May 16, 2016

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re. Planned construction of presumed institutional settings

Dear Mr. Slavitt:

On behalf of LeadingAge New York and the Adult Day Health Care Council (ADHCC), we are writing to share our serious concerns with recent guidance from the Centers for Medicare and Medicaid Services (CMS), entitled *HCBS Final Regulations 42 CFR Part 441: Questions and Answers Regarding Home and Community-based Settings.* This guidance on planned construction of presumed institutional settings is fundamentally flawed for a number of reasons and should be reconsidered:

- CMS discourages investments in co-located settings prematurely, sending the message that the physical location alone determines institutional characteristics rather than person-centered planning processes or community integration;

- Limiting new construction is antithetical to the scope and intent of the HCBS Settings Rule which is to promote choice among Home and Community-based Services (HCBS) settings and focus on the quality of individuals' experiences; and

- CMS exceeds its authority when clearly, nowhere in the final rule is construction of settings limited or strongly discouraged.

Background

LeadingAge NY and the ADHCC have been monitoring the development of these regulations over the years, and the subsequent implementation process. Both directly and through our national organization, LeadingAge, we have consistently provided input and feedback. One of our fundamental concerns has been that the rule doesn't differentiate between the various populations that are served by Medicaid HCBS waivers. Specifically, the rule fails to appreciate that the needs and desires of seniors may differ from those of a younger disabled population.

Furthermore, the rule fails to provide flexibility for states like New York that have a long history of providing HCBS. Ironically, states that offer few Medicaid-covered HCBS will have a far easier time complying with the rule. New York is struggling because we already have a longstanding infrastructure of services, providers, and consumers that rely on them. While we wholeheartedly agree that services should be provided in a person-centered manner, we have struggled with CMS's position on settings that require heightened scrutiny, and with rules that simply don't make sense for the senior population.

13 British American Blvd. | Suite 2 | Latham, NY 12110
P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

We appreciate CMS's efforts to provide guidance to states and the provider community. Since the HCBS settings rule was published, there have been many questions about the implications for service providers, particularly those with new projects in development. Unfortunately, the guidance provided seems to impose standards that exceed the authority granted in regulation.

Reasons for Concerns

LeadingAge NY and ADHCC understand that heightened scrutiny cannot be conducted until after the setting is operational and occupied by beneficiaries. However, to discourage construction altogether, purely on the basis of the location, is tantamount to issuing a judgement before the evidence is heard. CMS circumvents its own process of heightened scrutiny and states' roles to write a transition plan and provide evidence that the setting is in fact home and community-based. This guidance on construction of presumed institutional settings disregards due process that states are given, and demonstrates the agency's bias against settings co-located with a hospital or nursing home.

In *Questions and Answers Regarding Home and Community-Based Settings – Residential,* in the answer to question number one, CMS states, "Settings that are on the grounds of or adjacent to a private institution are not automatically presumed to have the characteristics of an institution." CMS guidance issued in April on construction of presumed institutional settings is contrary to prior guidance and therefore creates confusion for stakeholders.

Limiting construction of affordable senior housing, adult day health care and Medicaid-funded assisted living, contradicts the intent of the final rule "…to protect individual choice and promote community integration." LeadingAge NY and ADHCC believe that CMS should ***promote*** new, co-located construction. In no way does the construction and physical plant of a co-located setting infringe on what CMS considers the five qualities of HCBS settings:

1. Is integrated in and supports full access of individuals to the greater community.
2. Is selected by the individual from among setting options including non-disability specific settings and options offer a private unit in a residential setting.
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizes individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
5. Facilitates individual choice regarding services and supports and who provides them.

The final rule appears to be flexible, allowing states to defend settings presumed to be institutional. However, with this recent guidance, CMS rejects this flexibility and mispresents the final rule. Nowhere in the final rule is there language supporting the limitation or elimination of co-located settings. Discouraging the construction of settings presumed to be institutional is well beyond the authority of the agency.

Conclusion

It is important to remember that the HCBS settings final rule requires "heightened scrutiny" for settings that are co-located (i.e., on the same campus as, under the same roof, adjacent to, etc.) with a hospital or nursing home. The rule *does not* say that these settings are inherently unacceptable; rather it asserts that these settings are at risk of having institutional qualities given that relationship.

LeadingAge NY and the ADHCC believe that co-location of such services is actually a benefit and desire of the senior population; and in this regard, the rule's "one size fits all" approach is fundamentally flawed. That being said, we believe that our members are indeed person-centered in their approach and are not institutional in nature. In addition, CMS should not discourage the development of co-located services; rather, such settings should be based on an evaluation of the services provided *and the needs of the population being served*. That is person-centered care.

Co-location of services can not only add convenience and enhance safety for frail elderly persons, it also ensures greater access to services and takes greater advantage of the limited caregiver workforce and other service infrastructure. In this way, co-location increases consumer choice which is an underlying objective of the final rule.

We again urge CMS to approach implementation of the rule and the concepts of community integration with an understanding of the varying needs of the populations served by HCBS waivers. We strongly urge CMS to revise the most recent guidance to explicitly clarify that construction of co-located services is not discouraged, but under the rule would be subject to heightened scrutiny, which will review the nature of the services provided for that population. Finally, we urge CMS to review previously issued guidance, as we believe interpretations and guidance regarding what constitutes "institutional" and what community integration means have exceeded the regulatory authority granted to CMS; creating unintended consequences that actually limit choice and promote institutionalization.

New York State boasts one of the best, if not the best, selection of home and community-based options for chronically ill, developmentally disabled, and frail elderly individuals. It should be understood that, as we struggle to understand the implications of this rule, long term care and health care services in New York are undergoing fundamental changes that present significant challenges and financial stressors. We worry about the fate of longstanding programs, and the consumers that rely on them if CMS's guidance stands as written.

Thank you for this opportunity to comment. We look forward to CMS's response to the issues addressed herein.

Sincerely,

Diane Darbyshire

Diane Darbyshire, Senior Policy Analyst
LeadingAge NY

Anne S. Hill

Anne S. Hill, Executive Director
Adult Day Health Care Council

Cc:

	Sen. Schumer	Mark Kissinger
	Sen. Gillibrand	Valerie Deetz
	Jason Helgerson	Shelly Glock