January 22, 2024

Ms. Dianne Kiernan
New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza, Room 1623
99 Washington Avenue
Albany, NY 12210

Ms. Karen Meier
Director, Bureau of Policy
Office of Aging and Long-Term Care
New York State Department of Health
99 Washington Avenue, Suite 1624
Albany, NY 12210

Re: HCBS Rule Implementation and Compliance for SADC Programs

Dear Mss. Kiernan and Meier:

On behalf of the New York State Adult Day Services Association (NYSADSA) and LeadingAge New York, we would like to convey our concern regarding the State's implementation of the federal Home and Community-Based Services (HCBS) Final Rule in relation to the remediation and compliance review process for Social Adult Day Care (SADC) programs.

Our concerns are focused on the Department's use of review and remediation standards that are designed for residential settings or for managed care plans, rather than for providers of day services, or that are infeasible for social day programs that serve older adults. In particular, as detailed below, Remediation Plan Items #9 and #16 relating to access to food at any time and #20 relating to access to visitors at any time should not be applied to a day program. Similarly, certain person-centered planning standards are inapplicable to SADC programs. Further, the Department's community integration requirements for outings and activities exceed the Centers for Medicare and Medicaid Services' (CMS) standards and render compliance virtually impossible for social day programs.

These inappropriate interpretations of the Rule threaten access to social day programs selected by participants. We understand that SADC contracts with Managed Long Term Care (MLTC) plans are being cancelled and participants are being deprived of their preferred programs. Further, Federal Medical Assistance Percentage (FMAP) distribution payments could be withheld from SADC programs based on requirements that go beyond the HCBS Rule.

The Department of Health's (DOH) stringent interpretation of the Rule is not driven by CMS guidance or regulation. The exploratory questions, designed to assist states in assessing the presence of HCBS qualities, emphasize that these are not rigid compliance checklists, but tools to illustrate qualities within the context of each service. Each program should be assessed for its unique qualities, including duration and location and the needs and preferences of the people it serves.

The following is a detailed summary of each of the items that are being applied improperly to SADC programs:

Remediation Plan Item #9

Does the site provide for more than one meal option and private dining space if requested by a member?

Remediation Plan Item #9 references 42 CFR 441.301(c)(4)(vi)(C) and a CMS HCBS Settings Standard Description requiring participants to have access to food any time.

While SADC programs are working diligently to provide flexibility in food options in their programs, it should be noted that this requirement in the State's Remediation Plan, citing 42 CFR 441.301(c)(4)(vi)(C), applies to "provider-owned or controlled residential settings" only. According to CMS, a provider-owned or controlled residential setting is a physical place in which an individual resides that is owned, co-owned, leased, or operated by a provider of HCBS. This includes homes, apartments, or other living arrangements that are owned or controlled by the provider. The Department recognizes elsewhere in its remediation plan that SADC sites are not residential. Access to food at any time is not required for non-residential settings like SADC programs.

Further, federal Child and Adult Care Food Program (CACFP) regulations which apply to many SADC programs provide strict guidelines on meal services during program. While these guidelines ensure that participants receive nutritious meals and snacks, they are not designed to accommodate continuous access to food, given the limited hours of operation.

During the remediation process, the State has required certain programs to remove scheduled mealtimes from the calendar, even though participants enjoy a structured calendar and congregate meals. The HCBS Rule emphasizes the importance of individual autonomy and access to food at any time only in provider-owned or controlled *residential* settings. SADC programs are not equivalent to residential settings, and their service models, including meal provision, should be treated differently.

It is our understanding that the intent of the HCBS Final Rule is not to impose residential standards on non-residential programs. In the context of a SADC program, this would mean providing congregate meals and snacks during the program hours, with considerations for choice and dietary needs and preferences, and allowing participants the option to eat outside of the scheduled mealtimes if they so choose.

We respectfully request that DOH consider the unique nature of non-residential SADC programs when applying the HCBS Final Rule criteria and recognize that compliance can be met through the provision of scheduled meals and snacks as per federal program guidelines like CACFP.

Remediation Plan Item #27

Setting is integrated and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work/volunteer in competitive integrated settings?

Sample determination of compliance: The reviewer observed the SADC has an English and Spanish sign posting for those interested in employment, which includes steps for the member to take with site staff and their MLTC plans, as well as information on a different sign for those seeking volunteer opportunities. The SADC representative advised that members are supported from the point of initially expressing interest, up to and including successful placement in a job or volunteer position.

SADC programs support the intent of the Rule's requirement to offer and encourage participant employment, volunteering, and other productive activities. However, a blanket requirement for all SADC programs to organize and deliver habilitation and/or employment/volunteer matching services in integrated settings is beyond the scope of the SADC program.

SADC programs should be afforded flexibility when offering opportunities for participants to seek work/volunteer opportunities and employment in competitive integrated settings. A person-centered approach, which is at the heart of the HCBS Rule, should be taken. Considering the age and life stage of most SADC participants is crucial, as many in their 80s and 90s are not seeking employment or volunteer opportunities – a factor which should guide the application of HCBS requirements. In addition, many SADC participants have cognitive challenges, including dementia and Alzheimer's. It is essential that DOH applies flexibility and discretion in interpreting these criteria, recognizing that meaningful community integration for elderly participants may involve activities other than competitive employment.

Programs should be discussing and offering some opportunities for volunteering and direction for employment options, if a participant is interested, but full habilitation services in competitive settings should not be required of SADC programs. These are not SADC services, and their program staff are not trained to provide them.

Remediation Plan Item #20

Does the site allow members to have visitors of their choosing at any time?

Remediation Plan Item #20, which references 42 CFR 441.301(c)(4)(vi)(D), also applies only to "provider-owned or controlled residential setting[s]" and requires participants to have visitors of their choosing at any time in program. Again, while we support reasonable access to visitors at any time, it is essential to apply common sense to the operational context of SADC programs.

Programs often run only four to five hours, are not residential in nature, and their participants live independently in their own homes and in the community.

Expecting SADC programs to operate with an open-door policy akin to residential settings disregards their operational limitations, such as safety, infection control, and certificate of occupancy constraints. While visitor access can be a positive element of programs, it must be balanced with practicality, ensuring that programs can manage guest visits without compromising safety or exceeding capacity and recognizing that participants' autonomy outside program hours is not impacted. SADC participants live at home, in the community, and therefore have other opportunities to visit with others and access the community.

Remediation Plan Item #42

HCBS standard: 42 CFR 441.301(c)(4)(vi)(F)

Based on SADC PCSP Review: Does the SADC PCSP document and appropriately justify any modification to the freedoms allotted all members via the HCBS Settings Final Rule?

HCBS Standards 42 CFR 441.301(c)(4)(vi)(C) and (D): Are there any modifications listed and justified for the member not being allowed the freedom and support to control their schedules and activities, or have access to food any time, or unable to have visitors of their choosing at any time?

MLTC plans are the more appropriate entity to manage the overall person-centered planning process referenced in §441.301(c)(1)(i)-(ix) and §441.301(c)(2)(i)-(xiii)(A)-(H). SADCs should be responsible only for modifications that are applicable to the SADC program setting and risks and individualized assessed needs that arise in that setting, consistent with person-centered planning principles. Notably, MLTC plans must be engaged in this process, as they employ nurse care managers. SADC compliance with this aspect of person-centered service planning (PCSP) is not possible, as program staff do not perform functional assessments. Any changes to the rights outlined under §441.301(c)(4)(vi)(A) through (D) must be based on assessed needs and justified within the care plan. This underscores the non-residential and non-medical nature of SADCs. We reiterate the need for MLTC plans to share PCSPs of participants so that SADC programs can carry out any modifications that MLTCs determine appropriate in the SADC setting.

We also urge the Department to amend MLTC PCSP template signature panels to ensure full participation of the participant and family members in the PCSP process and require MLTC plans to share the PCSPs with their members' HCBS Medicaid providers.

Remediation Plan Item #21

Does the setting support members to: Make their own decisions? Associate with others? Access their money?

SADC programs do not assist program participants with accessing or managing their money. Assistance with money management, paying of bills, or personal spending has never been included as a benefit or service of the SADC program. Several programs have faced HCBS Rule non-compliance issues for not informing participants about access to their funds. This misapplication of HCBS Rule standards causes confusion for participants and highlights the need for compliance reviews to be tailored to the SADC setting and the services actually offered by SADC programs.

Community Integration Requirement

NYSADSA and LeadingAge New York also have concerns with the State's interpretation of the HCBS Rule's community integration requirement. The Department has shared several slides and presentations regarding this requirement along with examples of compliance. It has stated that group outings into the community are not considered community integration. The Department guidance and presentations call for one-on-one or small group outings tailored to an individual's PCSP. Some of the examples include accompanying participants to swim class, dropping off and picking up participants at book club, events, and volunteer opportunities.

SADC programs understand the importance of integrating individuals into the greater community and the responsibility to ensure that participants are engaged and interacting with individuals in the community who are non-Medicaid and non-disabled. However, CMS does not require one-on-one integration and has never made this clarification. There is limited ability for SADC programs to fully carry out community integration in this format. This might be accomplished to a limited degree. However, SADC programs do not have enough staff to accommodate and accompany individual participants to events or errands in the community, while also ensuring that there is sufficient staff to provide personal care, meals, socialization, activities, and other core services of the program.

We urge the Department to consider the purpose of the SADC program, its non-residential nature, and its operational and regulatory responsibilities and limitations. Its intent is to provide for the care and supervision of its participants, bring individuals together to connect with each other, enjoy a meal together, and take part in group activities. We support community integration of participants, but programs should be provided with a reasonable degree of flexibility when complying with this aspect of the Rule. Further, many attend SADC programs to socialize and interact with others. Again, these are people who live in their own homes in the community. We should note that other HCBS Medicaid providers are not subject to this limited interpretation of community integration.

Remediation Process

We wish to stress the importance of adequate time to complete the remediation process. SADC providers require at least several days to ensure that changes to policies and plans are consistent with all regulations and in the best interests of participants. A rushed remediation process risks undermining the person-centered approach required by the HCBS Rule, potentially leading to

hasty and less meaningful compliance efforts. This approach could make compliance a procedural formality rather than a genuine effort to enhance individual care, raising concerns about the integrity of the person-centered planning process.

The above concerns underscore the need for a clear and applicable set of criteria, consistent with the actual HCBS Rule regulations, to fairly and accurately assess compliance for SADC programs. We respectfully request that DOH reassess the remediation items and issues mentioned above to reflect the operational realities and goals of SADC programs, ensuring that compliance measures are both practical and aligned with the participants' best interests.

NYSADSA and LeadingAge New York request an opportunity to discuss the above items with the Department. While the requirements have been communicated directly with MLTC plans, there has been little communication between DOH and SADC programs, and we feel it is important to connect with the Department on implementation of this significant mandate.

We look forward to meeting with you at your earliest convenience.

Sincerely,

Ann Selfridge

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