May 12, 2025

Russell T. Vought, Director
Executive Office of the President, Office of Management and Budget
725 17th Street NW
Washington, DC 20503

RE: Document Identifier: 2025-06316 (90 FR 15481)
Comments on Request for Information: Deregulation (submitted via regulations.gov)

Dear Director Vought:

On behalf of the American Network of Community Options and Resources (ANCOR), thank you for the opportunity to provide feedback to the Office of Management and Budget's (OMB's) request for information (RFI) on deregulation.

Founded 55 years ago, ANCOR is a national, nonprofit association representing more than 2,500 private community providers of long-term services and supports to people with intellectual and developmental disabilities (I/DD) across all 50 states. For more than a half-century, we have worked to shape policy and share solutions to strengthen the ability of community providers to support people with I/DD to reside successfully in their homes and communities.

ANCOR offers the following details, supporting data, and recommendations in response to the RFI. We have organized our feedback by section below, with a focus on regulations impacting home and community-based services (HCBS) for people with I/DD and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).

Home and Community-Based Services for People with I/DD

Due to decades of insufficient Medicaid funding, access to HCBS is fragile and regulations impacting the HCBS service delivery system must be approached cautiously and with confidence that such regulations will strengthen the system. When a regulation increases the cost of service delivery, there must be commensurate and simultaneous funding available to achieve the underlying intent of the rule. As Medicaid payment rates continue to stagnate, providers are often forced to make impossible decisions to shutter programs when well-intended policy initiatives are undermined by inadequate funding and a lack of stakeholder engagement to fully understand the impacts of the rulemaking.

Community providers do not have the ability to unilaterally increase Medicaid revenue to cover new expenses, including expenses required by federal regulations. Funding for community-based

services is directed through Medicaid reimbursement rates determined by the state and funded through a state-federal partnership. Those rates must cover nearly every expense required by providers to operate, including wages for staff and other costs associated with maintaining facilities, developing programs, along with ensuring compliance with regulatory requirements. Unfortunately, those rates have failed to keep pace with inflation and rising expenses. In turn, the amount of funding available to providers has deteriorated while the cost of operating has soared.

Long-term underinvestment in HCBS, together with insufficient reimbursement rates, have further hampered the ability of community providers to offer direct support professionals (DSPs) competitive wages and benefits. DSPs are the workforce delivering crucial supports that enable people with I/DD to live full and independent lives in their homes and communities. This has led to an exodus of qualified workers from the field and the resulting workforce crisis has had a profound impact on the ability of community providers to deliver essential programs and adequately support people with I/DD in our communities.[1]

Within this grim paradigm, we have seen a significant number of recent federal regulations heralding major system changes to the way HCBS for people with I/DD are authorized, delivered, and tracked. A number of these regulations have attempted to address the workforce crisis but, without the necessary funding for implementation, such regulations have the potential to further damage the fragile system of supports for people with I/DD. While community providers acknowledge the need for new policies that strengthen our system of care, the direct support workforce crisis creates significant challenges in application of any new federal policymaking, especially those policies that increase the cost of service delivery without commensurate funding.

1. *CMS should rescind the HCBS payment adequacy mandate, codified at 42 C.F.R. §441.302(k) and §441.311(e).*

We appreciate the Centers for Medicare and Medicaid Services' (CMS) recognition of the direct support workforce crisis during the promulgation of the HCBS payment adequacy mandate[2] and the impact it has on access to services and quality of care.[3] We agree that an insufficient supply of HCBS providers can increase the prevalence of costly and unnecessary placements in hospitals and institutions.[4] However, the HCBS payment adequacy mandate only imposes another unfunded mandate on certain services and may result in further program closures and decreased access to disability services. The payment adequacy mandate on homemaker, home health aide, and personal care services—requiring at least 80% for compensation of direct care workers and necessitating a cap of 20% on all other necessary expenses—would not resolve the direct

[1] *The State of America's Direct Support Workforce Crisis 2024*. Alexandria, VA: ANCOR, 2024
[2] See *42 C.F.R. §441.302(k) and §§441.311(e)*
[3] *Ensuring Access to Medicaid Services*, 92 Fed. Reg. 40609 (May 10, 2024)
[4] Id.

support workforce crisis or ensure adequate payment; rather it risks further diminishing access to these crucial services.

When the rule was initially proposed, CMS requested comment on whether the mandate should be expanded to residential habilitation services, day habilitation services, and home-based habilitation services for people with I/DD. ANCOR and hundreds of community providers submitted comments responding to the question with a resounding "no". Without commensurate funding to meet the mandate, community providers would have been forced to cut funding from other areas which ensure access, such as training, supervision, quality oversight, and transportation. While CMS ultimately did not expand the 80% threshold requirement to habilitation services, it did impose HCBS payment adequacy reporting requirements on habilitation services, while simultaneously failing to provide adequate guidance to states in differentiating habilitation services for people with I/DD from other services. This failure to address the foundational issue of Medicaid payment adequacy, risks misclassification of habilitation services and dangerous application beyond the rule's intent.

HCBS systems are not one-size-fits-all, and a single percentage threshold does not adequately capture the inherent and unique differences in programmatic and administrative expenses across distinctly separate services and states. While direct care compensation is a crucial expense in service delivery, it is not the only category of expense necessary to delivering services. Sufficient funding for infrastructure-related expenses is also a critical element of high-quality service delivery. Program expenses, such as quality assurance, direct care supervision, and administrative reporting measures, are a key component of service providers' infrastructure and of service quality. Additionally, providers need sufficient administrative structures, such as billing and accounting, human resources, and office supplies and leases, to successfully manage their organizations and remain in compliance with state and federal laws.

Further, simply assigning a percentage does not equate to consistency of raised wages for the direct care workforce. If the state already limits investments in quality oversight and program support, it may have fewer expenses to cut from (e.g. transportation, staff training, higher staffing ratios), which would mean decreased quality of care for minimal, if any, substantive increase to wages across thousands of direct care workers. Moreover, since the threshold is expressed as a percentage, the dollar value will vary vastly across reimbursement rates. For example, assuming the program cuts could be shouldered, a $100/unit reimbursement rate would equate to $80 for direct care compensation whereas a $50/unit reimbursement rate would only equate to $40. This disparity, together with insufficient guidance on implementation, could worsen issues of parity across the same direct care workforce.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §441.302(k) and §441.311(e).

2. *CMS should replace the HCBS payment adequacy mandate with rulemaking which addresses insufficiency of Medicaid payment rates.*

In order to address the workforce shortage, CMS should instead consider rulemaking that provides oversight of stagnant and insufficient Medicaid payment rates that do not include adequate funding for competitive wages. The source of the direct support workforce crisis is state-determined payment rates left unadjusted for rising costs, inflation, and increased service expectations for decades at a time. Regular review of payment rates which adjust for inflation and include a competitive wage within the underlying payment rate model would better effectuate the rule's intent to address the direct care workforce crisis and increase access to HCBS.

States are required to conduct rate-setting activities for HCBS services which identify critical components of service delivery necessary to ensure quality supports and meet federal and state regulatory requirements.[5] When any rate is left unadjusted for increased costs and inflation for years at a time, each of these cost components become insufficiently funded and risk access to services. If a payment rate does not already allocate 80% of its rate to compensation, community providers will be forced to cut the remaining already under-funded components related to programmatic and administrative functions to meet the mandate. If a payment rate does already allocate 80% of its rate to compensation, direct care workers and all other cost components will remain under- compensated at the same funding level. This will inherently cause disparate negative impacts on services and states with higher programmatic needs and leave the remaining states and workforce without impact of any kind.

If CMS truly intends to shore up the direct support workforce and ensure access to services, it is imperative that each cost component within the payment rate is accounted for, appropriately funded, and routinely reviewed for necessary increases.

For the reasons stated above, we urge CMS to replace the rescinded regulations with rulemaking that ensures the provision of adequate Medicaid payment rates for HCBS.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

It is essential that current and future rulemaking recognize the unique services offered by ICF/IIDs within the spectrum of care. ICF/IIDs are a Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to promote health and independence. Although it is an optional Medicaid benefit, all states offer ICF/IID services and there are few resources like it under any payment source.[6] The program's central purpose is to provide specialized active treatment which supports people with I/DD to achieve their highest level of independence. There is a strong emphasis on personal planning, which

[5] Ctrs. for Medicare & Medicaid Servs., Tech. Guide, Application for a §1915(c) Home and Community- Based Waiver V. 3.6 (2019) [2019 CMS Tech. Guide].

[6] See CTRS. FOR MEDICARE & MEDICAID SERVS, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) (last visited November 4, 2023).

results in services to improve a person's quality of life and community integration and engagement.

ICF/IID facilities vary greatly in design, size, and staffing structures, but all share a home-like environment model. In contrast to other institutional services, ICF/IIDs often operate at a smaller scale, commonly providing residential support services for only four to six people in a single-family residential home. ICF/IIDs also routinely, through regulatory requirements or otherwise, contract with other providers offering HCBS on behalf of certain beneficiaries to offer choice of provider and access to other community-based services.

ICF/IID staff also undergo specialized training to meet the unique and often complex needs of people with I/DD, primarily relying on DSPs to deliver direct support services. Given the emphasis on active treatment, multiple tiers of positions are necessary to support the development and implementation of care plans, which has led to state and federal requirements for Qualified Intellectual Disabilities Professionals (QIDPs) to coordinate all services. The workforce itself is diverse and multifaceted, reflecting the variety of roles and responsibilities within these programs.

The marked number of voluntary closures of ICF/IIDs has steadily increased over the past 14 years, with approximately a thousand closures in the last 10 years alone. Meanwhile, the waiting lists for HCBS continue to rapidly grow. Nationally, there were 497,354 people with I/DD on state waiting lists for HCBS waivers this year, which is an increase of 15,753 in just the last year.[7] Without access to ICF/IIDs, people with I/DD are at significant risk of being forced outside their communities or to more restrictive care facilities to receive supportive long-term services.

1. *CMS should rescind the payment transparency reporting mandate, codified at 42 C.F.R. §442.43.*

While we support CMS's goal to increase transparency, we have concerns that the payment transparency reporting mandate[8] may unintentionally generate inconsistent data and further administrative burdens upon ICF/IID providers without addressing the root cause of the direct support workforce crisis.

The definitions for direct care workers and support staff in the regulation appear more tailored to nursing facility settings and do not acknowledge the types of support delivered in ICF/IIDs. Direct care workers in ICF/IIDs often assume a broad spectrum of job responsibilities that overlap with traditional support staff roles such as assistance with cooking, cleaning, and laundry. Their responsibilities do not neatly fall within categories of direct care or support staff nor do the definitions recognize the specialized role of QIDPs within ICF/IIDs. This may lead to inconsistency in the categorized expenditures of the same staff performing diverse duties. Further, and as

[7] Alice Burns, Abby Wolk, Molly O'Malley Watts, Maiss Mohamed, and Maria T. Peña; *A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024*. October 2024.
[8] See *42 C.F.R. §442.43.*

noted above, ICF/IIDs frequently engage contracted services including community habilitation and integration services offered through HCBS providers.

Providers report concern that HCBS services and ICF/IIDs alike will be disincentivized to offer these arrangements if doing so creates a new burden on both providers to ensure reporting for the HCBS staff. Requiring compensation reporting on third-party vendors using contracted and subcontracted services is simply not feasible for ICF/IIDs and, additionally, non-Medicaid regulated vendors may simply decline to report confidential or proprietary information about their staffing standards and compensation. Moreover, each state operates its own reimbursement system, with varying ICF/IID program designs encompassing various caps and cost categories, further complicating the ability to compile valid aggregate data.

Facility-level reporting presents challenges, especially without contextual information regarding differing costs, including resident acuity, facility size, state staffing requirements, and state payment models. Most, if not all, ICF/IIDs report much of the qualitative data CMS is soliciting to states directly through cost reporting requirements and it will not require further rulemaking to access. Restating available data has the potential to create new and unnecessary burdens on ICF/IIDs to resubmit their data twice in two separate formats.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §442.43.

2. *CMS should replace the payment transparency reporting mandate with rulemaking which addresses insufficiency of Medicaid payment rates for ICF/IIDs.*

We appreciate CMS's recognition of the direct support workforce crisis and the impact it has on access to providers and quality of care. Providers must be able to attract and retain qualified workers to remain in operation and available to provide high quality services and supports. Beyond enough workers, the direct support workforce must also have adequate training, expertise, and experience to meet the diverse and often complex needs of individuals with I/DD. Without both a sufficient supply of workers and the ability to provide training and quality oversight, providers may find themselves unable to meet regulatory standards, ultimately leading to the potential closure of essential programs and services.

We disagree with CMS's assertion in the preamble when the rule was proposed that as a result of these new reporting requirements, some nursing facilities and ICF/IIDs "would likely increase staffing independent of [CMS's] proposed minimum staffing standards."[9] While we understand this statement was likely intended to address nursing facilities exclusively—as the minimum staffing standards provisions do not impact ICF/IIDs—we see this as indicative of a broader issue of implicating ICF/IIDs within a rule more substantively intended to impact staffing within nursing facilities. ICF/IIDs are a unique and separate program from nursing facilities and there are

[9] *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*, 88 Fed. Reg. 61352 (September 6, 2023)

unintended consequences, discussed in further detail above, to constructing definitions and standards to simultaneously capture services provided in both nursing facilities and ICF/IIDs without regard for their separate and distinct characteristics.

We also have concerns that while the preamble references the intent to promote public transparency of States' statutory obligation to provide equal access under the Social Security Act, the rule does little to address the core objective of the enacting equal access statute: to assure state plans include payments which are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers. While the payment transparency reporting provision would create new reporting requirements, it is silent in providing redress to the underlying cause of the direct support workforce crisis and ensuring sufficiency of Medicaid payment rates.

For the reasons stated above, we urge CMS to replace the payment transparency reporting regulations with rulemaking that ensures the provision of adequate Medicaid payment rates for ICF/IIDs.

3. *CMS should rescind the regulations requiring recertification surveys for ICF/IIDs, codified at 42 C.F.R. §442.109, and replace with a tiered methodology for determining the frequency of ICF/IID recertification surveys based upon the number of facility citations.*

Recertification surveys for ICF/IIDs are currently required every 12 to 15 months. However, many ICF/IIDs have been deficiency-free for multiple years in a row but are still subject to frequent recertification surveys. This one-size-fits-all approach to monitoring and oversight is inefficient and wasteful, particularly when there are no findings or concerns with prior surveys.

Recertification surveys are comprehensive and, depending upon the size of the facility, can take multiple days or weeks to complete. The administrative burden associated with this regulatory activity is significant and monopolizes the time and attention of facility staff and management before, during and after the surveys. In addition to diverting resources from the support of ICF/IID residents, the current frequency of recertification visits precludes surveyors from devoting more time and attention to those facilities which are struggling to maintain regulatory compliance.

CMS should replace the current regulations with a tiered methodology for determining the frequency of ICF/IID recertification surveys based upon the number of facility citations as follows:

- Surveys shall occur annually if the facility has received an Immediate Jeopardy notification, condition-level citation, or more than ten standard level citations since the last recertification survey;
- Surveys shall occur every 2 years if the facility has received between six and 10 standard level citations since the last recertification survey; and

- Surveys shall occur every 3 years if the facility has received 5 or less standard level citations since the last recertification survey.

For the reasons stated above, CMS should rescind 42 C.F.R. §442.109 and replace with a tiered methodology for determining the frequency of ICF/IID recertification surveys based upon the number of facility citations.

4. *CMS should replace the regulations governing the use of PRN medications in ICF/IIDs, codified at 42 C.F.R. §483.450(e)(2), with rulemaking which clarifies appropriate use, approval, and oversight.*

ICF/IID services are increasingly supporting individuals with complex medical and behavioral health needs. Unfortunately, current regulations do not distinguish between medications prescribed for medical and mental health reasons, including managing anxiety and depression symptoms. These current restrictions hinder the ability of people with disabilities to receive timely and appropriate care, create obstacles for medical professionals to prescribe necessary medication, and limit access to certain essential medications.

Certain medications offered on a PRN basis at times may offer quick relief from acute symptoms necessary to promptly support the recipient's comfort and ability to acquire, retain, and improve skill-development. For prescribing medical professionals, there are challenges related to navigating complex regulations and approval processes, which limit their ability to exercise professional judgment in determining the best course of treatment for their patients. Consequently, this results in some medical professionals opting not to serve people receiving ICF/IID services.

The existing regulatory language implicating PRN medications should be replaced with language that:

- Clarifies that reduction plans are unnecessary if medically contraindicated;
- Clarifies the definition of inappropriate behavior and/or symptoms to address how certain medications, such as Depakote for seizures or Zoloft for depression, should be treated within the Specially Constituted Committee (SCC) and what requirements would apply;
- Specifies which medications require SCC review when used to address an ongoing medical condition, including but not limited to epilepsy or a mental health condition, including but not limited to depression; and
- Allows the use of PRN medications to support behavioral management needs if:
    - Prescribed by a medical provider;
    - Approved by the interdisciplinary team;
    - Complies with SCC requirements for medication management of inappropriate behaviors;

- Medication administration is specifically outlined in the recipient's approved Individual Program Plan; and
- The ICF/IID has established policies and procedures to ensure the appropriate use of PRN medications with layers of oversight and approval before such medications are administered.

For the reasons stated above, we urge CMS to rescind and replace 42 C.F.R. §483.450(e)(2), with rulemaking which clarifies appropriate use, approval, and oversight of PRN medications.

We further recommend the requirement to develop and implement written policies and procedures governing the management of inappropriate behavior, codified at 42 C.F.R. §483.450(b)(1), be modified to require the use of positive behavior support, trauma-informed care, and other supportive and person-centered care approaches to incorporate best practices regarding the care and support of people with disabilities.

5. *CMS should rescind the current educational requirements for the QIDP workforce, codified at 42 C.F.R. §483.430(b)(5)(x), which requires a bachelor's degree in a human services field and replace with rulemaking that also recognizes other degrees with relevant education and practical experience.*

There is currently a direct support workforce crisis due to insufficient funding and long-term underinvestment which has drastically impacted access to services for people with I/DD. A sufficient and qualified QIDP workforce is critical to the success and support of ICF/IID services. Unfortunately, ICF/IID services nationwide struggle to hire and retain QIDPs to maintain access to support.

Recognizing other bachelor's degrees and associate degrees with relevant education and practical experience would allow ICF/IID facilities to tap into a broader talent pool while maintaining competency standards. Further, establishing alternative pathways, such as a QIDP certification, would ensure individuals with degrees in fields other than human services can meet the role demands while increasing the workforce and addressing staffing shortages. Moreover, adopting a national framework for evaluating the appropriateness of foreign degree programs would reduce barriers for qualified applicants.

The existing regulatory language requiring at least a bachelor's degree in a human services field should be replaced with language that:

- Allows an associate's degree in a human services field as an alternative to a bachelor's degree.
- Allows someone with either an associate or bachelor's degree that is not in human services to work as a QIDP with preparation and training to successfully carry out the duties, e.g., a QIDP certification or completed a series of training in QIDP work.

- Clarifies the process for approving individuals with foreign degrees to work as a QIDP.

For the reasons stated above, we urge CMS to rescind and replace 42 C.F.R. §483.430(b)(5)(x) with rulemaking that also recognizes other educational degrees with relevant education and practical experience for QIDPs.

6. *CMS should rescind redundant regulations on Tuberculosis control, codified at 42 C.F.R. §483.460(a)(3)(iv).*

There are currently regulations in place which are redundant of precautions governed through other regulation and policy. For example, further regulation for tuberculosis control is unnecessary as infection control tag W455 mandates a program that "there must be an active program for the prevention, control, and investigation of infection and communicable diseases," which covers Tuberculosis control.[10] Eliminating the current overlapping regulation would simplify compliance without compromising safety.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §483.460(a)(3)(iv).

7. *CMS should rescind and replace current regulations which create unnecessary and overly rigid standards for mealtimes, codified at 42 C.F.R. §483.480(b)(1)(i,ii) and §483.480(d)(4).*

The current regulations governing mealtimes are unnecessary, redundant and contrary to person-centered principles. Mealtime flexibility is necessary to accommodate the variety of lifestyles of people accessing ICF/IID services. For example, some people get up early on weekends for commitments while others prefer to sleep later during the week due to differing schedules. Further, although family-style dining can benefit some, it may not suit everyone. Regulation and accompanying policy should reflect these person-centered principles, and any specific goals or concerns related to dining should be addressed within a person's Individual Program Plan.

CMS should rescind and replace these regulations with language that requires the provision of meals in accordance with a resident's preferences and his or her Individual Program Plan.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §483.480(b)(1)(i,ii) and §483.480(d)(4) and replace with language that provides appropriate flexibility and respects individual preferences during mealtimes.

8. *CMS should rescind and replace the regulations requiring quarterly review of each ICF/IID resident's medication regimen, codified at 42 C.F.R. §483.460(j)(1), to allow for annual*

[10] *State Operations Manual (Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities)*; Rev. 178, 04-13-18.

review.

Shifting the medication review requirement from a quarterly to an annual basis, unless otherwise determined by the IDT, would allow for a more individualized, clinically appropriate approach. This flexibility supports person-centered care, reduces unnecessary administrative burden, and minimizes resource use without compromising safety or quality.

The IDT already requests medication reviews at any point during the review cycle for those residents who may require them. Moreover, requiring quarterly reviews for residents who have had the same medication regimens for many years without issues or concerns diverts time and attention from those residents who require more frequent and intensive pharmacological oversight.

An annual review, or more frequent as deemed necessary by the IDT, will ensure continued medication safety while promoting efficiency and responsiveness to each client's unique needs.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §483.460(j)(1) and replace with language that requires an annual review unless a greater frequency is determined necessary by the IDT for each individual.

9. *CMS should rescind and replace the regulations, codified at 42 C.F.R. §456.360(a)(1)(A) which prevent physician assistants (PAs) and nurse practitioners (NPs) from providing initial certification that ICF/IID services are needed.*

Current regulation requires that a physician must certify for each applicant or beneficiary seeking ICF/IID services that ICF/IID services are or were needed. After the initial certification, a physician assistant or nurse practitioner, acting within the scope of practice as defined by State law and under the supervision of a physician, is also authorized to complete the certification.

The current regulatory limitation does not reflect the evolving roles and capabilities of other licensed healthcare professionals. PAs and NPs, as defined in 42 C.F.R. §491.2, are highly trained and often serve as primary care providers, particularly in underserved or rural areas. Allowing PAs and NPs—acting within their state-defined scope of practice and under physician supervision—to complete initial certifications would enhance access to timely care, reduce administrative delays, and better utilize the full capacity of the healthcare workforce.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §456.360(a)(1)(A) and replace with language that permits a physician assistant or nurse practitioner, acting within the scope of practice as defined by State law and under the supervision of a physician, to also complete initial certifications.

10. *CMS should rescind and replace the regulations, codified at 42 C.F.R. §456.370(b), to allow for psychological evaluations to be conducted within one year prior to admission.*

The current requirement that a psychological evaluation be conducted no more than three months prior to admission is unnecessarily restrictive and administratively burdensome. Many individuals entering ICF/IID settings have long-standing, well-documented psychological conditions that remain stable over time. Requiring a new evaluation within a narrow three-month window can lead to redundant assessments, increased costs, and delays in admission—particularly in areas with limited access to qualified mental health professionals.

CMS should rescind this regulation and replace with language allowing for the psychological evaluation to be conducted within one year prior to admission or, alternatively, within 30 days after admission.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §456.370(b) and replace with rulemaking that allows psychological evaluations to be conducted within one year prior to admission.

11. *CMS should rescind and replace the regulations, codified at 42 C.F.R. §483.475(d), to allow for emergency preparedness plan testing on an annual basis.*

ICF/IIDs must currently test their emergency preparedness plans twice a year. One test must be a full-scale, community-based exercise, or a facility-based functional exercise if community participation isn't possible. If the facility experiences a real emergency requiring plan activation, it is exempt from the next full-scale or functional exercise. The second test can be another drill, a mock disaster, or a tabletop exercise with a facilitated discussion.

ICF/IIDs already operate under rigorous emergency preparedness standards outlined in §483.470(h), which include comprehensive drills and emergency preparedness requirements such as total evacuations on every shift at least once per year. Requiring two additional large-scale exercises annually creates redundancy, increases administrative burden, and diverts resources from direct care without significantly enhancing preparedness. Aligning the regulation to require one full-scale or functional exercise annually, with a second, lighter exercise (e.g., tabletop or mock drill) in alternating years, maintains a high standard of readiness while recognizing the extensive testing already in place. This approach supports both safety and operational efficiency.

CMS should replace this regulation with language that requires emergency preparedness plan testing on an annual basis. This should include participating in a full-scale, community-based exercise, or if unavailable, conducting a facility-based functional exercise every two years. If the facility experiences a real emergency requiring activation of the plan, it would be exempt from the next required full-scale or functional exercise. In alternating years, the ICF would be required to conduct a second type of exercise, such as a mock drill or tabletop discussion.

For the reasons stated above, we urge CMS to rescind 42 C.F.R. §483.475(d) and replace it with language which allows for emergency preparedness plan testing on an annual basis.

12. *CMS should rescind and replace the regulations, codified at 42 C.F.R. §483.470(i)(2)(i), to permit evacuation simulations for drills taking place between 10 pm and 6 am.*

Regulation currently requires that each ICF/IID fully evacuate clients during at least one drill each year on each shift; requiring the entire occupancy to evacuate. However, overnight evacuations can pose significant risks to some people with disabilities, particularly those with medical fragility, mobility impairments, seizure disorders, or behavioral needs, especially during overnight hours and in areas where winter weather conditions are often sub-zero.

Simulation-based training is widely recognized as an effective methodology for emergency preparedness. Staff can demonstrate knowledge of evacuation procedures, routes, and roles without physically moving clients, especially during overnight hours. Permitting the use of evacuation simulations for drills taking place between 10 pm and 6 am, without requiring total evaluation of the facility, would meet the intention of the current regulation without risking health and safety of people being served by the ICF/IID.

Other Policies That Should be Rescinded

Although this RFI is intended to target regulations to rescind and replace, we also recommend that OMB review and consider the impact of significant interpretive guidance documents that often accompany statutes and promulgated rules. Pursuant to an OMB memorandum issued on March 26, 2025, significant guidance documents, which can include memoranda, policy statements, bulletins, and advisories, can be considered regulatory actions as described within Executive Order 14192 and thereby subject to deregulation efforts.[11] Such guidance documents may impose additional burdens upon the provider community beyond the scope and intent of the underlying statute or regulatory text.

For example, the 21st Century CURES Act established Electronic Visit Verification (EVV) requirements for specified Medicaid services in 2016. The Centers for Medicare and Medicaid Services (CMS) subsequently released a series of comprehensive informational bulletins, trainings, and FAQ documents that implicated disability services in a manner that was not expressly implicated in statute. As a result, community providers delivering habilitation services were subjected to EVV compliance even though the statute applied explicitly to personal care services. The fundamental nature of habilitation services for people with I/DD, as well as the manner in which they are delivered, are inherently incompatible with EVV requirements. We therefore recommend that the aforementioned guidance be rescinded for the purpose of excluding I/DD supports from EVV requirements.

We also encourage the OMB to carefully review those regulations that have been proposed but have not yet been finalized. One such regulation is the "HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information," originally published by the

[11] Guidance Implementing Section 3 of Executive Order 14192; OMB Memo; March 26, 2025.

Department of Health and Human Service (HHS) as a Notice of Proposed Rulemaking on January 6, 2025.[12] That proposed rule is intended to revise existing standards to better protect the confidentiality, integrity, and availability of electronic protected health information and modernize our electronic systems to better prepare and position ourselves against emerging cybersecurity threats. Although ANCOR unequivocally agrees with the intent of the proposed rule, we have requested that HHS carefully consider the challenges and barriers facing community providers in attempting to comply with this regulation within a relatively short timeframe without the necessary funding and resources.

Conclusion

Thank you again for the opportunity to provide feedback to OMB's RFI on deregulation. We recommend the following as further detailed above:

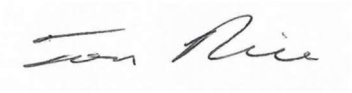
- **Rescind 42 C.F.R. §441.302(k) and §441.311(e) and rulemaking that ensures the provision of adequate Medicaid payment rates for HCBS.**
- **Rescind 42 C.F.R. §442.43 and replace the payment transparency reporting regulations with rulemaking that ensures the provision of adequate Medicaid payment rates for ICF/IIDs.**
- **Rescind 42 C.F.R. §442.109 and replace with a tiered methodology for determining the frequency of ICF/IID recertification surveys based upon the number of facility citations.**
- **Rescind and replace 42 C.F.R. §483.450(e)(2), with rulemaking which clarifies appropriate use, approval, and oversight of PRN medications.**
- **Rescind and replace 42 C.F.R. §483.430(b)(5)(x) with rulemaking that also recognizes other educational degrees with relevant education and practical experience for QIDPs.**
- **Rescind 42 C.F.R. §483.460(a)(3)(iv).**
- **Rescind 42 C.F.R. §483.480(b)(1)(i,ii) and §483.480(d)(4) and replace with language that provides appropriate flexibility within mealtimes.**
- **Rescind 42 C.F.R. §483.460(j)(1) and replace with language that requires an annual review unless a greater frequency is determined necessary by the IDT for an individual.**
- **Rescind 42 C.F.R. §456.360 (a)(1)(A) and replace with language that permits a physician assistant or nurse practitioner, acting within the scope of practice as defined by State law and under the supervision of a physician, to complete initial certifications.**
- **Rescind 42 C.F.R. §456.370(b) and replace with rulemaking that allows psychological evaluations to be conducted within one year prior to admission.**
- **Rescind 42 C.F.R. §483.475(d) and replace it with language which allows for emergency preparedness plan testing on an annual basis.**

[12] *HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information,* 90 Fed. Reg. 898 (January 6, 2025)

As OMB reviews and considers further deregulation efforts impacting disability services, we implore agencies to provide sufficient opportunities for public input, even under circumstances where traditional notice and comment procedures are not explicitly required. This practice will ensure that the unique perspectives of people with disabilities and the providers who support them are shared with policymakers to inform sound and effective policymaking. Moreover, we urge agencies to protect those existing regulatory requirements that support and empower individuals with disabilities. For example, a lengthy regulation identified for rescission may also include several provisions which provide accommodations to people with disabilities that must be preserved through deregulation efforts.

Please do not hesitate to reach out to me at trice@ancor.org if we can provide additional information or clarification to the comments above and we look forward to being a resource to the administration in supporting people with I/DD in their homes and communities.

Sincerely,



Tom Rice
Director of Policy and Regulatory Affairs