State of California
Office of the Attorney General

ROB BONTA
ATTORNEY GENERAL

September 28, 2021

Via Federal eRulemaking Portal

The Honorable Xavier Becerra
Secretary of the U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

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

RE: Notice of Proposed Rulemaking: "Medicaid Program; Reassignment of Medicaid Provider Claims" [RIN: 0938-AU73; file code CMS-2444-P]

Dear Secretary Becerra and Administrator Brooks-LaSure:

The undersigned Attorneys General of California, Connecticut, Illinois, Massachusetts, Oregon, and Washington (the States) write in support of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule seeking to confirm States' authority to make payments to third parties to benefit individual practitioners by ensuring health and welfare benefits, training, and other benefits customary for employees. 86 Fed. Reg. 41,803 (Aug. 3, 2021). This proposal reverses a 2019 Rule, 83 Fed. Reg. 32,252, which has been enjoined in *California et al. v. Azar*, 501 F.Supp.3d 830 (N.D. Cal. 2020). As explained in that litigation, we believe that the 2019 Rule was contrary to law and an unreasonable, unwarranted interpretation of the Medicaid Act's anti-reassignment provision, 42 U.S.C. § 1396a(a)(32) (known as Section (a)(32)). We therefore strongly support CMS's new Proposed Rule.

Each of the undersigned States has elected to offer consumer-directed home care services as part of our state Medicaid plans, and has enacted laws authorizing collective bargaining for

home care providers, including withholding of normal payroll deductions. We agree that the Proposed Rule will "ensure flexibility for states to pay […] costs directly on behalf of practitioners and ensure uniform access to benefits, such as health insurance, skills training and other benefits customary for employees." 86 Fed. Reg. at 41,807. These benefits help strengthen the provider workforce and improve care for Medicaid beneficiaries who need assistance with activities of daily living like taking medications, meal preparation, bathing, housecleaning, and mobility. These services in turn, enable beneficiaries to remain in their homes and communities, an important value that our states have chosen to promote in our state Medicaid plans.

As described below, the States retain a strong interest in ensuring that the federal government does not invent novel, ahistorical applications of the Medicaid Act that disrupt state operations and Medicaid programs' ability to reduce the risk of institutionalization for seniors and people with disabilities. On the contrary, the federal government should seek to strengthen the direct care workforce that makes home and community-based living possible. The 2019 Rule was just such a disruption, which the Proposed Rule effectively reverses. We respectfully request that CMS consider our comments opposing the 2019 Rule and the evidence submitted in support of the plaintiffs' motion for summary judgment in *California v. Azar* in finalizing this regulation.

I. The 2019 Rule Was Deeply Flawed and Contrary to Law

The 2019 Rule purported to reinterpret Section (a)(32) in a manner that would prohibit the States from directly withholding ordinary, voluntary deductions from homecare workers' paycheck. It did so by rescinding a regulation enacted in 2014, former 42 C.F.R. § 447.10(g)(4), which provided that "[i]n the class of practitioners for which the Medicaid program is the primary source of service revenue, payment may be made to a third party on behalf of the individual practitioner for benefits such as health insurance, skills training and other benefits customary for employees." See 79 Fed. Reg. 2948-1, 3001 (Jan. 16, 2014). Although the 2019 Rule impacted a wide range of typical payroll deductions, its aim was clear: to prohibit the States from deducting workers' voluntary union dues. 83 Fed. Reg. 32,252, 32,254 (July 12, 2018) (suggesting that the impact of rescission of the 2014 rule would be to prohibit states from "reassigning homecare workers' dues to unions").

But Section (a)(32), the Medicaid Act's anti-reassignment provision, requires only that the States "provide that no payment under the plan for any care or services provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or services, under an assignment or power of attorney or otherwise." 42 U.S.C. § 1396a(a)(32). It includes certain enumerated exemptions (e.g. for Medicaid providers who are required as a condition of employment to turn their entire fee for care over to their employer), all of which entail transfer of rights to payments to a third party. The text of Section (a)(32) and the overall statutory scheme make clear that in prohibiting reassignment of Medicaid payments, Congress was *not* speaking to ordinary deductions of payments made to third parties on behalf of individual Medicaid practitioners for benefits such as health insurance, skills training and other benefits customary for employees. First, the statute prohibits

assignments of payment "*for* any care or services provided to an individual" (emphasis added). Deductions for employee benefits that are part and parcel of paying a Medicaid provider are not "payments *for* [Medicaid] services"; rather they are payments for benefits and other negotiated payments that accrue to the provider as an employee. Second, the 2019 Rule's reasoning that "or otherwise" encompassed every type of non-direct payment that was not an "assignment," including payroll deductions, was illogical, because a general term like "or otherwise" should be construed to mean arrangements similar to assignments, not every kind of indirect payment. *See* 86 Fed. Reg. at 41,805; 501 F.Supp. at 840. This is especially so where the statute's enumerated exemptions are all "assignments" or similar contractual arrangements. 501 F.Supp. at 840. As the Proposed Rule now correctly concludes, the statute "addresses only assignments and related payment arrangements wherein a provider's right to claim and/or receive full payment for services furnished to Medicaid beneficiaries is transferred to a third party." 86 Fed. Reg. at 41,805. We further agree that the relevant legislative history supports an interpretation that Section (a)(32) does not prohibit ordinary employee deductions.

As the district court in *California v. Azar* held, the 2019 Rule was founded on "legal error." 501 F.Supp.3d at 833. Although the district court remanded the issue to the agency for further review, it stated: "[C]onsidering the language of the statute as a whole, along with its legislative history and programmatic purpose, arguably *the only reasonable interpretation of the statute* is that it does not bar" the States' payroll practices." *Id*. (emphasis added). The overall lack of legal basis for the 2019 Rule lends credence to the intervening homecare provider unions' allegations that the 2019 Rule was motivated by anti-union animus. Pls.-Int. Mot. for Summ. J. at 17-18.

For these reasons, we strongly agree that the Proposed Rule correctly acknowledges that deductions for benefits such as health insurance, skills training, and other benefits customary for employees are not prohibited by Section (a)(32). Because Section (a)(32) is not an unbounded prohibition on all third party payments, further direction to states regarding permissible types of benefit deductions may be helpful but is not necessary. In making payments to Medicaid providers, the States follow all other applicable laws, including state laws authorizing collective bargaining (described in detail in *California v. Azar*), state laws protecting public employees' rights to refuse union membership (e.g., Cal. Gov't Code § 3502), and *Harris v. Quinn*, 134 S.Ct. 2618 (2014), which prohibits payment of "fair share" or "agency" fees to cover the costs of collective bargaining for workers who decline to join the union.

II. The Proposed Rule Will Benefit States and Medicaid Beneficiaries

The Proposed Rule would benefit States and their Medicaid programs by restoring clarity and certainty regarding the States' payroll practices and preserving the States' flexibility in a manner that is consistent with Congressional intent. As explained in *California v. Azar*, for some states, direct employment of Medicaid homecare workers is a well-established practice that has helped expand availability of home and community based services and reduce risks of institutionalization of seniors and younger persons with disabilities. California, which has the

largest homecare program in the nation, pioneered consumer-directed services as early as the 1950s.[1] It was also the first state in the nation to seek to improve the quality of its homecare workers by extending its public sector bargaining laws to include In-Home Supportive Services (IHSS), beginning in the early 1990s with the establishment of county-level Public Authorities to negotiate contracts with the workers' union representatives and coordinate the delivery of IHSS services across the state. 1992 Cal. Stat. Ch. 722, § 54; 1993 Cal. Stat. Ch. 69, § 55. Other States, including the undersigned, have established similar programs that use collective bargaining as a tool to improve Medicaid homecare providers' working conditions, and consequently the services available to vulnerable beneficiaries.

The States have invested considerable time and resources into constructing arrangements to allow older adults and individuals with disabilities to maximize their autonomy and independence by directing their own care, with support from state and local governments relating to the financial logistics of paying care providers. In promulgating the 2019 Rule, CMS ignored relevant legislative history, decades of state practice, and its own 2014 rulemaking. This abrupt and unfounded reversal in interpretation would have brought significant administrative costs to the States if implemented. As CMS is aware, home and community based services involve complicated programs that generally serve a large number of beneficiaries. Changes to the administration of these programs are generally subject to extensive consideration and effort. When Washington State, for example, decided to shift toward a Consumer Directed Employer model that included hiring an outside vendor to become the legal employer of 45,000 contracted Medicaid homecare providers, it was a time consuming, resource-intensive project that required extensive evaluation of alternative vendors and consultation with stakeholders. If the 2019 Rule had been implemented and enforced, it would have imposed significant additional financial and administrative burdens that would have negatively affected Washington's ability to accomplish a smooth and timely transition. A consistent interpretation of Section (a)(32) helps preserve the States' investments and avoid excess costs and waste of agency time and resources.

As the evidence submitted by the States in *California v. Azar* demonstrates, our laws and employment arrangements have contributed to a number of improvements to the States' Medicaid provider workforces, including greater training opportunities, better wages and benefits, and increased retention. Historically, homecare providers have faced low wages, few benefits, frequent injuries, and unpredictable hours, with little or no means to collectively address such challenges with their individual Medicaid beneficiary employers. The States all enacted laws authorizing collective bargaining in this sector in an attempt to help remedy this situation. As one study found, prior to unionization, homecare workers in San Francisco "earned the state minimum wage, which was $4.25 at the time, and none received benefits of any kind." After the authorization of collective bargaining, the "annual retention rate of new providers rose

[1] California Department of Social Services, In-Home Supportive Services Program, https://www.cdss.ca.gov/agedblinddisabled/res/vptc2/1%20introduction%20to%20ihss/history_of_ihss.pdf.

from 39 percent to 78 percent following significant wage and benefit increases." [2] Overall, workers covered by collective bargaining agreements (which generally provide for payroll deductions) have improved wages, benefits, and access to training.[3] For example, in Washington State, the local union worked with the state to establish the Washington State Long-Term Care Workers Training program. This initiative significantly increased training standards for those serving seniors and people with disabilities, and provided substantial funding to make that training accessible. Women, immigrants, and workers of color are most likely to benefit from increased health insurance coverage because of contracts achieved through collective bargaining.

Medicaid beneficiaries and their providers have identified an inextricable link between working conditions and the quality of patient care.[4] A higher-quality workforce empowers consumers to stay in their own homes, all the while saving the state money that would otherwise be spent on institutionalization. We therefore agree with Judge Chhabria's conclusion that the 2019 Rule "appears contrary to the overall purpose of the Medicaid statute," in light of the "abundant evidence in the record explaining how the states' payroll practices directly serve this objective [to provide medical assistance] by facilitating an orderly system for the provision of home care and by improving conditions for home care workers, which in turn improves the quality of care those workers provide to Medicaid patients themselves." 501 F.Supp.3d at 842.

The ongoing COVID-19 crisis has further reinforced the importance of strengthening the Medicaid homecare workforce. As HHS itself has recognized, COVID-19 "is reshaping the provision of home care services and policy," as home care is "now viewed as an important means for reducing institutional care and preventing hospitalization."[5] In particular, increased wages are seen as promising responses to the challenges wrought by the pandemic.[6] These and other prescriptions for home care workforce improvement have already been anticipated in some of the States' agreements with homecare unions, such as those raising wages above the minimum wage, or providing training or personal protective equipment. The Proposed Rule will ensure that States have the flexibility needed to respond to crises like COVID-19.

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[2] Candace Howes, Living Wages and the Retention of Homecare Workers in San Francisco 44 INDUSTRIAL RELATIONS 139 (2005).

[3] Anastasia Christman and Caitlin Connolly, Surveying the Home Care Workforce, National Employment Law Project (2017), https://www.nelp.org/publication/surveying-the-home-care-workforce/.

[4] Linda Delp & Katie Quan, Center for Labor Research and Education, University of California Los Angeles & Berkeley, *Homecare Worker Organizing in California: An Analysis of a Successful Strategy* (April 1, 2002), p.4

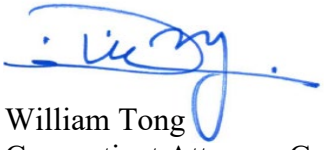
[5] U.S. Dep't of Health and Human Servs., *COVID-19 Intensified Home Care Workforce Challenges*, at 2. https://aspe.hhs.gov/sites/default/files/private/aspe-files/265686/homecarecovid.pdf.

[6] *Id*. at 11.

In conclusion, the States applaud CMS's swift action to undo the 2019 Rule. This regulatory change is in the public interest and will help the States in their efforts to allow older adults and individuals with disabilities to access needed Medicaid services in their homes and communities, and to protect the rights of the essential workers who provide those services.

Sincerely,

Rob Bonta
California Attorney General



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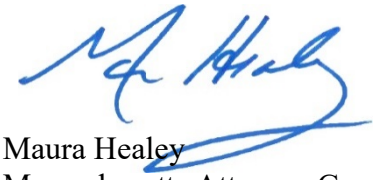

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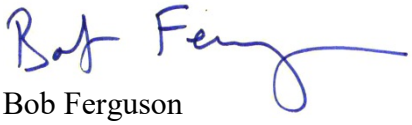

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