July 12, 2021

Centers for Medicare & Medicaid Services/Department of Health and Human Services
Attention: CMS-3414-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

ANCOR recognizes that Federal regulatory requirements regarding the education and offering of COVID-19 Vaccine for clients and staff of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) is a reasonable measure to help protect the health and safety of ICF/IID clients. Though, with these regulations, there are a couple areas of concern. First, staff vaccination offering and education requirements are included in both the Facility Staff and the Health Care Services Conditions of Participation. Does this mean that staff vaccination non-compliance will be citable under both? If so, what is the rationale for such? And, regarding the requirement to provide ongoing education to those not vaccinated, is there a defined frequency for "ongoing"? Finally, some providers are concerned with privacy implications of tracking and documenting staff vaccination status and did not plan to do such. These areas of concern could be further elaborated with a QSO memo to the State Survey Agency Directors specific to the ICF/program.

Providers appreciate that the Centers for Medicare and Medicaid Services (CMS) recognizes the challenges for ICF/IID providers regarding data collection and opted for voluntary data reporting to NHSN. Data is essential for system improvement, and the lack of such on the make-up/function of the ICF/IID programs did affect pandemic response but NHSN reporting is not a feasible undertaking at this time for ICF/IID providers. With the exasperated Workforce Shortage, Managers, Administrators, and Supervisors are spending some to all their time providing direct care. While workforce shortages have been something faced in IDD service sector for years, it is at an all-time critical peak right now. In addition, the NHSN enrollment and setup process is time-consuming, cumbersome, and complicated; processes that providers do not have the time to focus on currently. Many providers report attempts at sign-up failing due to time constraints and system navigation issues. Another complicating factor is that setup is by each facility; providers that operate multiple small homes face an increased burden of the need to enroll each location separately. As alternatives to requiring ICF/IID's to utilize NHSN for data entry, we recommend that CMS/CDC seek out alternate avenues such as:

1. most states have their data collection process, CMS/CDC could access the already compiled and available data from state entities.
2. using existing federal data collection processes such as the CMS-3020G form completed during re-certification surveys. This form could be modified to capture desired data sets,

including client and staff turnover rates, expanded comorbidity statistics, vaccine acceptance, etc.

3. collecting the desired data through a more straightforward system than NHSN, such as the REDCap database system used for the Federal Pharmacy Partnership Vaccine Program. With this, it would be essential to recognize that weekly data submission is unnecessary in the ICF/IID sector, given that the median number of clients per home is six and the turnover of clients is minimal.

We certainly agree that COVID-19 had a monumental impact on the ICF/IID program, staff, and clients. There was the obvious client/staff illness and death, need to implement drastic protective practices, and devasting social-emotional client impact brought on by isolation. Another significant response challenge faced by ICF/IID providers was navigating which CDC guidance was applicable. ICF/IID's vary significantly in program design state by state and even home by home (number of residents per location, comorbidities of clients served, staffing credentials/ expertise). They have long struggled with where they fit in the service delivery system. While by certification, they fall into the long-term care category, they are ill-fit to be aligned with a traditional SNF/NFs as their clientele and size often more mirror a traditional group home. In addition, providers cited varying interpretations and directions regarding what guidance applied to the ICF/IID program. Whenever there was confusion over what guidance, requirements, or program applied, providers had to take precious time to figure out the correct information which slowed response timelines.

Aside from their ambiguous place within the public health response, the ICF/IID program faced both advantages and challenges that set them apart from a typical long-term care facility. As an advantage, ICF/IID's have minimal client turnover, with the same people being supported within their facilities for decades. For challenges, the Active Treatment/Habilitative program design finds that people supported in ICF/IID's spend considerable time outside the facility within their communities and interacting with various people. In addition, facility designs often promote a communal family-like living environment. These factors, coupled with clients often being unable to wear face coverings or understand the need for physical distancing, created specific challenges to virus mitigation strategy implementation and contact tracing should a positive case arise.

While COVID-19 vaccine access is not currently reported as a problem, access initially varied from state to state. It was unclear, and there was conflicting communication regarding whether or not the ICF/IID program was included in the Federal Pharmacy Partnership program. As outlined above, this is a prime example of how confusion regarding where the ICF/IID program within the public health system impeded efficient response.

The COVID-19 pandemic created additional burdens for ICF/IID providers with unexpected financial expenses and supply access problems to include staff retention costs, the procurement of PPE, improved ventilation/environmental modifications expenses, the implementation of Respiratory Protection Programs and staff screening processes, and the cost of education/training for staff, the list goes on and on. Yet, while already funding strapped, providers doubled down on their commitment to the clients working closely with state and federal entities to minimize the pandemics spread and the potential dire outcomes.

As vaccine access is readily available and states are winding down their response, energy would be best spent focusing on the future to allow for a nimbler system moving forward. To achieve this, we recommend formulating a stakeholder group specific to the ICF/IID program. This stakeholder group can explore ways to improve the public health response for the ICF/IID program along with assessing current data collection processes, to assist with modernizing them moving forward.

In closing, we appreciate the opportunity to comment on this Interim Final Rule and provide feedback on the pandemic's impact on the ICF/IID program. Thank you.

Sincerely,

Catherine Thibedeau
ICF/IID Consultant, ANCOR