NATIONAL DOMESTIC WORKERS ALLIANCE

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Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services,
Attention: CMS–2442–P
7500 Security Boulevard
Baltimore, MD 21244–1850

***Comments on Medicaid Program: Ensuring Access to Medicaid Services (CMS-2442-P)***

To: Centers for Medicare & Medicaid Services

The National Domestic Workers Alliance ("NDWA") submits these comments in support of the Centers for Medicare & Medicaid Services (CMS)'s ("CMS") Notice of Proposed Rulemaking ("NPRM") on ***Medicaid Program: Ensuring Access to Medicaid Services***. NDWA is the leading voice for the estimated 2.2 million domestic workers who work as direct care workers, nannies and house cleaners in private homes. Founded in 2007, NDWA works to raise wages and strengthen industry standards to ensure that domestic workers achieve economic security and protection, respect, and dignity in the workplace. NDWA reaches and engages over 400,000 domestic workers on a regular basis through our 70 affiliate organizations in 50 cities and 19 states, our state and local chapters in North Carolina, Georgia, Houston (TX), San Jose (CA), Philadelphia (PA), the DMV (Washington D.C., Virginia & Maryland), and New York, and through our digital platforms.

NDWA deeply appreciates how the proposed rule not only highlights the importance of the direct care workforce, but also recognizes how improving the wages and working conditions for direct care workers is necessary to ensure both access to home and community based services and a higher quality of care. NDWA fully supports the measures proposed by CMS to ensure 80 percent of funds for personal care, home health and homemaker services go towards compensation for direct care workers. While NDWA strongly supports the inclusion of direct care workers in the Interested Parties Advisory Group ("IPAG'") to determine recommendations on rate-setting, we also urge CMS to expand "other interested parties'' to include participation of worker organizations that advocate for direct care workers or organizations with membership of direct care workers. These groups are in regular engagements with workers, and as such can be pivotal to provide input based on collective experiences of direct care workers in the state. NDWA is hopeful the proposed methods for payment transparency for HCBS at the state level will provide tools for meaningful analysis of sufficiency of rates and wages to IPAG whose

recommendations will lead States to stabilize the workforce by increasing rates and raising wages.

In this comment, NDWA specifically weighs in on the Provisions of the Proposed Regulations as it relates to :

- Section B ***Home and Community Based Services*** "HCBS,"
  - Subsection 5. ***HCBS Payment Adequacy***;[1]
  - Subsection 7 ***Reporting Requirements*** ( Part (4) Type, Amount and Cost of Services, part d. Payment Adequacy), and
  - Subsection 9. ***Website Transparency***[2], and
- Section C, **Documentation of Access to Care and Service Payment Rates**[3]
  - Subsection 2 **Payment Rate Transparency**[4] and particularly,
    - Part 6. **Interested Parties Advisory Group for rates paid by certain services**[5]

**Direct Care Workforce Crisis**

Despite the recognition during the pandemic that care work is truly essential work with direct care workers risking their lives every single day -- their safety and health, and that of their families -- to provide critical services and care, they persistently earn low pay, have access to limited workplace benefits and protections. The median annual income for home care workers is only $19,100[6] and one in six home care workers lives in a household below the federal poverty line. At the same time, direct care, in particular home care, is projected to be the fastest and largest growing occupation in our economy by 2030 with the aging of the baby boomer generation and increasing longevity with consumer preferences to receive care and services at home and within communities. States already struggle to recruit and retain enough direct care workers to meet escalating demand, and it is estimated that from 2020 to 2030 the home care sector will have 4.7 million[7] total job openings. Increased wages will help to stabilize the workforce and lead to better quality of care.

During the pandemic, there was growing recognition of the essential nature of care work at the national stage as demonstrated by the investment of federal funds specifically for Medicaids' Home and Community Based Services, including the 10 percent FMAP (Federal Medical Assistance Percentage) increase in the American Rescue Plan Act in 2021. CMS issued critical guidance that encouraged States to use increased federal funds to raise reimbursement rates

[1] §§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi),
[2] §§ 441.313, 441.486, 441.595, and 441.750
[3] § 447.203
[4] § 447.203(b)
[5] § 447.203(b)(6)
[6] PHI, "Direct Care Workers in the United States: Key Facts," 2022, p.9 available at: http://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/
[7] Id. at p. 11.

and increase wages for direct care workers. NDWA understands that while States must dedicate funds to increase rates for long term services and support, the federal government should make long-term investments to both expand HCBS and strengthen the HCBS workforce in order to meet the need for millions of new care jobs across the country in the years to come.

NDWA deeply appreciates CMS for proposing a federal standard that recognizes that the labor of the direct care workforce constitutes the majority of service costs, and to effectively put a cap on administrative overhead. We emphatically support the logic that the vast majority of reimbursement rates be directed to the wages of workers who provide hands-on assistance with activities of daily living to Medicaid beneficiaries. However, NDWA also wishes to acknowledge that Medicaid reimbursement rates are currently too low across the country for workers to earn livable wages - even with an 80 percent guarantee that it goes to their wages. NDWA appreciates that within the limits of its administrative authority and rule-making powers, CMS is striving to put forth methods for better analysis of sufficiency of payment rates through transparency, data collection and a dedicated body (the interested parties advisory group) that includes direct care workers to review and develop more informed rate-setting recommendations. NDWA remains clear that raising rates and a higher floor for wages for direct care workers across the long term services and support spectrum is the only way to address the growing demand and avert exacerbating the care crisis our nation faces.

NDWA also notes that higher rates and pay is also a critical issue of race and gender equity, as direct care workers are overwhelmingly women and disproportionately women of color and immigrants. These groups continue to experience discrimination in labor markets, and we should design and establish policies to ensure that these workers are earning fair wages and have better job quality.

**HCBS Payment Adequacy**

Percentage Pass Through

NDWA fully supports CMS's proposal to require that at least 80 percent of all Medicaid payments be spent on compensation to direct care workers for homemaker, home health aide, and personal care services. As CMS points out, states have been experimenting with strategies to address the shortages of direct care workers, including instituting "wage-pass through" laws, a popular approach is to designate a certain percentage of reimbursement rates be used for wages and benefits. At the end of 2019, 22 states had passed wage–pass through laws for direct care workers serving aging populations.[8] With the recent HCBS bump through the American Rescue Plan Act of 2021, 46 states dedicated funds for compensation/benefits to direct care workers, with 18 states providing temporary wage increases and 12 states making wage increases permanent.[9] Based on examination of state efforts, NDWA agrees that 80 percent is

[8] Institute for Healing Justice & Equity, "Wage Pass-Through Report," September 2022, available at: https://ihje.org/our-work/reports/wage-pass-through/

[9] New Practice Lab, "The American Rescue Plan and the Need to Strengthen the Home Care Workforce," July 6th, 2022, available at:

particularly appropriate for homemaker, home health aide and personal care services conducted in individuals' homes and general community settings, where there should be low facility or other indirect costs associated with the services. The Proposed Rule's model of a percentage wage floor is also a useful national standard because it requires that the compensation workers receive always be at least 80 percent of Medicaid payments, regardless of the hourly reimbursement rate, and does not require any additional action if rate increases. For programs within facilities or other categories of services, there are other streams of income to cover facility or programmatic costs and the lion's share of reimbursement for the services provided by direct care workers should go towards their compensation and a percentage floor is appropriate.

It is long overdue that direct care workers are treated with the same principles of transparency that underlie the use of public funds for other workforces, such as prevailing wage laws. Under the current Medicaid framework, there is no accountability or oversight as to how public dollars are spent on the direct care workforce, and the lack of transparency permits exploitative conditions. While Medicaid spends billions of dollars on these programs, direct care workers are forced to live below the poverty line. CMS's proposal of ensuring that 80 percent of Medicaid payments go to workers' compensation, is a critical step to ensuring responsible management of tax dollars. NDWA also recognizes that there are small community-based organizations that provide a type of care coordination for people that live in communities marginalized by racism and sexism and may need technical assistance to be in compliance with the proposed rule. NDWA recommends that CMS and States consider establishing programs to provide administrative support to small, values-driven organizations operating in communities that suffer from disinvestment and structural marginalization.

As mentioned, a closer pay rate analysis will demonstratively show that reimbursements are too low to guarantee that even 80 percent in compensation would not provide a sufficient living wage for the workforce and consequently a shortage of workers would persist as they are drawn into other industries. Accordingly, NDWA recommends CMS add language to to 441.302(k)(2) that would require states, as part of their assurances of compliance with the minimum percentage requirement, to acknowledge and explain any differences between the actual payment rates for home care services and the rate most recently recommended by the interested parties' advisory group. If the actual rate is lower than the recommended rate, the state should explain how it can sufficiently ensure access to services.

<u>Definition of compensation and direct care worker</u>

NDWA fully agrees with CMS proposal for the inclusive definition of direct care worker,[10] however has some concerns with the definition of compensation. We consistently hear from our direct care worker members across the country that their primary concern is a raise in the

https://www.newamerica.org/new-practice-lab/reports/the-american-rescue-plan-and-the-need-to-strengthen-the-home-care-workforce/

[10] CMS should maintain inclusion of all types of direct care workers as proposed regardless of educational attainment or type of employment relationship.

hourly wage rate from what they currently earn. Thus, if a part of compensation were utilized towards the example of benefits provided, it may not result in a change to hourly wage rates and could still make the job extremely unattractive in comparison with other jobs that guarantee minimums of at least $15 or $20/hr. This may be particularly concerning where direct care workers have limited ability to negotiate over the chosen benefits or where access to those benefits would still require a large financial contribution on their part. Until rates are high enough to ensure that direct care workers can earn between above $15/hr, it is critical that compensation goes directly towards wage rates.

We have some concern on the inclusion of the 7.65% employer share of FICA taxes as part of the proposed definition of compensation. The states that have implemented wage-pass throughs, have used different definitions that may exclude the employer share of FICA taxes, and thus appears lower than the CMS proposal of 80 percent. This may give rise to inaccurate comparisons between the federal and state standards. For the sake of clarity, NDWA recommends CMS mandate a 72.35% pass-through whereby the definition of compensation does not include the 7.65% employer share of FICA taxes for direct care workers.

The rampant misclassification of home care workers as independent contractors instead of employees, which the federal Department of Labor has been actively combating in the industry is another area of concern CMS should consider safeguards to ensure that States do not inadvertently incentivize providers to misclassify workers in order to avoid compliance with the 80 percent requirement.

Scope of the Rule

The rule must apply to services both delivered under Fee For Services and Managed Care delivery systems, in order to achieve consistent administration. NDWA agrees that consistent administration also requires equally applying the rule to 1915(c) waivers along with other HCBS authorities such as 1915(i),(j), and (k) services. Given that the self-directed service delivery model includes agency with choice, it should also be included under requirements of this rule.

We similarly see no difference between the pool of workers who provide services between HCBS waiver authorities vs. 1905(a) “medical assistance” State personal care and home health services. These services are nearly identical as those described as personal care, home care, and homemaker services and draw from the same workforce, and while the enrollment in 1905(a) may be less than waiver programs, the numbers are still significant nationally. Despite challenges in reporting[11], NDWA believes it is critical in stabilizing the direct care workforce that CMS fully includes State plan services within the proposed rule.

Timeline for Implementation

[11]CMS has the authority to require similar reporting for 1905(a) services pursuant to SSA section 1902(a)(6), which directs state Medicaid agencies to “make such reports, in such form and containing such information, as the Secretary may from time to time require.”

CMS' 4-year timeline for full implementation is reasonable, but NDWA recommends that there should be yearly benchmarks for interim actions, such as data collection, to monitor States progress and to allow opportunities for CMS to provide tailored assistance. CMS should provide robust assistance to States, which may need to include staffing, and maintain strong oversight in order for the rollout to be more successful. In tandem with requirements for payment rate transparency, data collected should be detailed and granular in order to make adjustments to effectively improve access where problems persist.

Annual Reporting Requirements

Given the significant benefit of data collection to properly analyze overarching questions of access, CMS should require states to report on the actual percentage of payments going to compensation for direct care workers in each category. Requiring data is imperative to ensuring compliance and NDWA opposes CMS permitting an attestation by states in lieu of data. The direct care workforce needs strong assurances that these policy changes intended for their benefit and to raise compensation will be fully implemented.

If CMS maintains its current definition of compensation, NDWA supports that the percent of payments should be reported at the delivery system and waiver program levels, the median hourly wage and on compensation segregated by category, ( i.e. salary, wages, and other remuneration; benefits; and payroll taxes.)

NDWA also supports inclusion of self-directed services in the reporting requirements. But NDWA recommends that CMS draw a distinction between providers and services on the basis of employment status (agency-employed vs Individual Providers) rather than delivery model. Self-direction as a delivery model can include both Individual Providers who are employed by consumer (or jointly-employed by the State) and the Community First Choice Option authorized by 1915(k) where the agency acts as an employer of record for a provider chosen by the consumer ("agency with choice"). CMS's rationale for separating out self-directed services is that compensation for workers in self-directed models tends to be higher and to comprise a greater percentage of Medicaid payment for services, which is true of the Independent Provider model but not necessarily of agencies with choice, who still have higher administrative costs. It would be better for reporting to separate these two and ensure that all agencies must meet the 80 percent threshold. CMS should also encourage States to collect information from providers as to how many of their direct care workers are considered W-2 employees vs. 1099 independent contractors and publish the numbers of direct care workers who are employees vs. independent contractors in the state as well.

**Payment Rate Transparency**

NDWA supports CMS proposal on payment rate transparency for Home and Community-Based Services, and appreciates the requirements for states to publish data on rates in uniform measures that would enable comparative analyses, particularly for the interested parties

advisory group. NDWA is concerned there may be confusion on the terminology with regards to payment rate, compensation, wage, individual providers, providers employed by agency, agency-providers (used in State laws), and the impact it may have achieving payment rate transparency. For instance, where there is an agency with multiple direct care workers as employees, how does one distinguish reimbursement rate paid by state to agency, with referenced payment rate to "providers employed by agency" (which seems to be total compensation reflecting benefits as well, divided by total hours) and the hourly base wage of the direct care workers.

NDWA supports requirements for publication of the following segregated by Personal Care, Home Health and Homemaker services under HCBS authority and State Plan medicaid authorities :

- Medicaid-authorized reimbursement rates
- Payment rates (total compensation per hourly) earned by Individual Providers and employees of Agencies
- Minimum base wages should be paid to direct care workers if 80 % requirement is met.
- Along with average rates and average wages, the minimum, maximum and median rates and wages
- Number of Medicaid-paid claims and beneficiaries
- Number of direct care workers
- Where rates vary, provide information of varying rates by population, provider type, or geographical location.

NDWA agrees that if States' Medicaid average hourly payment rates vary, the rates must separately identify the average hourly payment rates for payments made to individual providers and to providers employed by an agency, by population (pediatric and adult), provider type, and geographical location, as applicable.

Per § 441.313 website transparency, NDWA supports CMS and states publishing the relevant information in a centralized, easy to read, and accessible web-page. This would be particularly important to direct care workers, as beneficiaries of these policies. hey must be able to access the relevant information, and will be in an informed position to to validate whether they are indeed receiving the wages that reflect 80 percent pass-through.

**Interested Parties Advisory Group**

NDWA fully supports the development of the Interested Parties Advisory Group and the participation of members of the direct care workforce. NDWA recommends that in addition to direct care workers, worker advocacy organizations and organizations with direct care membership should also be included as an interested party. These worker organizations engage with impacted workers on a regular basis, and as such would play an invaluable role in bringing experiences of workers to the advisory group. NDWA also recommends that CMS issues guidance to the Finalized Rule to ensure a balanced composition of the advisory group to ensure that the voices of direct care workers are adequately represented along with the voices

of other relevant stakeholders. .  We also urge CMS to either require or encourage the IPAG to review and comment on managed care rates as well as Fee for Services (FFS) rates, particularly in light of the growth in use of managed care arrangements to provide HCBS.

We recommend that CMS strengthen the rules requirement as to the state's reliance and deference to the IPAG's input in the rate-setting process.  States should be required to consult the advisory group before making rate changes, give deference to their recommendations and engage the group to resolve any differences to achieve consensus.  Should the state choose not to adopt the recommendations of IPAG, they should be required to provide written justification for its alternate choice to the group as well as CMS.

NDWA also notes for effective implementation at the state level of the finalized rule, CMS will need to provide technical and financial support to support compliance with reporting requirements and establishing the IPAG.  CMS should make states aware of all available funding streams that would support IPAG and other new rule related activities to improve HCBS access.

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For these reasons and with consideration to additional elements raised above, the National Domestic Workers Alliance and its affiliates support CMS' proposed rule on *Medicaid Program: Ensuring Access to Medicaid Services* (CMS-2442-P).

We appreciate an opportunity to submit our comments. Should CMS have any follow up questions concerning our comment, please contact Reena Arora, Senior Policy Attorney at reena@domesticworkers.org and Haeyoung Yoon, Senior Director of Policy and Advocacy at haeyoung@domesticworkers.org.

Sincerely,

Ai-jen Poo
President, National Domestic Workers Alliance