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September 27, 2021

DELIVERED ELECTRONICALLY

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2444-P, P.O. Box 8016
Baltimore, MD 21244-8016

**RE: CMS-2444-P: Medicaid Program; Reassignment of
Medicaid Provider Claims**

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) appreciates the opportunity to comment on the [Notice of Proposed Rulemaking \(NPRM\)](#) amending regulations governing reassignment of Medicaid provider claims published in the Federal Register on August 3, 2021.

NHeLP protects and advances the health rights of low income and underserved individuals, by advocating, educating, and litigating at the federal and state level.

As an organization that works to ensure that older adults and people with disabilities have access to a full range of services that allow them to live as independently as possible in their homes and communities, we recognize the key role of the direct care workforce and the close connection between addressing workforce challenges, such as low wages and lack of benefits, and ensuring full access to these services. We

opposed CMS's 2018 reassignment proposal, finalized in 2019, to bar deductions from home care worker payments for standard employment benefits such as health care, training, and union dues.¹ We strongly support the current proposed amendments, which will ensure that home care workers can continue to make deductions for health, training, and other standard workplace benefits. Enabling home care workers to deduct standard employment benefits helps these critical positions be more comparable to other positions in the labor market and therefore helps with recruitment and retention of direct care workers. Recruitment and retention of home care workers is essential to the strength and stability of Medicaid home and community-based services (HCBS), including the self-directed model for HCBS delivery.

Strengthening the HCBS System

As the NPRM notes, the majority of spending for long-term services and supports now goes to HCBS, rather than institutional services. Decades of federal policy initiatives have encouraged states to rebalance their Medicaid-funded long term services and supports (LTSS) from institutional-based care towards more integrated, community living.² A driving motive for this rebalancing is the recognition that individuals with disabilities have long been subject to unjustified segregation, and that Medicaid has a vital role to play in helping states remedy this unlawful discrimination.³ CMS has recognized the important role participant-directed services plays in promoting independence.⁴

¹ Medicaid Program; Reassignment of Medicaid Provider Claims, 84 Fed. Reg. 19718 (May 6, 2019), <https://www.federalregister.gov/documents/2019/05/06/2019-09118/medicaid-program-reassignment-of-medicaid-provider-claims>.

² CMS, Dear State Medicaid Director (May 20, 2010) (SMD # 10-008) (community living initiative), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10008.pdf>.

³ *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

⁴ CMS, *Application for 1915(c) Home and Community-Based Waiver Technical Guidance: Instructions, Technical Guide, and Review Criteria* 140 (Jan. 2015), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf> (noting that a narrow list of types of providers in a waiver application could "pose[] obstacles to waiver participants obtaining waiver services from otherwise willing and qualified providers of services. . . ." The guidance goes on to note that the presumption is that the plan will permit the use of IP direct care workers: "When only agency providers may provide a service, CMS may request that the state furnish additional justification for not permitting individual providers to furnish the service.").



The proportion of total Medicaid spending on LTSS devoted to HCBS has grown from less than ten percent in the early 1980s to twenty-five percent by the late 1990s, and now represents more than half (fifty-two percent in 2014) of Medicaid LTSS spending.⁵ With this shift in spending, the demand for home care workers has outpaced the available workforce in many areas, and this gap is predicted to grow.⁶

We agree with CMS that the “increasing shortage of home care providers due to high turnover, low participation in Medicaid, low wages, and lack of benefits and training has significantly reduced access to home health care services for older adults and people with disabilities.”⁷ High turnover and low pay negatively affect the availability of direct care workers. 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.⁸ The report identifies a number of issues that contribute to this poor job quality, including low salaries, lack of benefits, high levels of physical and emotional stress, and job-related injuries. Other analyses have also noted the isolated nature of home care work and the lack of opportunities for professional advancement as additional factors that contribute to low job quality and satisfaction.⁹

⁵Audra Wenzlow et al., Truven Health Analytics, *Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014* 3 (June 3, 2016), <https://www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf>.

⁶ Robert Espinoza, *The Workforce Shortage Has Reached Long-Term Care. We Should Act*, THE HILL (Jan. 24, 2017), <http://thehill.com/blogs/congress-blog/healthcare/315919-the-workforce-shortage-has-reached-long-term-care-we-should>; Eduardo Porter, *Home Health Care: Shouldn't It Be Worth Doing?*, N.Y. TIMES, Aug. 29, 2017 (Economic Scene), <https://www.nytimes.com/2017/08/29/business/economy/home-health-care-work.html>.

⁷ Medicaid Program; Reassignment of Medicaid Provider Claims, 86 Fed. Reg. 41803, 41806 (Aug. 3, 2021).

⁸ Institute of Medicine, *Retooling for an Aging America 200-201* (2008), <https://www.nap.edu/read/12089/chapter/7#201>. (IOM is now known as National Academies of Sciences, Engineering, and Medicine).

⁹ See, e.g., PHI, *Caring in America - A Comprehensive Analysis of America's Fastest Growing Jobs: Home Health and Personal Care Aides* (Dec. 2011), <https://phinational.org/wp-content/uploads/legacy/clearinghouse/caringinamerica-20111212.pdf>; Amy Hewitt, et al., The Lewin Group, *A Synthesis of Direct Service Workforce Demographics and Challenges Across*



Self-directed workers have historically lacked a common employer, making it more difficult to form unions to bargain for improvements in pay, working conditions, and benefits such as health care. Since the early 1990s, States have helped expand and strengthen HCBS programs by allowing workers to elect to withhold a portion of service payments to pay for the costs of benefits and training.¹⁰ We agree with CMS that “[s]tate Medicaid agencies can play a key role in increasing such access by improving workforce stability of these practitioners by addressing training, wages and benefits, and provider reimbursement.”¹¹ Workforce improvements, in turn, help consumers by ensuring workers are available and well-prepared to deliver the hands-on services they need. Workers can receive the training, supports, and compensation they need to continue providing these critical services. Workforce improvements must be available across service models, as workers under both agency and self-directed models need access to these opportunities. Many states have recently formally recognized the importance of training opportunities and other supports to enhance the self-directed direct care workforce, as indicated by their decisions to invest American Rescue Plan funds in workforce improvement initiatives.¹² Over twenty states proposed training initiatives as a part of such initiatives, with other states proposing more global workforce development programs in their plans.¹³ But all of the plans for American Rescue Plan funds recognized the importance of direct care staff and workforce stability as critical to HCBS.

Finally, we also note that this is a matter of racial equity as well as program stability—the economic gains home care workers have won constitute a key step in addressing the past marginalization of this workforce, which is largely made up of women of color.¹⁴

Intellectual/Developmental Disabilities, Aging, Physical Disabilities and Behavioral Health (Nov. 2008), <https://www.medicaid.gov/medicaid/ltss/downloads/workforce/a-synthesis-of-dsw.pdf>.

¹⁰ *Becerra v. Azar*, 501 F.Supp.3d 830, 836 (2020) (noting how California has used payroll deductions to help improve working conditions of direct care workers).

¹¹ *Supra* note 6.

¹² Nat’l Assoc. of State Dirs. of Developmental Disabilities Servs., *State Workforce Initiatives: ARPA Spending Plan Topical Analysis 3* (Aug. 2021), https://www.nasddds.org/wp-content/uploads/2021/09/NASDDDS-ARPA-Workforce-Topical-Analysis_September2021-publish.pdf.

¹³ *Id.*

¹⁴ PHI, Workforce Data Center, National Data, Race and Ethnicity, <https://phinational.org/policy-research/workforce-data-center/#tab=National+Data&natvar=Race+and+Ethnicity>; PHI, Workforce Data Center, National Data, Gender, <https://phinational.org/policy-research/workforce-data-center/#tab=National+Data&natvar=Gender>.



Reassignment of Provider Claims

As the court in *Becerra v. Azar* held, the Medicaid statute did not unambiguously compel the administration to reissue regulations in 2019 to prohibit the current payroll practices at issue.¹⁵ We appreciate CMS' commitment to quickly reexamining the statutory language and legislative history of the reassignment provision, and agree that the prohibition against reassignment of provider claims is properly read to only be applicable to "assignment-like payment arrangements."¹⁶

The statute itself states that "no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise," and then lists a series of exceptions to this rule.¹⁷ A basic canon of statutory interpretation is that a provision of a statute should be understood in the context of the whole statute, and not read in isolation.¹⁸ When the statute is read in its entirety, it is clear that Congress' prohibition of "payments" to others actually prohibits assignments of the right to payment, and the words "or otherwise" means assignments that could open the government to claims for payment from individuals other than providers or agencies. A state that chooses to withhold deductions on behalf of self-directed workers does not implicate any of the concerns that Congress intended to address, and such arrangements are not prohibited by the statutory text.

Voluntary Consent Requirement

CMS proposes to defer to states to ensure that consent for deductions is obtained, but raises the possibility of being more prescriptive concerning the form of consent, and specifically of requiring written consent. States typically implement deductions according to state law or policy, provisions in a collective bargaining agreement, or other regulations. Given the wide variation in state law, and the fact that states generally maintain the authority to administer

¹⁵ *Becerra v. Azar*, 501 F.Supp.3d 830 (2020).

¹⁶ *Supra*, note 6 at 41805.

¹⁷ 42 U.S.C. § 1396a(a)(32).

¹⁸ *King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (We "follow the cardinal rule that a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context.") (internal citations omitted).



their individual and unique Medicaid programs, we support CMS' proposal to defer to the states to determine how to obtain the consent of self-directed care workers for deductions. Additionally, as CMS notes in a footnote in the NPRM, some deductions, such as union dues, already require the affirmative consent from workers. If CMS became too prescriptive on this matter, it could become unduly burdensome on state programs and workers within those programs.

We thank you for the opportunity to comment on this matter, and look forward to working with CMS on HCBS access, equity, and workforce issues in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Lav", with a stylized flourish at the end.

Jennifer Lav

