



July 9, 2021

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-3414-IFC  
PO Box 8010  
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

LeadingAge appreciates the opportunity to comment on CMS-3414-IFC *Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) Residents, Clients, and Staff*.

About LeadingAge: We represent more than 5,000 aging-focused organizations that touch millions of lives every day. Alongside our members and 38 state partners, we address critical issues by blending applied research, advocacy, education, and community-building. We bring together the most inventive minds in our field to support older adults as they age wherever they call home. We make America a better place to grow old. For more information: [www.leadingage.org](http://www.leadingage.org)

These comments address the specific information requests for application of related policies to home and community-based services and assisted living providers. We incorporate by reference our separate comments and concerns on the rule itself as it relates to the nursing home setting.

### **REQUEST FOR FEEDBACK FOR HOME AND COMMUNITY-BASED SERVICES**

We appreciate CMS' inclusion of questions about home and community-based services (HCBS) providers, particularly those who receive Medicaid reimbursement. Throughout the pandemic, providers of Medicaid-funded adult day programs, assisted living communities, and home/personal care services all reimagined their service offerings to both keep the people they serve safe and connected to the care and supports they need. The same also applies to Programs of All-Inclusive Care for the Elderly (PACE), which of course is dually funded by both Medicare and Medicaid.

State policy varied with respect to how Medicaid programs handled policy responses, including provider/telehealth flexibilities, rate setting/other payments, and eligibility processes. They also varied in terms of vaccine provision, and as a result many HCBS provider staff and recipients struggled to access the vaccine. We respond to questions posed in CMS-3414-IFC as they relate to HCBS below and share the experiences our members faced and continue to navigate.

***How can equitable access to COVID-19 vaccine be ensured for residents and clients of congregate living facilities and related agencies?***

Related agencies in this question includes providers of HCBS. As we saw with the Pharmacy Partnership Program, which prioritized nursing facilities and other residential providers, a strong federal response was critical toward connecting staff and older people to the vaccine.

No such centralized response existed, for example, to provide vaccine to people in adult day health services or workers in those settings. Instead, their access to vaccine depended entirely on state action. In some states, onsite clinics were available early on to vaccinate older adults and workers in these settings. In many other states, however, vaccine access was individualized (e.g., adult day participants would get the vaccine as a result of being 65+, not through their Medicaid HCBS recipient status, HCBS workers had prioritized access through community settings *if* states included that worker category in a priority tier among other health/essential workers).

As a result, access to the vaccine for HCBS workers and recipients, in the early days of its availability, was conditioned on their state, resulting in an unequal patchwork across states and certainly not at parity with counterparts in nursing homes.

While more than half of older adults have been vaccinated, the federal government could still take steps to ensure access for all Medicaid HCBS enrollees and workers (including those in PACE) via a program similar to the Pharmacy Partnership. **LeadingAge recommends development of additional federal partnerships and programs to address vaccine access for HCBS workers and recipients, in which center-based providers would have the option to host onsite vaccine clinics for any workers or recipients who have not yet been vaccinated.** Similar partnerships could be developed for in-home service providers and recipients, particularly since we know more about vaccine storage, that could make it easier for providers to travel from home to home with the vaccine. They could also extend availability to families (e.g., the parent of an HCBS worker, the adult child of an older person receiving adult day services).

Onsite and easy access may make a significant difference to these populations, and with abundant supply available, such an effort could help promote vaccination among the unvaccinated.

***Has your State or county included residential and adult day health or day habilitation staff on the vaccine-eligible list as health care providers? What other impediments do staff face in getting access to vaccines?***

Eligibility list status varied by state. Some states included HCBS workers, including those in adult day, in the highest priority groups for the vaccine. Others did not list HCBS workers at all. This should not be the case. **LeadingAge recommends that any future prioritization effort should come with a federal requirement that HCBS workers be given the same priority as other health care workers, including nursing home and hospital staff.**

Direct care workers often earn low incomes. Barriers typically associated with low income status, like transportation, certainly apply to HCBS workers. Minimizing these, including by providing onsite access to those yet to be vaccinated, could do much to help ensure full vaccination among HCBS workers.

***If a vaccine policy applied to both shared living and day programs for adult day health or day habilitation, for example, who or what entity should have the responsibility for ensuring that all residents and staff have access to COVID-19 vaccination? Is there existing or capacity for***

***case management for individuals engaging with both residential care and programs that occur outside the residential setting?***

For vaccination and otherwise, **LeadingAge recommends that CMS and/or the state agencies should be tasked with the function of ensuring access to vaccination through a centralized and equitable distribution and response.** Across settings, providers struggled to combat the pandemic and should not have additional burden layered on top of that to ensure vaccination and other supports.

**REQUEST FOR FEEDBACK FOR ASSISTED LIVING PROVIDERS**

We also appreciate CMS' inclusion of questions about assisted living (AL) providers and whether to apply the requirements in the IFC to "other Medicare/Medicaid participating shared residences."

LeadingAge AL providers support quality in the delivery of services and supports and getting both residents and staff vaccinated against COVID-19. AL providers throughout the country have been on the frontlines of protecting vulnerable older and disabled adults during the pandemic and have implemented protocols to protect residents and staff against the harms of COVID-19. AL providers have also participated in the vaccination programs on the state and federal levels to vaccinate both residents and staff and continue to educate and encourage them to get vaccinated.

**LeadingAge does not, however, believe that the requirements outlined in the IFC should be mandatory for AL providers. The requirements are overly burdensome on AL providers, they are duplicative of the many state educational and reporting requirements imposed on AL providers, and CMS lacks the regulatory or oversight authority over AL providers (especially those that do not participate in a state Medicaid waiver program).**

AL providers are regulated in all states and those regulations define the scope of care and services that AL providers may provide. States have implemented reporting requirements for AL providers to report vaccination rates and COVID-19 cases for residents and staff. In addition, the majority of AL providers participated in the Pharmacy Partnership Program to vaccinate residents and staff. The data from those efforts were collected and reported by the pharmacy partners because they administered the vaccinations. Requiring AL providers to directly report vaccinations would only add administrative and cost burdens on providers already facing dire financial situations and workforce challenges. At bottom, the feasibility of requiring additional reporting requirements for AL providers at this stage appears overly burdensome, unnecessary, and redundant to what may already exist in many states.

Despite robust educational efforts, the reporting of staff vaccination rates implies a level of control over employees that simply does not exist. The current vaccines, only having Emergency Use Authorization (EUA), are not widely mandated by employers. In fact, some states and the federal government have discouraged the use of mandatory vaccinations as a condition of employment. If the goal is to increase vaccination rates, there either needs to be mandatory vaccinations or a unique educational push that does not punish providers. This all must be done with the understanding of the current workforce challenges facing AL and other long-term care providers. The opportunity to find employment in other industries that do not require a vaccination can only hurt the recruitment and retention of AL and other long-term care providers. This is a potential unintended consequence of expanding these requirements to other settings such as AL providers.

The percentage of AL providers that participate in a state Medicaid HCBS waiver programs is about 17%, and the remaining 83% do not take Medicaid, Medicare, or other federal funding, but instead rely on private payment from those receiving services. As currently proposed, these reporting requirements would only apply to those that participate in a state HCBS Medicaid waiver program, which could lead to a bifurcated reporting system whereby the minority of AL providers report and others would not. The resulting data would have little value and this only highlights the jurisdictional issues facing a federal approach to regulating AL providers that are regulated on the state level. CMS has not had jurisdiction over AL providers and it should not be expanded in this instance for the reasons stated above.

LeadingAge appreciates your time and attention to these issues. Should you wish to discuss these concerns further or have any questions, please contact Cory Kallheim [ckallheim@leadingage.org](mailto:ckallheim@leadingage.org) We value CMS's commitment to collaboration and look forward to continued work together to ensure quality care for all older adults wherever they call home.

Sincerely,

Cory Kallheim  
VP, Legal Affairs and Social Accountability