from certain aspects of the rule (for example, children and the elderly). We also urge the State and CMS to implement the rule with a great deal of thought and consideration, engaging stakeholders and allowing logical, systematic approaches to documentation, modification, and the "heightened scrutiny" process. LeadingAge NY would like to a part of this planning process.

Thank you again for the opportunity to comment on the transition plan. If you have any questions or want to discuss the above further, you can reach me at 518-867-8383 or ddarbyshire@leadingageny.org.

Sincerely,



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