LeadingAge New York

September 9, 2016

New York State Department of Health
Office of Health Insurance Programs
Division of Long Term Care
Attn: Deborah Rhatigan
One Commerce Plaza
99 Washington Ave., Suite 1620
Albany, NY 12210

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

Dear Ms. Rhatigan:

On behalf of LeadingAge New York, we appreciate the opportunity to provide comments on New York's Transition Plan to implement the federal rule on Home and Community Based Services (HBCS) Settings for Medicaid-funded long term services and supports provided in non-institutional residential settings ("the HCBS Settings Rule" or "the Rule"). LeadingAge NY represents nearly 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout the State, and we offer comments from the perspective of our members and the people they serve.

The plan has evolved significantly since the first draft, and it reflects considerable work on behalf of all of the state agencies involved. We appreciate these efforts, and the opportunity to work together to put together a plan that makes the most sense for New Yorkers. We have specific comments on the plan and assessment tools, but also want to comment on the processes.

PUBLIC INPUT PROCESS

We are concerned that there has not been careful examination and public input into the implications of applying the HCBS Settings Rule in its entirety specifically to New York's Medicaid 1115 Waiver program. As you know, the provisions of the HCBS Settings Rule are intended to apply to HCBS provided through Medicaid authorities under sections 1915(c) HCBS Waiver programs, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. Although the Rule's provisions do not apply by their terms to 1115 waivers, they are incorporated by reference into New York State's 1115 waiver by agreement between the State and the federal government through the waiver's Special Terms and Conditions (STCs).

However, when the STCs governing the managed long term care (MLTC) amendment were negotiated in 2013, the final HCBS Settings Rule had not yet been published. Nor had the Centers for Medicare and Medicaid Services (CMS) published guidance concerning the implementation of the final Rule. Thus, the implications of applying various aspects of the Rule to a mandatory managed care program may not have been fully understood. Subsequent solicitations of public comment on the 1115 Waiver

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and the HCBS Settings Transition Plan have proceeded on separate tracks. It is not clear that the interactions between these two complex bodies of policy have been fully analyzed. Because nearly all Medicaid-eligible individuals are being enrolled into managed care and MLTC plans under the authority of the 1115 waiver in New York, the implications of the Rule are far reaching.

At a minimum, we recommend the creation of a stakeholder advisory group to work with an inter-office team at the Department of Health (DOH) to examine how the Rule interacts with the 1115 waiver and the many associated initiatives underway, and to develop approaches that support and enhance the already robust home and community-based services in the state. However, we believe a dedicated public comment process on the Rule as it applies to the 1115 waiver is warranted.

In addition, we find the Rule and subsequent guidance to be at odds at times with the needs and preferences of elderly New Yorkers. As we have noted before, the universe of people receiving Medicaid-covered HCBS is extremely diverse. We have found that the Rule and guidance don't always fit the needs and wants of the elderly population, and we recommend that CMS and the state develop separate guidance designed specifically for that population. While the Rule is designed to ensure choice for Medicaid beneficiaries, it appears as though the implementation could limit choices for seniors and promote nursing home placement. Clearly, this contrary to the underlying intent of the Rule.

GENERAL COMMENTS ON THE TRANSITION PLAN

1. <u>Heightened Scrutiny</u>

LeadingAge NY has concerns about the lack of clarity surrounding the heightened scrutiny process, given the potentially significant implications of that process. There seems to be confusion about what the heightened scrutiny standards are, what the priorities should be in an assessment of a setting, and what the implications of the process will be. It's also unclear what consumers and their representatives can do if they disagree with a heightened scrutiny determination and want to remain living somewhere or receiving services in a place that CMS does not deem ''home and community-based." What if there are no other suitable HCBS alternatives for the consumer in his or her home community? Lastly, is there any sort of appeal process, if the provider or consumer disagrees with the assessment?

a. Confusion about the Standards

Under the Rule, services are presumed to be institutional in nature, and heightened scrutiny is triggered, if they fall into any of the following three categories:

1. Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or
2. Located in a building on the grounds of, or immediately adjacent to, a public institution, or
3. Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid

There continues to be considerable confusion about the second category ("located in a building on the grounds of, or immediately adjacent to, a public institution"), and many have taken it to mean that any services provided in a setting on the campus of any nursing home or hospital is subject to heightened

scrutiny. However, in the preamble to the Final Rule, CMS clearly defines "public institution" as an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. It further notes that, "medical institutions, intermediate care facilities, child care institutions and publicly operated community residences are not included in the definition,[1]" meaning this category does not include skilled nursing facilities, and appears to be limited to penitentiaries and/or detention centers. Thus, merely being located on the same grounds of or adjacent to a county- or municipality-owned nursing home or medical facility does not trigger heightened scrutiny. Further, it states in the CMS issued Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community 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. We urge the state and CMS to apply the same approach to CCRC-*like* campus settings by clarifying that CCRCs and CCRC-like settings *do not require* the type of heightened scrutiny that CMS contemplates for other settings. Such settings have been designed not to inhibit choice or isolate individuals, but to *increase* choice, improve access to services, and enable elderly individuals to maintain strong social and marital relationships in familiar surroundings, as their functional limitations and service needs grow.

Lastly, we disagree with DOH's broad interpretation of the third heightened scrutiny category. We understand that the standard set forth in the third category is vague. We are concerned that the state's expansive interpretation of that category will result in rather subjective decisions to apply heightened scrutiny review and unnecessarily trigger heightened scrutiny for a significant number of settings, which will yield inconsistent outcomes. For example, we question why the State is gathering information about all campus settings (absent a public institution) in the ALP self-assessment process, with the assumption that they have the potential to isolate individuals from the broader community. If CMS had intended for all campus settings to undergo heightened scrutiny, it would not have used the narrow term "public institution" in the second category to distinguish it from other settings. Instead, it would have used a more general term like "medical institution." This is just one example, however; and the determination of what may have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community seems highly subjective.

b. What will be the focus of heightened scrutiny assessments?

Much of the focus of the Rule is on person-centered planning. LeadingAge NY providers have long embraced that concept, and we believe that these tenets should be at the crux of the heightened scrutiny review. The CMS guidance regarding the heightened scrutiny process, however, seems to focus on other details that don't seem to have a direct correlation to the individual's experience of care. The guidance points the states to demonstrate that the setting is not *operationally interrelated* with the facility setting to demonstrate that it is not institutional in nature. We continue to object to the idea that shared finance, human resource services, or other administrative functions results in services being institutional in nature. Such arrangements have no effect on the level of community integration, the physical environment, the programmatic elements, or the individual's experience of care. Rather, these administrative arrangements enable providers---consistent with state and federal policy—to spend public dollars in the most efficient manner possible. Instead of focusing on shared

[1] 42 CFR §435.1010.

administrative resources, heightened scrutiny should focus on issues that directly relate to the quality of individuals' experience of care and their level of community integration.

This CMS guidance also focuses on transportation, with an emphasis on using transportation other than that provided by a facility. We again want to note that the transportation provided to the frail elderly population should be appropriate to the needs and desires of the resident, and CMS's preference for public transportation may not always be consistent with a senior's wants and needs.

Lastly, the CMS guidance points to whether or not someone in the community would associate the setting with the provision of services to persons with disabilities. We struggle to understand how a senior services provider can serve the community well without clearly describing who they serve and what types of services they are providing. This seems an impractical and unattainable objective for many service providers that, ironically, could make it more difficult for older adults and their families to locate and access services. Accordingly, this element of the CMS guidance should be omitted.

Overall, the CMS guidance seems to depart from the Rule to focus on issues that have little or no bearing on the nature of the actual services, could be quite costly to change (which will have implications for both consumers and providers), and have limited value to the consumer. If the guidance is the standard by which the State must assess settings, we urge CMS to revise the guidance.

c. What are the implications of Heightened Scrutiny?

There is considerable anxiety in the provider community about the implications of being targeted for "heightened scrutiny." Would they know if they were categorized as requiring heightened scrutiny? Will they be required to close their programs? Will their residents or consumers have to go elsewhere to receive services? Will other service alternatives even be available in the local area? 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 waiting lists for affordable housing are the norm. This begs the question—what then happens to the consumer? Where will they go? Lastly, what if the potentially costly remediation steps that a provider undertakes are not deemed to be acceptable by CMS?

We agree with CMS that this should be a transparent process. Those providers or settings that have been identified as requiring heightened scrutiny should be notified of their status. There should be clearly defined standards for the onsite heightened scrutiny review. The provider should receive clear, written guidance about how to come into compliance with the Rule, if failing to do so during the on-site review. Consumers should understand that the setting is under heightened scrutiny and understand the implications of that process.

These steps will help ensure the most rational process possible moving forward. It is our hope that we can work to ensure that all of our members are successful in overcoming the heightened scrutiny process; failure to survive that process could have devastating impacts on seniors and their families who rely on services and settings.

2. <u>Education of Providers</u>

We appreciate the efforts of DOH to provide education to the provider community, and talk with stakeholders about the Rule and its implementation. Given the complexity of the Rule and the outstanding questions, we urge CMS and DOH to continue to provide education and opportunities for dialogue on areas that are unclear, including specific implementation issues and operational concerns.

In addition, we would like to see some more training and discussion regarding Person-Centered Planning. We would like to understand better the interplay between the managed care or MLTC entity and the subcontracted provider as it relates to these requirements.

Cost Burden and Reimbursement

These regulations will increase the cost of providing care. Depending on the circumstance, compliance may require enhanced case management, dedicating more resources to provide frail elderly with supports to ensure safe access to the broader community, and perhaps even costly changes to physical structures. CMS and DOH must consider increasing reimbursement to address the costs of providing care. Current Medicaid reimbursement is inadequate, and federal and state wage mandates will be making the cost of providing services even more expensive. Failing to adequately reimburse providers of Medicaid-covered HCBS will ultimately result in increased nursing home placement.

As a practical matter, any such programmatic and physical plant changes resulting in increased compliance costs will affect payers other than Medicaid, since affected providers will offer the same services to all consumers. This means that the Medicare program should also recognize any increased costs, and that consumers and commercial insurers will see increases in charges for these HCBS.

COMMENTS ON NEW YORK'S REVISED STATE TRANSITION PLAN DOCUMENT

1. Section III. Assessment Methodology (pg.7, by the pdf pages in the Introduction of the document) discusses the State's Request for Proposals (RFP) to hire a contractor that will take on a variety of activities including conducting and validating site-level residential and non-residential assessments; developing a menu of remediation strategies to address each characteristic and quality of an appropriate home and community-based setting for DOH/State agency approval; and more. Because some of the standards can be subjective, we urge that these processes be developed with the input of stakeholders to ensure that the contractor enforces the Rule as written in a consistent manner. The process should be made as transparent and objective as possible, so everyone understands the expectations and what is required to address any deficiency. It should be noted that any remediation plan should also consider the unique needs and preferences of the particular individual being served. The selected contractor must have the requisite experience and knowledge base to conduct this type of analysis for HCBS provided to elderly individuals.

2. Section IV. Assessment Process (pg.7 in the Introduction of the document) provides that the contractor will use the same assessment tools used by OPWDD in its site-based assessments. In light of the distinct and distinguishable needs of the elderly population served by long term care providers in New York, we offer the following comments and suggestions on the tool, with the hope that they are useful in adapting the tool to work in other settings with other

populations. Given that some of the areas of assessment are nuanced or subjective, it's important that the assessments are conducted in a consistent, clear manner.

- On pg. 3 of HCBS PART II Site Review –Section 1: The Home is Not On/Adjacent to an Institutional Setting (Heightened Scrutiny), it may be useful to revise the wording of questions to elicit a clear and consistent response. For example, "*The home is not part of a group of multiple settings co-located and/or clustered and operationally related*" could be modified to state: "Is the home part of a group of multiple settings that are 1) co-located and/or clustered and, 2) operationally-related?"
- With regard to question 2.c on pg. 4 of the tool, "*The home is not labeled or identified in a way that sets it apart from the surrounding private residences."* Is this question intended to imply that providers such as assisted living operate without any sort of signage? This is not a requirement of the Rule, and there are very practical reasons why signage is important. See our related comments on page 4 above.
- We also have concerns with questions such as 3a on pg. 4*: 3a. "There are no blanket house rules (or polices/procedures) or practices that limit individual rights, independence, choices, or autonomy, including but not limited to: the right to choose one's own schedule, to come and go from their home at any time (e.g., no curfew), the right to have visitors at any time; the right to have access to food 24 hrs./day, etc."* The questions do not reflect some of the nuances expressed in the guidance that CMS has issued around having access to food, or safety considerations for people with dementia (guidance to be forthcoming). We urge that the guidance be built into the assessment process to ensure clarity for the provider and the assessor.
- With regard to question 3b on pg. 5, *"The home is an environment that supports individual comfort, independence, and preferences and is not institutional in appearance or operation:"* We find the question to be very subjective and would like to know what criteria will be used to determine whether a setting meets these standards and how the assessors will be trained to assess this in a consistent manner.
- With regard to question 3e on pg. 5, "*The home has a mechanism to offer and provide keys to peoples' bedrooms/front doors if desired:"* We would appreciate guidance from CMS and the state about how providers should approach this requirement given safety concerns about some of the populations being served in, for example, assisted living.
- With regard to question 3j on pg. 6, *"There is evidence that the home optimizes community/natural resources including public transportation (if applicable) to ensure that individuals have full access to the community according to their preferences:"* We want to note that, due to the frailty of some of the individuals served in assisted living and other aging services settings, public transportation is not always the ideal choice. Providers of those services access the most appropriate transportation for an individual based on his/her needs and preferences. In some cases, it could be public transportation; but it may also be facility transportation, family members, or more specialized medical transportation. We suggest that the focus be on whether or not arrangements have been made for the individuals to access the community to the degree they desire.

3. Section VI. Remediation and Quality Improvement Strategies (pg. 8). This section states: "Ongoing compliance with the Statewide Transition Plan is expected to be achieved for DOH waivers and the 1115 Demonstration by requiring the contractor to develop a regular schedule of surveillance based on the existing state schedule for surveillance and quality oversight in collaboration with DOH surveillance staff." Does this mean that the contractor will be participating in the regularly occurring DOH surveys for the providers, or a separate survey process? And is it the MLTC or managed care plan's survey, or the provider setting in which the service is being provided?

TRANSITION PLAN FOR THE ASSISTED LIVING PROGRAM

We appreciate the efforts of DOH to be mindful of the HCBS settings rule in the conversations we have had regarding regulatory reform and transitioning to managed long term care. This thoughtful approach will help ensure a smoother transition for ALPs and their residents. Given the complexity of the Rule and subsequent guidance, however, we urge DOH and CMS to conduct ongoing education for the provider community, allowing time for questions and answers to ensure they understand the Rule and what it means for their setting and service.

1. Campus Settings are not Settings that Isolate Individuals from the Community

As noted in the transition plan, many seniors seek out organizations that provide a continuum of care, to ease transitions as their needs increase. Campus settings can allow couples with different needs to be near one another. Campus settings also allow seniors access to more resources, with greater efficiencies. We continue to question the premise of the Rule that such campus settings are bad or isolating. Further, despite all of the guidance released, we still do not know what exactly the "test" will be to overcome the presumption that a service is institutional in nature as result of triggering heightened scrutiny. We firmly believe that the evidence should focus on the nature of the services being provided; whether or not the setting offers a person-centered approach and provides the individuals with as much independence as appropriate.

2. The ALP and Heightened Scrutiny

In Section IV. Heightened Scrutiny Activity, it notes that 15 ALPs are presumed institutional as a result of the heightened scrutiny standard. Has the Department informed those facilities that they fall under that category, and the reasons why they have been categorized as such? LeadingAge NY advocates that these conversations begin early.

Among the 15 ALPs subject to heightened scrutiny are ALPs with special needs assisted living residence (SNALR) licensure for those with dementia or other cognitive impairment. In the transition plan, they are characterized as not being able to fully comply with the HCBS Settings Rule. We disagree with the premise that they cannot fully comply with the Rule. The heightened scrutiny process provides a pathway for those settings to be in full compliance. That being said, given the evolving understanding of CMS's intent with the Rule, we question whether heightened scrutiny remains necessary. A recent CMS/Alzheimer's Association educational program seemed to reflect an understanding of the need to balance a consumer's access to the greater community with safety for this population. While we have yet to see written guidance from CMS on this issue, we question whether heightened scrutiny will indeed be required for these settings.

We would also note that most, if not all, ALPs that serve the dementia population also serve individuals who do not reside in the dementia unit and may not be Medicaid eligible. Thus, the residential community provides opportunities for those residents to interact with the broader community of individuals not receiving Medicaid-funded HCBS.

In Section III. Process and Methodology for Assessing NYS ALP Compliance with the Final Rule, it is noted that the State will develop a survey protocol to assess each ALP provider's efforts towards compliance. We respectfully request that DOH share the protocol with LeadingAge NY and other stakeholders to help ensure a clear and common understanding of expectations. Our objective is to try and make the expectations well understood for all. We would like to be included in the development of guidance and look forward to participating in the regulatory reform discussions as well. We appreciate that DOH seems committed to working with providers to help them come into compliance; LeadingAge NY is committed to working with the Department and our members to that end as well.

Below are some fundamental issues that remain unclear in the ALP provider community; we would appreciate a dialogue with DOH to identify a logical approach to compliance:

- Providing access to food at all times in a safe and sanitary way that does not violate special diets;
- Ensuring safety and avoid disruption while allowing visitors at any time; and
- Managing the requirement to provide keys to resident units while ensuring safety.

From a broader policy perspective, LeadingAge NY has been advocating for ways in which we can provide more options for Medicaid-eligible people with advanced dementia. It's extremely difficult to provide the environment and staffing necessary to adequately meet the needs of people with dementia within the ALP Medicaid rate. As a result, there are a small number of facilities that are trying to provide specialized dementia services and units to Medicaid beneficiaries. These units provide a wonderful option for a certain segment of the Medicaid eligible population that has dementia but does not require the clinical services of a nursing home. This policy issue should be considered in the implementation of the Rule, as it could have the effect of discouraging rather than encouraging serving Medicaid-eligible people with dementia in assisted living settings. Currently, the opportunities are very limited in New York.

APPLICABILITY OF TRANSITION PLAN TO MANAGED LONG TERM CARE

As noted above, the provisions of the Rule apply to HCBS provided through Medicaid authorities under sections 1915(c) HCBS Waiver programs, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. Although the Rule's provisions do not apply directly to 1115 waivers, they are incorporated by reference into New York State's 1115 waiver by agreement between the State and the federal government through the STCs of the State's waiver. Specifically, the STCs require "[b]eneficiaries receiving Medicaid HCBS and LTSS services furnished through the 1115 demonstration . . . to receive services in residential and non-residential settings located in the community, which meet CMS

standards for HCBS settings as articulated in current 1915(c) policy, including regulations at 42 CFR §441.301." [1]

Because the Rule is intended to ensure that service delivery "settings" satisfy specified standards related to community-integration, physical environment, and person-centered planning, it does not neatly apply to managed care plans which typically are not "settings," and typically do not directly provide services other than care management. Accordingly, the transition plan's compliance charts (which are designed for providers) should not be applied to MLTC plans.

In addition, we urge the State to carefully consider the person-centered planning standards to be applied in the context of an MLTC program.[2] We would like to highlight some of the points made in a CMS slide presentation earlier this year on the application of the person-centered planning and conflict of interest provisions to managed care programs. CMS recognized that although freedom of choice of supports and services is a key tenet of person-centered planning, there may be authorized restrictions on choice in the context of managed care programs.[3] CMS also noted that HCBS Rule transition plans "are not authorized" to include conflict of interest provisions. [4] Accordingly, the State's transition plan does not address the conflict of interest provisions of the Rule.

Nevertheless, it is important to recognize that the State has already taken steps to comply with the Rule's conflict of interest provisions, including the implementation of the Conflict Free Evaluation and Enrollment Center to conduct eligibility assessments for MLTC. While MCOs may not conduct assessments for purposes of determining eligibility for programs, CMS has indicated that they may conduct functional assessments for other purposes (e.g., determining service needs).[5] Further, according to CMS, MCOs may also provide case management.[2] The conflict of interest provisions set forth at section 441.301 apply to "providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual." As noted in the CMS slides, only those MCOs that "own and operate direct LTSS services (such as personal care and Nursing Facility) and provide case management . . . must demonstrate to CMS that they are the only willing and qualified case manager."[6] According to CMS, if an MCO "contracts for, but doesn't operate or own direct services, it is not considered a conflict of interest for the [MCO] to perform case management." Thus, the Rule's conflict of interest standards do not apply to an MCO that merely shares a common parent or other affiliation with an LTSS provider, but does not "own or operate" direct services. To the extent

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[1] Centers for Medicare & Medicaid Services. Section 1115 of the Social Security Act Medicaid Demonstration New York Partnership Plan, Waiver No. 11-W-00114/2, Oct. 1, 2015, Section V(5).
[2] *See* Kako E, Cooper R, Centers for Medicaid and Medicare Services, Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, "Conflict of Interest in Medicaid Authorities," slide presentation, Jan. 2016, available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf .
[3] *Ibid.*, slide 14.
[4] *Ibid.*, slide 27.
[5] *Ibid.,* slide 26.
[2] *Ibid.,* slide 26.
[6] *Ibid.*

that any policy changes are contemplated in relation to conflicts of interest, we encourage the Department to consult closely with stakeholders.

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) NOT SUBJECT TO THE HCBS SETTINGS RULE

PACE programs are not subject to the requirements of the HCBS Settings Rule. PACE programs are not waiver services, and as such are not covered by the Rule. The inclusion of PACE programs in New York's 1115 waiver as a type of plan available to satisfy mandatory managed care enrollment requirements neither converts PACE programs into waiver services nor triggers the applicability of the Rule. This conclusion was confirmed by CMS on a stakeholder conference call regarding recently proposed PACE regulations on August 15, 2016. It was also confirmed in the proposed PACE regulations themselves, which solicit comments on whether services arranged or delivered by PACE programs should comply with the HCBS setting standards, but do not affirmatively propose applying those standards to PACE programs. Thus, as PACE programs are not currently subject to the Rule, it would be premature to subject PACE programs to HCBS setting standards. The compliance chart for PACE programs (page 29) should be removed.

ADULT DAY HEALTH CARE TRANSITION PLAN

At present, the transition plan for adult day health care (ADHC) programs is vague. Given New York State Law – which requires ADHC programs to be sponsored by nursing homes – and applicable regulations, most ADHC programs are housed within an institution and it is our understanding that they will therefore be subject to heightened scrutiny. Many of our member nursing homes provide this valuable service and are unclear about what will be expected to overcome heightened scrutiny. We urge DOH and CMS to work closely with the Adult Day Health Care Council on this issue to ensure that we find a way to preserve and protect this important program.

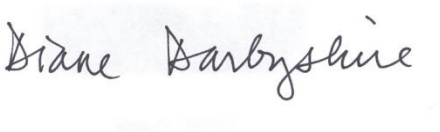
The ADHC is unique in that it provides a high level of clinical services to people who live in the community. The programs are able to provide that level of care because of their relationship to the nursing home. ADHC is operationally and financially feasible because it is related to an institution. It is critical to remember, too, that ADHC registrants *live in in their own home*. Registrants essentially require nursing home care, and thus are most likely going to have to be in a nursing home absent the support of the ADHC. For these reasons, reasonability must prevail in the heightened scrutiny assessment; the actual location of the service is far less important than the nature of the services being provided and their critical role to keep people in the community.

CONCLUSION

Thank you again for the opportunity to comment on the transition plan. LeadingAge NY's not-for-profit, mission-driven providers are passionate about the services they provide and the people they serve. We embrace person-centered care and an empowering approach to caring for and supporting seniors. We remain concerned, however, that the Rule and associated guidance could have significant detrimental effects on access to HCBS in New York. We urge you to consider our comments in the implementation process to ensure that we enhance – rather than undermine – the robust network of

HCBS in New York. 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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