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OHIO HEALTH CARE ASSOCIATION

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting [CMS–3442–P] RIN 0938-AV25

Dear Administrator Brooks-LaSure:

The Ohio Health Care Association (OHCA) advocates for quality care and services across the long-term care continuum in the state of Ohio. Our membership includes providers of services for individuals with intellectual and developmental disabilities (ID/DD) including intermediate care facilities for Individuals with intellectual and developmental disabilities (ICFs). We are writing today to provide comments on the "***Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting.***"

OHCA advocates for the continuing vitality of the ID/DD provider community. We are committed to developing and advocating for public policies which balance economic and regulatory principles to support quality of care and quality of life. We have significant concerns and questions around CMS' proposal focused on Medicaid institutional payment transparency reporting.

1. The definition of direct care staff doesn't include some of the typical positions in an ICF/IID, including Direct Support Professionals (DSPs) or Qualified Intellectual Disabilities Professional (QIDP). The language should be inclusive of such critical ICF-related positions.
2. DSPs in ICFs often have multiple job responsibilities, ranging from providing direct care to laundry services to maintenance activities. It is difficult to split compensation between direct care compensation and support services compensation cost categories. We would encourage CMS to allow the full employee compensation for these DSPs to be included in the direct care cost category.
3. The proposed rule would require compensation reporting requirements to extend to contractors and subcontractors of the ICF. Not only would obtaining this information from contractors and subcontractors be extremely challenging, it may impact the contractor/subcontractor's ability to provide services to the ICF. This could have an unintended impact on ICF residents' ability to access their communities. For example, many ICF providers contract with community day services providers to allow their ICF residents to attend community day programs. If community day programs are required to submit this information to ICFs, they may decide to not accept ICF residents into their community programs because of the additional administrative burden associated with reporting. Similarly, ICFs may contract with a local YMCA, bowling alley or similar recreational activity in the community, which would not be able to provide the breakdown of direct care and support staff compensation data CMS is requesting. We recommend for CMS to allow the full cost of contracts to be allocated based on the

general type of service being delivered, as most states allow in current ICF cost reporting.

4. The proposed rule contemplates increased reporting requirements for ICF providers. Facility level reporting is a burden which CMS should minimize; however, it is important for the industry to be proactive and support the effort. CMS recognizes their responsibility to "specify a reporting methodology as part of the reporting instrument, which would be submitted separately through formal public comment". We encourage CMS to complete a scan of current ICF cost reporting requirements from each state to determine if additional detailed reporting is required. If there are states which are not currently collecting ICF data at the level necessary for CMS to understand the percentage of reimbursement spent on direct care and support staff compensation, we recommend CMS utilize the time period between the publishing of the final rule and the effective date of these requirements to determine the best approach to obtaining the data necessary while minimizing the additional administrative and financial burden passed onto ICFs. Ohio already has a robust Medicaid cost report and should require very minimal, if any, modifications to collect the necessary data. We would encourage CMS to only require cost report modifications that are absolutely necessary and consider using existing accounting frameworks where a robust framework already exists (like in Ohio) without the needed for additional administrative burdens.
5. CMS also requested comment in the context of future rule making on whether it should be required that a minimum percentage of the payments for Medicaid-covered ICF/IID services be spent on compensation for direct care workers and support staff. OHCA does not support this for multiple reasons:
    1. We applaud CMS' recognition of the lack of data for initial decisions in this area but suggest that even in future rule making cycles -- CMS establishing a minimum percentage would be erroneous and potentially harmful to providers.
    2. Requirements that mandate certain spending levels (with or without compensation reporting standards) **must** be accompanied by funding from appropriate payers, most notably Medicaid. Any gap in funding will continue to problematic and harmful to individuals served.
    3. Any mandate for a minimum percentage of payments to be spent on compensation limits providers ability to effectively compete in an open market.
6. Additionally, while the minimum staffing standards being proposed in this rule do not apply directly to ICFs or other providers of services to people with intellectual and developmental disabilities, ID/DD providers are concerned that long-term care facilities struggling to meet the minimum standards will entice current and potential nurses and direct care staff away from providing services to people with developmental disabilities. ID/DD providers are facing a workforce crisis and already are taking drastic actions such as not accepting new residents, closing homes or only caring for those with low care needs. With no new workers, and a declining working-age population, enacting minimum staffing requirements on one sector of long-term care will negatively impact the ability for other sectors of long-term care, including DD providers, to meet the needs of those they support.

We recommend that any final rule is delayed at this time until a more stable workforce exists and more data is available nationwide on the adequacy of existing staffing. However, if CMS moves forward with a final rule that you take into account the unique challenges ICF providers are facing and provide flexibility. If you have any questions about these comments or would like further information about IDDD services

in Ohio, please do not hesitate to contact OHCA's Debbie Jenkins at djenkins@ohca.org and/or Josh Anderson at janderson@ohca.org.

Sincerely,
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