Adult Day
Health Care
Council

November 21, 2017

Mr. Mark Kissinger
Special Advisor to the Commissioner of Health
Office of Primary Care and Health Systems Management
New York State Department of Health
Empire State Plaza, Corning Tower, 14th Floor
Albany, NY 12237

Dear Mr. Kissinger,

We are writing in regard to the 2014 rule promulgated by the Centers for Medicare & Medicaid Services ("CMS") that, among other things, set new standards for settings where Medicaid-funded home and community-based services ("HCBS") are provided. Adult day health care ("ADHC") services are among the benefits included in the 1115 waiver service offerings and thus, subject to the new requirements. The New York Adult Day Health Care Council ("ADHCC") continues to have concerns about how the Rule will apply and impact ADHC providers across New York State.

As you may be aware, CMS initially authorized the ADHC program in 1983 through the 1915(c) HCBS waiver, and based federal approval on New York's Long Term Home Health Care Program (Lombardi Program). New York ADHC programs provide daily, comprehensive, integrated care which leads to the stabilization of chronic health conditions and reduces the incidence of costly health crises. Member's needs are assessed and met through an individualized plan of care that is developed and implemented by an interdisciplinary team of medical professionals, including the individual's personal community physician. Members are provided with the medical and social services they need to remain at home and a part of the community. ADHC programs also serve individuals who need physical assistance and who are wheelchair-bound to leave the isolation of their home and join a group setting. Importantly, the services provided by ADHC programs are precisely the types of services that the HCBS rule purports to promote.

Unlike other states, New York requires ADHC programs to be affiliated with a nursing home. By operation of law, ADHC programs may not operate independent of the nursing home.[1] This allows ADHC programs to utilize the resources of a nursing home (e.g., facility, staff and other resources), while focusing on providing members with all of their health care needs and helping them to continue to live in their homes. The Rule states, any setting "in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment . . . ," will be presumed institutional, which includes nursing homes. However, the Rule does not contemplate the co-location of HCBS with nursing homes. In New York, because of the nursing home affiliation, and the fact that most ADHC programs are located inside the sponsoring facility, the HCBS Rule will effectively disqualify ADHC programs from participating in the Medicaid program.

This is problematic because while the Rule promotes people having full access to the community and encourages states to have programs that optimize autonomy and independence in making life choices, it is effectively excluding a critical segment of providers. Under the Rule, ADHC centers in New York are presumed to be institutional even though individuals only attend program for a portion of the day and only attend on days determined by the individual and person-centered care plan. ADHC social workers

[1] 10 NYCRR Part 425

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also provide case management by referring the individual to other community-based providers. The services delivered by the ADHC program effectively allow these individuals to stay in their homes longer and avoid nursing home placement altogether.

CMS appears to appreciate that flexibility is necessary to accommodate state-based programs providing critical services to a fragile population in communities that do not meet the strict criteria set forth in the Rule. States may demonstrate how certain programs that do not meet the standards set forth in the HCBS Rule, still qualify as HCBS by meeting a "heightened scrutiny" analysis. The analysis requires the state to submit evidence that "interconnectedness between the facility and the setting in question, including administrative or financial interconnectedness, does not exist or is minimal." In addition, a state must demonstrate that persons receiving services are not isolated from the greater community of individuals not receiving Medicaid Home and Community Based Services and the information indicates that there is strong evidence the setting does not meet the criteria for a setting that has the qualities of an institution.

This "heightened scrutiny" analysis is flawed because it does not recognize that in New York, ADHC programs, while affiliated with nursing homes, are providing daily medical services to members and allowing them to reside in their home and communities. In New York, ADHC programs share administrative and clinical functions, as well as physical space. This integration allows ADHC programs to maximize efficiencies and provide greater services to its members. Without the ADHC option, the members would be consigned to living in the nursing home rather than the community. This is particularly true in upstate New York where caregiver and workforce shortages are prevalent and the ADHC program is the only reliable non-institutional choice for long term care services. Even today, DOH, itself, views ADHC as a community based service and uses it as an example of long-term services and supports for the Community First Choice Option Program.[2]

We think a reasonable approach is for States to have greater flexibility with the "heightened scrutiny" standard. The State has the experience, expertise and understanding of the provider capacity to ensure its residents are living in the most integrated and least restrictive setting, safely and with appropriate supports. ADHC programs are uniquely positioned to offer both; they allow recipients to receive needed services and social interaction, while being able to live in the community and familiar neighborhoods. The member is critically involved in determining the amount and duration of service and often needs only a few hours a day to maintain his/her independence and to remain in their own home.

Accordingly, at a minimum, the New York State Department of Health should be given the authority to assess the program and then, if needed, to request reasonable changes that won't diminish the ability of the program to efficiently offer the services and to continue to meet the needs of the growing elderly community in New York. Alternatively, CMS should discontinue efforts to implement the rule in its current form in favor of a more balanced approach.

We welcome the opportunity to meet with you to discuss how best to achieve this goal.

Sincerely,

Anne S. Hill

Executive Director, ADHCC

Cc: New York Congressional Delegation

[2] https://www.health.ny.gov/health_care/medicaid/redesign/2016-27-16_cfco_sph_webinar.htm