May 12, 2025

Executive Office of the President
Office of Management and Budget
725 17th Street, NW,
Washington, DC 20503

Re: Request for Information - Deregulatory Recommendations

Good afternoon Sir or Madam,

On behalf of LeadingAge New York and the Adult Day Health Care Council, we appreciate the opportunity to provide comments to the Office of Management and Budget regarding the federal Medicaid Home and Community Based Settings Rule. In addition to the comments below, we support the broader comments submitted by our national organization, LeadingAge.

Federal Home and Community Based Settings Rule: Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers

The HCBS Settings Final Rule, implemented by states and overseen by the Centers for Medicare and Medicaid services, sets forth requirements for several Medicaid authorities under which states may provide Medicaid home and community based long term services and support. LeadingAge New York is supportive of many aspects of the Rule as it serves to enhance the quality of HCBS Medicaid services by providing individuals with access to the benefits of community living and ensures services are provided in the most integrated setting. However, it also imposes undue financial, programmatic and administrative burdens on Medicaid providers serving older adults with functional limitations and people with disabilities who reside in their homes and communities.

LeadingAge New York represents more than 350 not-for profit and government-sponsored providers of long-term and post-acute care (LTPAC) and senior services throughout the State. Our members include nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living and community service providers, including home care and adult day care programs. Leading Age New York's more than 350 members employ an estimated 150,000 professionals serving more than 500,000 New Yorkers annually. The Adult Day Health Care Council, an affiliate of LeadingAge New York, is a statewide association representing 60 medical model adult day health care programs in New York State.

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As background, the HCBS Final Rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act and State Medicaid Plans.[1] We have several overarching concerns with the Rule:

- The Rule is oriented towards younger, working-age people with disabilities and, in certain respects, does not appropriately address the needs and preferences of older adults. As a result, the Rule has the effect of discouraging the development of community-based models tailored for older adults. This one-size-fits-all approach is the opposite of person-centered care.

- The Rule's "Heightened scrutiny" requirements for settings that are presumed to have institutional qualities limits the ability of organizations to expand access to services and discourages organizational and operational efficiencies, without adding any value for consumers.

- The Rule's "Conflict of Interest" provisions result in duplicative administrative layers that create inefficiencies in the delivery of long-term services and supports, without offering added benefits for consumers.

- There has been no acknowledgement of the additional cost and resources required to comply with, and oversee compliance with, this Rule. In the years since the Rule first took effect, providers have been experiencing increased financial distress and serious workforce challenges. The Rule adds unnecessary administrative and physical plant expenses at a time when resources are extraordinarily scarce.

- Absent a collaborative, flexible approach to implementation, the Rule has the unintended effect of *promoting* institutionalization due to its chilling effect on the development of additional community-based service capacity.

Heightened Scrutiny

CMS has said HCBS Medicaid settings are presumptively institutional and require "heightened scrutiny" if any of the following apply to them:

- Settings in a publicly- or privately-owned facility providing inpatient treatment;
- Settings on grounds of, or adjacent to, a public institution; and
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Unfortunately, the application of heightened scrutiny, at least in New York state, has been so broad as to pull in:

- Settings in which the provider generally serves a private-pay population, but occasionally has served a few Medicaid beneficiaries;

[1] Available at: https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider .[1]

- Settings that are adjacent to a hospital or nursing home, but not necessarily a public facility; and,
- Settings that are on the same campus as an institution, such as retirement communities that offer multiple levels of care.

Although the providers subject to Heightened Scrutiny review have generally been successful in demonstrating that they are not institutional in nature and in remediating any identified deficiencies, some have had to make changes in their physical plants (e.g., creating separate entrances) or relocating services in order to pass muster. Moreover, CMS has indicated that the development of new HCBS settings that trigger heightened scrutiny should be discouraged. This policy is likely to have a chilling effect on the development of new HCBS program models.

In particular, the Rule's Heightened Scrutiny provisions have imposed new regulatory burdens on Adult Day Health Care (ADHC) programs in New York State. ADHC programs deliver skilled care and services, therapy, case management, recreation and activities, and meals in a day setting. Participants in ADHC programs live in their homes and communities, while receiving a full array of services in a day setting keeping them healthy and preventing placement in more intensive and costly settings.

New York's ADHC programs are required by state law to be sponsored by a nursing home and have historically been located in or near their sponsoring nursing homes. This relationship with an existing nursing home enables ADHCs to efficiently provide nursing home level services to people who live in their own homes in the community. However, the ADHC's relationship with and proximity to a nursing home almost always triggers Heightened Scrutiny.

Rather than focusing on the sponsor or neighboring facilities of ADHC programs, we urge CMS to focus on person-centered care planning and community integration in gauging whether ADHC programs satisfy Heightened Scrutiny. Further, we urge CMS to allow the future development of ADHC programs under the same roof as a nursing home. If not deemed compliant with the Rule, ADHC programs will close, and participants will likely need nursing home care. Rather than promoting home and community-based care, the Rule will diminish it.

The Heightened Scrutiny provision is also inhibiting the development of new HCBS service capacity in New York State. In New York, many nursing homes have reduced their bed complement. These organizations could use the vacant space to create new assisted living, day programs or other HCBS. This is beneficial in that it allows efficient use of space, the creation of new, needed HCBS services often at a lower Medicaid cost, and also promotes access to multiple levels of care in close proximity. This enables couples, who may have different needs, to reside and receive services in the same building or on the same campus.

Indeed, CMS has recognized the benefits of "Continuing Care Retirement Communities" which offer such benefits. We should not be discouraging such arrangements; in fact, they are actually *preferred settings* for older adults. These communities allow an individual to remain on the same campus as a person's needs increase, receiving services from an organization they trust, in their community. To support the goals of the Rule, the provider can still be required to ensure that the services provided are not institutional in nature. CMS must remove barriers to the delivery of multiple levels of care in close proximity.

Access and Employment Provisions as Applied to an Older Adult Population

The Rule's community access and employment provisions were developed with younger adults in mind and pose several challenges for providers serving older adults. These requirements should be tailored more closely to the population served and the specific service under review.

Access to the Community:

The Rule has created a tension between state regulatory requirements governing the nature of the services to be provided, the provider's obligation to protect the safety of the individuals under its care, and the ability of program participants to freely access the community. For example, an ADHC participant who lives in the community and attends an ADHC for 5 hours does not expect the program to provide access to the community during those 5 hours. Rather, the participant expects, and the program is required to provide, nursing home level of care services, including nursing care, rehabilitation therapies, personal care, and meals. The participant cannot receive the medical, rehabilitation, and personal care service they are entitled to if they are shopping and going to the library during program hours.

Moreover, complying with the community access requirement requires additional staff to assist an individual or small group in their engagement. This is extremely difficult as ADHCs' professional staff are delivering necessary skilled nursing services, providing meals, assisting with activities of daily living and more.

The Rule also requires HCBS providers to allow registrants the freedom to come and go from the program or setting. Delayed egress door locks to deter elopement and other potential safety breaches, are at odds with the federal Rule. However, providers are also required to ensure the safety of the individuals under their care, who generally have significant cognitive, health and/or functional challenges. Although the Rule allows for modifications of the access requirements through person-centered planning, providers are exposed to civil liability and regulatory penalties, if the care plan uses less intrusive means (as required) to provide the necessary safeguards, and an individual with functional limitations elopes. The Rule creates a barrier to an individual receiving the services they need in a setting that can provide the necessary safety measures if needed. Once again, it incentivizes nursing home care over more homelike settings.

The Rule also requires providers to ensure that Medicaid beneficiaries have opportunities to seek employment and work in competitive integrated settings. Providers are supposed to share this opportunity with Medicaid beneficiaries and facilitate steps to employment for those interested. Typically, older adults who are reliant on services like assisted living or adult day health care are retired, do not want to work, and/or do not have the ability to maintain employment. The vast majority of the individuals who receive these services have cognitive impairment and significant health care needs. Again, this requirement is better suited to a working-age population and should not be applied to all Medicaid HCBS beneficiaries.

Financial and Administrative Burden

The Rule has significant costs associated with its implementation, despite statements claiming otherwise. To date, there have been no Medicaid reimbursement increases to help cover the costs for administrative and programmatic burdens associated with the implementation of the Rule.

Transportation and staffing expenditures are required to comply with the Rule's community access requirements. COVID-19 exacerbated what were already significant staffing challenges for long term care providers. Providing participants with individualized community integration opportunities is nearly

impossible when providers have limited staff and are required to deliver standard services and ensure the safety of all participants.

Transportation costs to ensure community integration are also challenging. Fuel, wages, staffing and insurance costs have increased in recent years. This expense comes out of the pockets of health care providers which impacts and detracts from other important services Medicaid providers are required to provide.

Person-centered planning requires extensive administrative resources. While modifications of HCBS requirements are permitted, there is an extensive process for putting in place any modification, including assessment, justification, prior trials of less intrusive interventions, ongoing measurement of the effectiveness of modifications, informed consent and documentation of every step.

CMS guidance regarding the Rule also prohibits shared office services and efficiencies between facility-based providers and their HCBS counterparts. The sharing of back office, food service, and other overhead costs among multiple provider settings and providers is an economical and efficient approach to scaling the care and services being delivered. With the escalating cost of health care, such overarching approaches to streamline operations should be encouraged, not admonished and prohibited.

Conflict of Interest

The Conflict of Interest (COI) provisions of the Rule require New York State to implement an additional layer of care coordination in order to separate the case management function from service delivery. An entity separate from the Medicaid HCBS provider is paid by the State for coordinating Medicaid HCBS, including person-centered service planning.

This "conflict-free" case management and service planning will have a particularly detrimental effect on New York's Medicaid assisted living program (ALP). The ALP in New York provides a package of services, including several HCBS services, assessment, and person-centered service planning, that are required by regulation and paid for in a single rate.

While segregating case management and service planning may make sense for other programs, implementation of this process in ALPs and similar provider settings will require a whole new overarching entity to provide person-centered planning for beneficiaries. This entity and its staff will be so far removed from the daily lives of the people being served by their ALP program that this planning process will essentially be done in a vacuum, with staff who know little about the individuals for whom they are care planning, and who will likely change from meeting to meeting. This seems an unnecessary layer that adds cost to the Medicaid system while providing little to no benefit to the consumer. We believe there is a simpler and more efficient way to ensure that consumers have choice.

The Rule also imposes COI requirements for New York's Nursing Home Transition and Diversion/Traumatic Brain Injury 1915(c) waiver programs. This requirement was implemented recently. As expected, separating service coordination from service delivery has led to capacity challenges and fragmentation. Participants have had to move to different providers or service coordinators, despite decades of successful and meaningful relationships between participants and their providers. Staff serving participants on these waivers - particularly those with the needed expertise to do so – are in limited supply, and implementation of the conflict-free requirement has only exacerbated staffing challenges.

New York could have accomplished the goal of COI regulations through the existing structure of independent contractors that both disseminate information about available providers and approve final plans. The existing 1915(c) TBI and NHTD waivers are tremendously successful and provide both

independent care coordination and comprehensive COI protections to waiver participants. The requirement continues to threaten the viability of the waivers in New York; creating bottlenecks at care coordination and ultimately creating barriers to access to access care.

Conclusion

LeadingAge New York and the Adult Day Health Care Council urge CMS and OMB to allow for a "blanket waiver" in instances the HCBS Settings Rule requirements do not apply to the particular population or service. We recommend that the HCBS Rule be modified or rescinded to ensure the different needs and preferences of an older adult population are accommodated. Specifically, the Heightened Scrutiny parameters should be eliminated or modified significantly to reflect the needs and preferences of older adults. CMS should also explicitly rescind the guidance that discourages the development of new settings that trigger Heightened Scrutiny and rather, encourage the efficient development of HCBS, while maintaining the expectation that the HCBS will not be operated in a way that is institutional in nature.

We greatly appreciate the opportunity to share our concerns.

Sincerely,

Sebrina Barrett

President and CEO

LeadingAge New York