Demos
AN EQUAL SAY AND AN EQUAL CHANCE FOR ALL

August 13, 2018

ELECTRONIC DELIVERY

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2413-P, P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2413-P: Medicaid Program; Reassignment of Medicaid Provider Claims

Dear Ms. Verma:

I am writing on behalf of Demos to urge you to withdraw the proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) and published in the Federal Register on July 12, 2018, which would repeal a current regulatory provision clarifying that states may make deductions from provider payments for costs such as health care and skills training without violating the Medicaid prohibition on reassignment of provider claims at 1902(a)(32) of the Social Security Act.

Demos is a public policy organization working for an America where we all have an equal say in our democracy and an equal chance in our economy. A core part of attaining an equal chance in our economy is guaranteeing the freedom of all working Americans to join a union. As an organization dedicated to racial and gender equity, we are particularly concerned that the proposed rule restricts that freedom and endangers job standards for the home care workforce, 90 percent of whom are women, and more than half of whom are women of color.

We know that the ability for home care workers to choose to join a union and have dues deducted from pay not only puts this historically marginalized workforce on the same level as other private and public sector workers who have this ability, but has also led to improvements to workforce standards that have improved the lives of home care providers and strengthened Medicaid home and community-based services (HCBS) programs. The proposed rule would reverse that progress and represents an attack on home care workers. Apart from the substance of the proposal, we are also troubled by the process that led to this NPRM. We know of no state Medicaid program that has requested this change, nor do we understand why CMS is proposing an action that completely reverses previous policy and that the agency acknowledges could be economically significant with so little discussion of its rationale for the change and almost no analysis of its economic and other impact. Also troubling is the fact that CMS has taken the extraordinary step of limiting the public comment period to 30 days, allowing little time for the hundreds

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of thousands of workers who will be affected by it to provide input. We urge you to withdraw this rule, for the reasons described below.

Role of Home Care Workers in Medicaid HCBS Programs

In recent decades, the proportion of total Medicaid spending on long-term services and supports (LTSS) devoted to HCBS has grown from a level of less than ten percent in the early 1980s to more than half (53 percent in 2014) of Medicaid LTSS spending,[1] in response to both changing consumer preferences and legal decisions. HCBS that are provided in a consumer's home typically include assistance with activities such as bathing and toileting, meal preparation and feeding, as well as some health-related tasks, and accompanying a consumer to medical appointments. HCBS programs cannot function without home care workers—without a worker there is no access to care. While many home care workers provide care to a family member, and doing so is their full-time job, most do not—and the need for workers will become increasingly acute as the population of people needing care increases rapidly in future years.

There are two basic models for delivering home care services. Under the agency model, the state Medicaid HCBS program contracts with home care agencies that employ home care providers and the home care agency assigns workers to beneficiaries, directs their work, sets wages, and issues a paycheck to them. In contrast, self-directed models of HCBS, under which consumers retain greater power to hire and direct services, individual providers (IPs) of home care contract directly with the state and are typically paid via a fiscal intermediary that processes payments in the same way that private businesses may hire a payroll processing companies to compute tax, health care and other deductions and cut checks for employees—functions that would be extremely burdensome for the consumer to perform. From the perspective of CMS, the formal Medicaid payment to agencies is made in the form of a rate payment to the agency that incorporates costs of labor and administrative costs, a portion of which the agency then uses to pay the worker. In contrast, in the case of IP home care workers the analogous payment occurs at the individual provider level, when the state makes a payment to the provider—yet from the worker perspective there is little difference: in both cases a worker receives what amounts to an hourly payment for providing identical types of services.

The Role of Home Care Worker Organizations

A key challenge in ensuring access to care for elders and people with disabilities is the poor quality of home care jobs. It is no secret that there is a shortage of home care workers—the vast majority of states have already reported "serious" or "very serious" shortages in the home care workforce generally,[2] and the shortage of workers has affected Medicaid HCBS programs as well as the broader market for some time. A 2008 Institute of Medicine (IOM) report that examined the direct services workforce, including home and personal care workers, found that "a major factor in the deficit of direct care workers is the poor quality of these types of jobs," noting that "much more needs to be done to enhance to the quality of these jobs" in order to create an effective workforce.[3] The IOM report identified a number of issues that contribute to this poor job quality, including low wages, lack of benefits, high levels of physical and emotional stress, and job-related injuries.

Unions have played an important role in helping address these issues by raising wages through the collective bargaining process and advocacy to increase Medicaid funding and payment rates, as well as providing opportunities for home care workers to share their experiences with each other and creating a mechanism to provide workers with a voice in decisions that affect them. One 2005 study that examined the effect of wage increases for 18,000 home care workers in San Francisco over the years 1996-2002, after workers won substantial wage increases through their union, found a significant decrease in turnover associated with the pay increase.[4] Perhaps equally important has been the role of home care worker unions in providing a voice and identity for a workforce that has historically been marginalized. For both cultural reasons and thanks to the design of social U.S. social programs, home care work has been devalued and providers of care treated as second class citizens, unworthy of basic labor protections or decent wages—treatment reflected in the exclusion of home care workers from Fair Labor Standards Act protections until quite recently.[5] This is particularly true in the case of IP home care providers who may experience even greater isolation and be regarded as less "professional" than home care workers employed by agencies, who typically had somewhat better access to standard employment benefits, such as health benefits, in the years before independent providers formed unions.[6]

In states where home care workers have formed unions, providers employed by home care agencies are able to join a union and collectively bargain with the agency under the federal National Labor Relations Act (NLRA). The unique structure of the IP employment situation means that these workers do not have the same collective bargaining rights under the NLRA. Instead, a number of states have created structures—such as a state authority— to allow IPs to join together in a union, allowing these workers to bargain for wages and provide input into discussions of issues that affect them and the consumers they serve. In this case, the state is authorized to deduct a portion of an IP home care worker's service payment for dues and any other benefits, in the same way that home care agencies make these deductions for workers they employ. Following the U.S. Supreme Court's 2014 decision in *Harris v. Quinn*, states may deduct dues *only* for independent providers who are members of a union and may not make such deductions for workers who have not joined the union. The ability for IP home care workers to make dues deductions thus provides an important measure of parity with agency home care and other institutional direct care workers who provide similar or identical services, and state's adoption of these structures is part of a larger set of policies to remedy the historically unjust treatment of this particular group of workers. In proposing to now apply a Medicaid payment rule that was never intended to apply to this group of workers (see discussion below), CMS seeks to exploit the unique employment and payment structure of IP home care providers to reverse the progress that has been made and to once again relegate these providers to second-place status. In so doing, it risks harming not only the workers, but also the consumers who depend on them.

The Anti-Reassignment Provision Does Not Apply To Home Care Provider Deductions

An examination of the history of the statutory provisions clearly shows that when Congress adopted the anti-reassignment provision (1902(a)(3)) in 1972 it did so to address concerns about the practice of "factoring," under which physicians and other providers assigned their payment claims to a third party,

such as a collection agency, a practice that Congress recognized had led to "incorrect and inflated claims for services and…created administrative problems with respect to determinations of reasonable charges and recovery of overpayments."[7] Neither the statute nor the relevant regulations say anything about dues deductions; moreover, courts have uniformly concluded that similar arrangements, where funds are automatically transferred to a third party (such as so-called "double lockbox" arrangements used to convey Medicaid provider payments to a third party pursuant to the provider's standing instructions) are valid so long as they are consistent with the purposes of the statute. The practice of states making deductions for union dues and other costs, such as health care, on behalf of independent home care providers existed well before 2014, starting with voluntary dues deduction arrangements in some California counties in the mid-1990s. CMS leaders under several previous administrations were aware of and did not oppose the practice, yet the NPRM singles out dues deductions to unions as the sole example of a practice that will be implicated by the new rule. This amounts to a substantial policy shift for which CMS provides no policy rationale, and one that will have a major impact on states, providers and consumers who have built consumer directed programs in reliance on CMS's position that payments like those described in 2014 regulation are allowable.

CMS' Characterization of the Current Payment Structure is Incorrect and Misleading

CMS provides little rationale for the NPRM, beyond an apparently sudden and new "concern" that the provision is "overbroad and insufficiently linked to the exceptions expressly permitted by the statute."[8] We addressed the second of these concerns in the section above, but it is difficult to assess what policy problem, CMS seeks to address, given the lack of discussion in the NPRM. No stakeholder organization has identified the ability of workers to make deductions for dues and other benefits as a problem. The press release CMS issued to announce the NPRM is somewhat more explicit about CMS' motive. It notes that the rule will end the ability of states to "divert Medicaid payments away from providers" and claims that the rule is "designed to ensure that taxpayer dollars dedicated to providing healthcare services for low-income vulnerable Americans are not siphoned away for other purposes." These claims echo the contention of Senator Ron Johnson, in a letter he sent to CMS and in a follow-up staff report from the Committee on Homeland Security and Government Affairs, that states are "skimming" dues from Medicaid payments that would otherwise go to provide care for Medicaid recipients. The NPRM's regulatory impact analysis reflects a similar misunderstanding, suggesting for instance that states may be increasing reimbursement levels in order to reassign portions of the provider payment to a third party and that they may lower those rates if providers are no longer able to deduct payments for dues or other benefits.[9]

This description of the flow of dollars under current payment arrangements is a gross mischaracterization that at best reflects a profound lack of understanding of IP home care payment structures and at worst is deliberately misleading. Deductions made by states on behalf of home care workers for dues and other costs, such as health benefits, do not "divert" or "siphon" Medicaid dollars from any state Medicaid program. Rather, individual provider home care workers receive payments from state Medicaid programs for services they provide to home care consumers. There is no "diversion" because the amount deducted for dues comes from the payment for services that has been made to the provider, who voluntarily

chooses to direct it to a union or other entity. If the worker chooses not to authorize dues deduction, she keeps the full payment for the home care work she has already performed; it is not suddenly available for new spending—Medicaid expenditures and the amount spent on care remain the same.

CMS's Analysis of the Regulatory Impact is Insufficient

Executive Orders 12866 and 13563 direct agencies to perform cost benefit analyses of proposed regulations and to select regulatory approaches that maximize net benefits, "including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity."[10] The criteria for determining whether a rule can be considered economically significant takes into account not only the impact of the regulation on the economy as measured in dollar terms, but also broader effects[11] ("Costs and benefits shall be understood to include both quantifiable measures (to the fullest extent that these can be usefully estimated) and qualitative measures of costs and benefits that are difficult to quantify, but nevertheless essential to consider.) Yet not only is CMS unable to provide an analysis of the direct dollar impact of the regulation—acknowledging that it lacks sufficient data and relying on citations from a single newspaper article to support a speculative and preliminary estimate,[12] the NPRM also lacks any discussion of the broader impact of the rule. Given the important role of unions in raising standards for the home care workforce, it stands to reason that curtailing the ability of workers to participate in unions through application of the reassignment prohibition will have an adverse impact on them. A full analysis of economic impact would also consider the effect on GDP of workers leaving paid work to care for family members because no provider is available due to increased worker shortages. We urge you to conduct and publish an analysis of these issues before moving ahead to finalize this rule and believe that a fair and full assessment will lead you to withdraw the rule.

For these reasons, Demos urges CMS to withdraw the proposed rule on the reassignment of Medicaid provider claims.

Sincerely,

Amy Traub
Associate Director, Policy and Research
Demos