Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care

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TESTIMONY OF MARY KILLOUGH

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Chair McMorris Rodgers, Ranking Member Pallone, Chairman Guthrie, Ranking Member Eshoo, and the members of the Energy and Commerce Health Subcommittee, thank you for the invitation to testify today and the opportunity to provide insight into issues related to the direct care workforce and access to Medicaid home and community-based services.

My name is Mary Killough and I serve as Vice President of Operations for AccentCare Personal Care Services in Illinois. Our agency serves almost 3,000 program participants and employs over 2,100 home care aides. Our agency started operating in 1984 and provides home and community-based services (HCBS) in the Illinois Department of Aging Community Care program, which allows older adults who might otherwise need nursing home care to remain in their homes by providing in-home and community-based services as an alternative to nursing home placement.

For over 30 years, I have worked to care for and protect the interests of older adults and people with disabilities – as Cook County Assistant State's Attorney, where I was responsible for investigating and prosecuting crimes against seniors and persons with disabilities, then as the Deputy Director of the Illinois Department of Aging, and now as a senior leader in one of the largest providers of home care in the Chicagoland area.

I served under two Illinois governors, where I managed the agency that directed and implemented most aspects of aging policy and planning throughout the entire state, which included the Illinois Elderly Medicaid waiver program that serves more than 100,000 older adults and their families.

As a leader in HCBS, home health, palliative and hospice services, AccentCare serves the entire home care continuum, providing patients and families with easier access to personalized, high-quality care, and delivering consistently positive outcomes for our patients. AccentCare operates over 260 locations across 30 states and Washington, D.C., employing more than 31,000 qualified professionals and providing care to more than 200,000 individuals and their families each year.

In addition to providing HCBS services in Illinois, AccentCare employs over 15,000 direct care workers who deliver over 15 million hours of care annually in Arizona, New York, and Texas.

If there is one message that I can leave with you today, it's that direct care workers play an integral role in supporting older adults and individuals with disabilities who receive services in

the setting of their choice. They are often the lifeline for these individuals. The demand for services provided in the home is only going to continue to grow and we must do something to address the current and future workforce shortage.

Solving the workforce shortage will require home care providers, state and federal policymakers, and key stakeholders to thoughtfully examine not only wages and benefits provided to the direct care workforce but a myriad of issues that have been identified over the past decade that are limiting employment growth – such as increasing job satisfaction, ensuring that these caregivers are respected and valued as a critical member of the care team, and enhancing education and training that could lead to career advancement. All of these issues are symptomatic of a workforce that is not valued at the level they deserve given the caring, compassionate benefits they provide to society.

AccentCare supports policy reforms that honor and protect the dedicated direct care workforce who delivers high-quality, cost-effective services to a large and growing population of older adults and individuals with disabilities. We fully support higher compensation levels for the direct care workforce and have been actively advocating in our operating states for higher reimbursement rates for the sole purpose of increasing wages to our direct care workforce.

AccentCare recently submitted comments on the Centers for Medicaid and Medicaid Services (“CMS”) Medicaid Program; Ensuring Access to Medicaid Services proposed rule that included a mandate that requires state Medicaid programs to assure that at least 80 percent of all Medicaid

HCBS payments are spent on compensation for direct care workers who support Medicaid program participants in activities of daily living at home. The remaining 20 percent of payments would be expected to cover all other program delivery operating expenses, including training, background checks, worker's compensation, mileage, quality review, nurse supervision, scheduling, information technology, and many other required expenses.

AccentCare strongly urged CMS to withdraw the proposed rule's HCBS Payment Adequacy provision that would require 80 percent of Medicaid payments to be passed through to direct care worker since the requirement will not achieve the desired objective of increasing access and improving wages for direct care workers.[1]

While we appreciate CMS's recognition that the availability and stability of agencies that deliver HCBS and a robust direct care workforce are crucial to access to care, the method by which the agency is attempting to address the shortage of direct care workers is significantly flawed.

CMS proposed the 80 percent wage pass through policy to address the pervasive low pay for direct care workers. However, the approach set forth in the proposed rule is not only unworkable but likely to undermine the stated intention of the underlying policy. Specifically, CMS's uniform, one-size-fits-all mandate will result in:

[1] Proposed Rule 42 CFR §441.302(k)(3)(i); HCBS Payment Adequacy proposal.

- HCBS provider (agency) closures or disenrollment from the Medicaid program. In particular, providers in rural areas and Black, Indigenous, and Persons of Color (BIPOC) providers that lack the economies of scale to distribute administrative costs.[2]
- HCBS providers reducing coverage service areas, particularly in high-cost low volume frontier and rural areas and high-cost urban areas.
- Reduced investment in optional initiatives or activities that support the direct care workforce such as enhanced training and skills development; diversity and equity inclusion activities; and expanded employee assistance programs.
- Decreased investment in innovative technologies, including health information technology and systems that support value-based arrangements and improve quality outcomes such as reduced hospitalization and emergency room visits.

Program Requirements Vary by State

In states that offer personal care services in multiple programs (State Plan Personal Care Option and more than one HCBS waiver), it is common for different standards to apply to essentially the same services. As noted in previous Medicaid access rulemaking, a uniform approach to meeting the statutory requirement under [the Medicaid Act] could prove difficult given current limitations on data, local variations in service delivery, beneficiary needs, and provider practice roles.[3]

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[2] National Association of Medicaid Directors (NAMD) Comment Letter on Center for Medicare and Medicaid Services' proposed rule, Ensuring Access to Medicaid Services [CMS-2442-P]; https://medicaiddirectors.org/wp-content/uploads/2023/07/NAMD-Comments-Access-Rule-FINAL.pdf.

[3] 80 FR 67577

In a 2006 report, the Department of Health and Human Services Office of the Inspector General (OIG) identified 301 different sets of requirements for personal care aides in Medicaid programs. The OIG further noted that "[s]tates have established multiple sets of attendant requirements that often vary among programs and by delivery models within programs…[t]he variations in requirements and the administration of programs by different State agencies and departments made capturing complete information about requirements challenging."[4]

For example, as noted by PHI[5] specific to personal care attendant (PCA) training requirements:

- 14 states have consistent training requirements for all agency-employed PCAs, while 7 states do not regulate training for PCAs at all. The other 29 states and the District of Columbia have varying requirements for agency-employed PCAs, depending on whether they work in specific Medicaid programs or for private-pay home care agencies.
- 26 states require a minimum number of training hours for PCAs in at least one set of training requirements, including 15 states and the District of Columbia that require 40 or more hours of training.
- 34 states and the District of Columbia require PCAs to complete a competency assessment after training in at least one set of training regulations.

[4] U.S. Department of Health and Human Services. (2006). States' Requirements for Medicaid-Funded Personal Service Attendants. Office of the Inspector General, OEI-07-05-00250.

[5] PHI is one of the leading authorities on the direct care workforce. See Personal Care Aide Training Requirements at https://www.phinational.org/advocacy/personal-care-aide-training-requirements/; accessed October 22, 2023

- 17 states regulate instruction methods in at least one set of regulations, including 11 states and the District of Columbia that require trainers to use a state-sponsored curriculum or curriculum outline.

Reimbursement Rates

The success of a state's HCBS program is dependent on providers' participation, and their participation is dependent on a sufficient payment rate structure for the delivery of services. Unless state Medicaid reimbursement rates under HCBS programs increase to cover the federal wage pass-through requirement, the proposed rule will result in individuals going without essential community-based LTSS and risk placement in a nursing home.

Unfortunately, the rule misses the mark because it does not address one of the most significant reasons that the current workforce crisis exists: the consistent, pervasive, underfunding of Medicaid HCBS payment rates. Requiring 80 percent of these reimbursements to be passed through to direct care workers only redistributes the substantially underfunded reimbursements rather than addresses the root cause of low wages – insufficient provider reimbursement.

Furthermore, it ignores all the mandated requirements that HCBS agencies must meet with their administrative expenses, such as: intake and scheduling functions not performed by a direct care worker; mandated nurse supervision of direct care workers; training of workers; personal protective equipment and other infection control expenses; quality oversight and reporting; electronic visit verification; health and welfare management activities; and mileage

reimbursement. These requirements are different across the country and, often, vary within states from program to program. The variability of administrative mandates coupled with the wide range of state reimbursement levels makes any federal minimum pass-through requirement incompatible with Medicaid HCBS delivery.

Lack of Legal Authority

Federal statute, regulations, and guidance do not specify or regulate wage and employee benefit levels in Medicaid, and federal law does not establish methods for setting Medicaid provider payments. The Medicaid Act requires that state Medicaid provider (that is, agency) payments are sufficient to ensure that beneficiaries have access to a level of care that is comparable to the care provided to non-Medicaid beneficiaries in a geographic area.[6] The federal government provides broad guidelines to states, and the specific provider payment methodologies and reimbursement rates are determined by each state.

The Clinton Administration filed a brief in a 9th Circuit case regarding the scope of section 1902(a)(30)(A) where the federal government opined that the purpose of 1902(a)(30)(A) was to give states "wide discretion to set Medicaid payments that are consistent with efficiency, economy, and access to quality care" and that "the Secretary does not dictate what level of payments will be sufficient to provide for equal access to such care and services … [n]or does the

[6] Under §1902(a)(30)(A) of the Social Security Act, state Medicaid programs must ensure that provider payments are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to provide access to care and services comparable to those generally available.

Secretary require the States to adopt any particular procedure or methodology for determining whether payments are necessary to meet the general criteria in the statute."[7]

Conclusion

The direct care workforce is in crisis and it will require a wide range of policy and programmatic changes to meet the current and future demands of HCBS. The issues surrounding access to HCBS are one of the most pressing challenges in delivering LTSS to older adults and people with disabilities today and should be addressed at the state and federal level in a holistic manner.

AccentCare welcomes the opportunity to work with the Committee, the Administration, and a broad group of stakeholders to provide a pathway for state Medicaid programs to increase investment in HCBS provider payment rates, which in turn would allow HCBS provider agencies to fulfill their long-standing commitment to maximize direct care workforce wages.

[7] *See* https://www.justice.gov/sites/default/files/osg/briefs/1996/01/01/w961742w.txt