September 28, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Comments on Notice of Proposed Rulemaking, File Code CMS-2444-P, RIN 0938-AU73

Administrator Brooks-LaSure,

As advocates for individual liberty and limited, accountable government, the Freedom Foundation (Foundation) strongly opposes the Center for Medicaid Services' (CMS) recent proposal, CMS-2444-P, to adopt a new regulation at 42 CFR § 447.10(i) permitting states to deduct "payments to a third party on behalf of an individual [Medicaid] practitioner for benefits such as health insurance, skills training, and other benefits customary for employees" in certain circumstances.

The proposed regulation both impermissibly violates the statutory direct payment requirement of 42 U.S.C. § 1396a(a)(32) and would enable exploitative practices harmful to the nation's home care aide (HCA) workforce serving Medicaid-eligible clients.[1]

The Foundation is a 501(c)(3) nonprofit organization founded in 1991 and based in Olympia, Washington, with offices in Oregon, California, Ohio and Pennsylvania and staff around the country. For seven years, the Foundation has worked to educate the hundreds of thousands of HCAs on the West Coast about their rights under the U.S. Supreme Court's 2014 decision in *Harris v. Quinn,* 573 US 616 (2014) ("*Harris*"), which held that the First Amendment prohibits states from requiring "partial-public employees" like HCAs to financially support a labor union.

Such educational efforts have met with significant resistance from labor unions and state government officials aligned with them politically. The Foundation has also provided free legal assistance, including representation in litigation in state and federal courts in all three states, on behalf of dozens of HCAs whose rights have been, and continue to be, violated by labor unions and state governments.

Our extensive experiences in court, in state legislatures and working with HCAs have led us to conclude that it is imperative for CMS to take strong action to prevent states from diverting union dues and political contributions from HCAs' wages in any capacity. Unfortunately, this

[1] While states have different legal names/job titles for their personal care workforces, this comment refers to them all simply as "home care aides" or HCAs for the sake of simplicity.

proposed regulation moves in the opposite direction by institutionalizing illegal and coercive union practices.

I. The proposed regulation conflicts with the statutory direct payment requirement and lacks legal authority.

A. The direct payment requirement is an important component of Medicaid's statutory and regulatory framework.

42 U.S.C. § 1396a(a)(32) ("Subsection (a)(32)") gives Medicaid providers a right to receive direct payment for their services and prohibits any diversion of those payments to any other party, except as expressly permitted. The statute states,

> "…that no payment under the [State] plan [for medical assistance] 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."

Subsection (a)(32) does not exist in a vacuum, but as one part of a comprehensive statutory and regulatory framework for administering one of the largest public assistance and health care programs in the country. While certain interests may desire that Medicaid perform the functions of an employer, including administering payroll deductions, the reality is that the provision of home care under Medicaid is based on a "fee-for-service"[2] model — far more akin to a vendor-client relationship than an employer-employee relationship — into which such employer functions cannot be forced.

The statute's requirement that Medicaid providers receive full payment for services provided to Medicaid beneficiaries — and its corollary prohibition against diverting payments to third parties that do not provide services to Medicaid beneficiaries — is clear on its face, but an examination of Subsection (a)(32)'s place within Medicaid's broader legal framework further reinforces this *prima facie* interpretation.

The official description of Medicaid is found in 42 CFR 430.0:

> "Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services."

[2] Medicaid and CHIP Payment and Access Commission. "The Medicaid Fee-for-Service Provider Payment Process." July 2018. https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-fee-for-service-provider-payment-process.pdf

(Emphasis added).

The types of services for which Medicaid will pay are listed in the definition of "medical assistance" in 42 U.S.C. § 1396d(a) and include, in relevant part, "home and community care… for functionally disabled elderly individuals" (paragraph 22), "community supported living arrangements services" (paragraph 23), and "personal care services" (paragraph 24). No allowance is made for payments to third parties that provide no services to Medicaid beneficiaries.

In fact, making such unauthorized payments violates generally applicable Office of Management and Budget (OMB) regulations governing awards of federal funds.[3] These regulations state that "any payment to an ineligible party, any payment for an ineligible good or service" and "any payment for a good or service not received" is "improper."[4]

Specific to Medicaid, OMB interpretations explain that,

> "To be allowable, Medicaid costs for Medical services must be… covered by the State plan… paid at the rate allowed by the State plan… paid to eligible providers, and only provided on behalf of eligible individuals… Funds can be used only for Medicaid benefit payments."[5]

(Emphasis added).

To protect the integrity of Medicaid's structure and funding, state plans for medical assistance[6] are statutorily required to abide by both broad principles and specific statutory requirements. Of relevance here, for example, 42 U.S.C. § 1396a(a)(19) provides that a state plan must "provide such safeguards as may be necessary to assure that… services will be provided[] in a manner consistent with simplicity of administration…"

Given this structure and these requirements, Subsection (a)(32)'s direct payment requirement prevents fraud and ensures Medicaid payments are not used for anything other than their intended purpose, namely, reimbursing providers for services to beneficiaries.

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[3] *See,* generally, 2 CFR Part 200.

[4] 2 CFR § 200.53.

[5] Office of Management and Budget. "2 CFR Part 200, Appendix XI: Compliance Supplement." April 2017. Pgs. 4-93.778-12 and 4-93.778-12.
https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A133/2017/Compliance_Supplement_2017.pdf

[6] "A Medicaid and CHIP state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state." *See* "Medicaid State Plan Amendments." Centers for Medicare and Medicaid Services. Accessed September 27, 2021. https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html

B. The statutory direct payment requirement prohibits the proposed regulation permitting state-administered third-party payroll deductions from provider payments.

Subsection (a)(32)'s language is categorical and clear:

> "[N]o payment under the [State] plan [for medical assistance] 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."

(Emphasis added).

Over the years, Congress has adopted four specific exceptions to this otherwise universal requirement, but none permit states to divert all or part of providers' Medicaid payments to third-party, non-providers for things like union dues or political contributions.[7]

CMS proposes, in the instant notice of proposed rulemaking (NPRM), to reinterpret the statute via a new regulation at 42 CFR § 447.10(g)(i), to read:

> "The payment prohibition in section 1902(a)(32) of the Act and paragraph (d) of this section *does not apply to payments to a third party* on behalf of an individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees, in the case of a class of practitioners for which the Medicaid program is the primary source of revenue, if the practitioner voluntarily consents to such payments to third parties on the practitioner's behalf."

(Emphasis added).

However, not applying prohibitions on payments to third parties clearly contradicts the statute prohibiting payments to third parties.

The language of the proposed regulation strongly resembles[8] 42 CFR § 447.10(g)(4), adopted by CMS in 2014[9] and rescinded in 2019,[10] which read:

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[7] The proposed rule does not identify a comprehensive list of specific, permissible deductions, but does mention the following as possibilities: "[F]ederal income taxes, Federal Insurance Contributions Act (FICA) taxes, state and local taxes, retirement benefits (for example, 401k, profit-sharing), health insurance, dental insurance, vision insurance, long-term care insurance, disability insurance, life insurance, gym memberships, health savings accounts (HSA), job-related expenses (for example, union dues with affirmative consent, uniforms, tools, meals, and mileage), and charitable contributions." *See* 86 FR 41803. https://www.federalregister.gov/documents/2021/08/03/2021-16430/medicaid-program-reassignment-of-medicaid-provider-claims

[8] CMS acknowledges in the NPRM that the proposed language for 42 CFR § 447.10(i) is "similar" to former 42 CFR § 447.10(g)(4).

[9] *See* 79 FR 2947. https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[10] *See* 84 FR 19718. https://www.federalregister.gov/documents/2019/05/06/2019-09118/medicaid-program-reassignment-of-medicaid-provider-claims

> "In the case of a 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."

When CMS proposed 42 CFR § 447.10(g)(4) in 2012, it acknowledged that the statute "does not expressly provide for additional exceptions to the direct payment principle."[11] Because federal agencies cannot adopt regulations without statutory authority and may only adopt regulations consistent with federal statutes, that should have been the end of the matter. But CMS proceeded to create the additional exception anyway.[12]

Perhaps cognizant of the poor optics of attempting to simply declare a new exception to a statute where Congress has not seen fit to do so, CMS now frames the recycled regulatory text in the present NPRM as simply a reinterpretation of Subsection (a)(32), rather than an addition to it. But the text and effect of the proposed rule is the same as former 42 CFR § 447.10(g)(4): The addition of an extra-congressional fifth exception to the statutory direct payment requirement that authorizes previously prohibited payroll deductions from Medicaid provider payments.

Further, CMS does not — because it cannot — cite statutory authority allowing it to permit deductions for "benefits customary to employees" in the first place. In some instances, Congress has specifically authorized specific deductions from Medicaid payments, proving that it knows how to authorize additional deductions if it sees fit to do so.

For example, 42 U.S.C. § 1301(c) provides,

> "Whenever under this chapter [the Social Security Act, which includes the statutes governing Medicaid] or any Act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for the purposes of this chapter the amount so deducted shall be considered to have been paid to the employee at the time of such deduction."

Thus, payroll deduction-type diversions from Medicaid payments are permissible *when*

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[11] *See* 77 FR 26361. https://www.federalregister.gov/documents/2012/05/03/2012-10385/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[12] *Ibid.* CMS attempted to justify its decision to create an illegal fifth exception to the statutory direct payment requirement by noting that, "some States have requested that we consider adopting additional exceptions to the direct payment principle," reasoning that such a development "was not contemplated under the statute," and therefore concluding that "the direct payment principle should not apply" to prohibit the requested payroll deductions from providers' Medicaid payments for third parties. But the subsequent wishes of a handful of states to process such deductions, often at the behest of political allies, does not *ipso facto* alter the statutory direct payment requirement or permit CMS to do so via administrative regulation.

lawfully paid to a government entity.[13] This provision aligns with the second exception to the direct payment requirement in Subsection (a)(32), which permits assignments of providers' Medicaid payments "made to a governmental agency or entity."[14]

However, no comparable statute authorizes deductions from Medicaid provider payments on behalf of private organizations — like labor unions or affiliated trust funds and political committees — that provide no services to Medicaid beneficiaries. The lack of any such authorizing provision, combined with Subsection (a)(32)'s broad mandate to make full payments directly to providers, simply leaves no room for CMS to authorize states to deduct other kinds of payments from Medicaid providers' reimbursements.

1. **Subsection (a)(32) applies to circumstances beyond assignment-like payment arrangements.**

In the instant NPRM, CMS contends that Subsection (a)(32) "only governs assignment-like payment arrangements" and is not "a broad prohibition on any and all types of Medicaid payment arrangements beyond those provided directly to Medicaid beneficiaries and providers or enumerated in the statutory exceptions."

To support its position, CMS claims the text of Subsection (a)(32),

> "…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."

In CMS' reading, the phrase "under an assignment or power of attorney or otherwise" modifies and narrows the broad preceding statement that "no payment… shall be made to anyone other than such individual or the person or institution providing such care or service."

However, as a matter of statutory construction and grammar, this is incorrect. The placement of a comma after "service" and before "under" indicates that the inclusion of "under an assignment or power of attorney or otherwise" is not grammatically essential to the integrity of the sentence. The broad prohibition on payments to third parties stands by itself whether or not the subsequent reference to assignment and power of attorney is present. Because it is not essential, "under an assignment or power of attorney or otherwise" does not restrictively modify the antecedent phrase.

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[13] Notably, the statute is *not* phrased to say that payroll deductions are permissible when remitted to government, but that amounts so deducted "*shall be considered to have been paid to the employee*…" (Emphasis added). Though the effect would be the same either way, the language used is in keeping with Subsection (a)(32) and the fee-for-service structure of Medicaid generally, which require payment to be made directly and completely to providers.

[14] "…[N]othing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction…" 42 U.S.C. § 1396a(a)(32)(b).

This statutory phrasing is likely best explained by the fact that, historically, the references to assignments and power of attorney were tacked on to the preexisting prohibition. As initially adopted via Public Law 92-603 in 1972, Subsection (a)(32) provided:

> "…that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner…"[15]

The present language of Subsection (a)(32), with the added specific reference to assignments, became operative with passage of Public Law 95-142 in 1977.[16] As discussed further below, there is no reason to believe the reference to assignments was intended to narrow the scope of the prohibition. In fact, the congressional record clearly shows it was intended to expand the prohibition by closing a perceived loophole.

And if Congress had intended to write the statute in such a way as to prohibit *only* payments made via assignments or power of attorney, it could have drafted the statute to clearly state such intent.[17]

The only reasonable interpretation of Subsection (a)(32) is that the reference to "an assignment or power of attorney or otherwise" is intended to clarify that the preceding prohibition is broad enough to encompass such devices, not so narrow as to apply only to them.

2. Subsection (a)(32) prohibits both complete and partial diversions of Medicaid provider payments to third parties.

CMS contends that the statute prohibits only the "*full diversion* of the right to claim and/or receive such payments to third parties absent an exception" but does not "apply to *partial deductions* from payments" (emphasis added).

Taken to its logical extreme, this interpretation would hold that the statute is satisfied so long as the Medicaid provider receives *any* portion of their payment directly, even if it's just pennies on the dollar. In CMS' view, the unequivocal words "no payment… shall be made to anyone other than" the provider really mean "any payment that amounts to less than 100 percent of what is owed to the

[15] *See* Public Law 92-603. October 30, 1972. Available online at: https://www.govinfo.gov/content/pkg/STATUTE-86/pdf/STATUTE-86-Pg1329.pdf

[16] *See* Public Law 95-142. October 25, 1977. Available online at: https://www.govinfo.gov/content/pkg/STATUTE-91/pdf/STATUTE-91-Pg1175.pdf

[17] For instance, Congress could have simply altered the placement of the reference to assignments/power of attorney in the statute as follows: "No payment under the plan for any care or service provided to an individual shall be made under an assignment or power of attorney or otherwise to anyone other than such individual or the person or institution providing such care or service."

provider may be made to a third party." In effect, this interpretation flips the statute on its head, turning it from prohibitive to permissive.

Furthermore, CMS' interpretation would render 42 U.S.C. § 1301(c) — which authorizes an employer to "deduct any [legally required] amount from the remuneration of an employee" on behalf of a government entity — unnecessary since, according to CMS, any deductions of less than 100 percent of providers' payments are already permissible under Subsection (a)(32). The need for 42 U.S.C. § 1301(c) to authorize deductions for government entities makes perfect sense, however, when Subsection (a)(32) is rightly viewed as a complete prohibition against diverting any portion of providers' payments to third parties absent a statutory exception.

It would make no sense for Congress to adopt a prohibition as meaningless as the one described by CMS in the NPRM, and its interpretation is completely at odds with the plain text of the statute.

3. **The four exceptions to Subsection (a)(32) do not support the conclusion that the direct payment requirement only applies to assignment-like payment arrangements.**

CMS claims that,

> "The fact that the only types of transactions that are explicitly excepted by the statute are assignment-like transactions that involve the transfer to a third party of either a provider's right to submit claims directly to the state and/or to receive all payments otherwise due a provider for services furnished supports our proposed interpretation that the scope of the statutory prohibition extends only to payments to a third party that involve similar types of arrangements."

But this is a *non sequitur.* That Congress saw fit to provide four exceptions from the direct payment requirement for certain, enumerated circumstances involving the complete transfer of a providers' right to payment to a third party does not mean that the only payment arrangements that remain prohibited are similarly complete reassignments. If the exceptions imply anything at all, it is that the prohibited arrangements are different in kind from the permissible ones.

4. **Even if Subsection (a)(32) only applied to assignment-like payment arrangements, payroll deductions from Medicaid payments for third parties would still be impermissible.**

CMS also appeals to the definition of "assignment" to bolster its position that "the statute was intended to address scenarios where the right to a provider's Medicaid receivables or the right to submit claims on behalf of the provider are transferred to a third party." But the definitions cited by CMS support no such conclusion.

Both sources cited in footnote four of the NPRM — Black's Law Dictionary and Merriam Webster — define "assignment" as simply a "transfer of property." Nothing in these definitions suggests that they encompass only *complete* transfers of a class of property; the transfer of only *part* of one's property — or paycheck, in this case — still satisfies CMS' own definition of "assignment."

In other words, Subsection (a)(32) prohibits non-excepted payroll deductions from Medicaid provider payments for the benefit of third parties *even if* "assignments" are all the statute governs because, according to CMS, assignments are merely transfers of property.

5. **The legislative history of Subsection (a)(32) confirms its purpose is to prevent fraud by ensuring full payment reaches Medicaid providers.**

When, as is the case with Subsection (a)(32), a statute's meaning is clear, no further analysis is necessary, and a statute's legislative history should not be used to needlessly complicate a clear law.[18]

Perhaps cognizant of the weaknesses of its interpretative arguments, CMS turns to the statute's legislative history to attempt to bolster its position. However, the legislative history actually supports an expansive interpretation of the statutory direct payment requirement, not the cramped view advocated by CMS via the instant NPRM.

CMS contends, not incorrectly, that,

> "When Congress adopted the original version of this statute in 1972, it was focused on the practice of factoring—a practice which often led to the submission of inflated or false claims, raising concerns that the factoring industry was a breeding ground for Medicaid fraud… [I]n 1977, Congress amended the anti-reassignment provision to close what it perceived to be a loophole that factoring companies were exploiting."

While factoring was certainly in congressional crosshairs at the time as a practice known for being subject to fraud, there are many indications that preventing Medicaid fraud generally, not just fraud via factoring specifically, was the purpose of the direct payment requirement.

The direct payment requirement in 42 U.S.C. § 1396a(a)(32) was originally passed as part of Public Law 92-603 in 1972.[19] Congress subsequently

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[18] "In statutory interpretation disputes, a court's proper starting point lies in a careful examination of the ordinary meaning and structure of the law itself. Where, as here, that examination yields a clear answer, judges must stop. Even those of us who sometimes consult legislative history will never allow it to be used to 'muddy' the meaning of 'clear statutory language.'" *See Food Mktg. Inst. v. Argus Leader Media,* 139 S. Ct. 2356, 2364 (2019).

[19] The change was largely uncontroversial, with the American Public Health Association supporting it because "it will guard against unethical—even immoral—practices, and it is overdue." *See* statement of Dr. James R. Kimmey, executive director of the American Public Health Association. "Social Security Amendments of 1970, Hearings

strengthened the direct payment requirement to prevent workarounds as part of a broader package of Medicaid reforms included in Public Law 95-142 in 1977, the purpose of which was to "detect, prosecute, and punish fraudulent activities" under Medicaid.[20]

Congressional records about both bills make it clear that, while a motivating factor behind the direct payment requirement was preventing factoring arrangements, Congress' concerns and the language it adopted were not necessarily confined to this one issue.

A Senate bill report on Public Law 95-142 explained the genesis of the direct payment requirement and the need to strengthen it:

> "In 1972, the Congress took action to stop a practice under which some physicians and other persons providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups. Under the conditions of these reassignments, the organizations or groups purchased the receivables for a percentage of their face value, submitted claims and received payments in their name. By 1972, it had become apparent that such reassignments were a significant source of incorrect and inflated claims for services paid by medicare and medicaid. In addition, cases of fraudulent billings by collection agencies and substantial overpayments to these so-called 'factoring' agencies were also found…
>
> The Social Security Amendments of 1972, Public Law 92-603, therefore, included a prohibition against the payment for services provided to anyone other than the patient, his physician, or other person who provided the service…
>
> Despite these efforts to stop factoring of medicare and medicaid bills, some practitioners and other persons have circumvented the intent of the law by use of a power of attorney. The use of a power of attorney allows the factoring company to receive the medicare or medicaid payment in the name of the physician, thus allowing the continuation of program abuses which factoring activities were shown to produce in the past…
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> [The bill] would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under

before the Committee on Finance, United States Senate, Ninety-First Congress, Second Session, on H.R. 17550." Part I. Pg. 712. June 17, and July 14, and 15, 1970.

[20] *See* Public Law 95-142. October 25, 1977. Available online at: https://www.govinfo.gov/content/pkg/STATUTE-91/pdf/STATUTE-91-Pg1175.pdf

medicare and medicaid…"[21]

But concerns about other types of fraud existed as well, including situations in which certain providers billed Medicaid for "the costs of services and items entirely unrelated to the provision of patient care," such as "dues for yacht and country club memberships, tuition for school expenses, advertisements in non-health related publications, restaurant meals, and travel."[22]

The types of third-party deductions proposed by the instant NPRM differ from these examples somewhat in that Medicaid is not being billed, *per se,* inappropriately by providers, but by third-party entities. Nevertheless, the payments for which the third parties would effectively bill Medicaid are likewise "entirely unrelated to the provision of patient care."

Further, while the exact details differ, the factoring arrangements specifically targeted by the congressional architects of Subsection (a)(32)'s direct payment requirement share many similarities with the third-party deductions proposed in the NPRM.

In remarks on the Senate floor supporting the direct payment requirement, Sen. Frank Church of Idaho explained:

> "Physicians and other providers who have large accounts receivable from medicare and medicaid can recover cash by selling these accounts receivable to a factoring, or brokerage, firm for cash while the firm takes 12 to 24 percent for collecting them. Medicaid payment can take 6 months or longer in some States, and so many providers have little choice but to go to factors. Congress did not intend that money appropriated for the care of the sick and aged to be diverted into the hands of such 'middlemen.'"[23]

(Emphasis added)

In both factoring arrangements and the third-party deductions proposed by the NPRM, a third party, non-provider receives a percentage of the Medicaid payment owed to a provider in exchange for services rendered to the provider, not Medicaid beneficiaries. The fact that providers may have had legitimate reasons for seeking the services of factoring firms was of no consequence to Congress,

[21] "Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, Report of the Committee on Finance, U.S. Senate, on S. 143." September 26, 1977.
[22] "Fraud and Abuse in the Medicare and Medicaid Programs." Subcommittee on Health, Committee on Ways and Means, and Subcommittee on Health and the Environment, Committee of Interstate and Foreign Commerce, U.S. House of Representatives. March 3, 1977.
[23] Remarks of Sen. Frank Church. Medicare and Medicaid Anti-Fraud Abuse Amendments of 1977. Congressional Record – Senate. September 30, 1977. S 16012.

which wanted to guard against fraud by ensuring full payment reached providers.[24]

Regardless of Congress' specific motivations for enacting Subsection (a)(32), it is clear that the statute's overarching purpose was to prevent fraud. It is equally clear that the plain language of the direct payment requirement — Congress' chosen mechanism to prevent fraud by ensuring full payment reaches providers — renders impermissible the kinds of third-party deductions CMS proposes to sanction in the NPRM.

C. CMS has historically interpreted 42 U.S.C. § 1396a(a)(32) as prohibiting third-party deductions for things like union dues from providers' Medicaid payments.

CMS claims in the NPRM that, "Since the 1990s, we have mostly understood this provision [Section 1902(a)(32) and 42 CFR § 447.10] as governing only assignments and other similar Medicaid reimbursement arrangements." CMS further characterizes its 2019 rescission of 42 CFR § 447.10(g)(4) and interpretation of the direct payment requirement "as applying more broadly to prohibit any type of Medicaid payment to a third party other than the four exceptions enumerated in the statute" as "a departure from our prior interpretation."

This is flatly incorrect.

It was the 2014 final rule establishing 42 CFR § 447.10(g)(4) and permitting third-party deductions that was the aberration from CMS' historical understanding of Subsection (a)(32). The 2019 final rule rescinding the extra-congressional exception to the statutory direct payment requirement corrected the 2014 error and reverted to the historical, and correct, position.

Though Subsection (a)(32) was originally passed in 1972, it was not until the early 1990s that a state — California — first began deducting union dues and political action committee contributions from providers' Medicaid payments.[25]

Years of documents exchanged between CMS and the Washington State Department of Social and Health Services (DSHS) indicate that, while it took some time for CMS to learn of the practice, its position across multiple presidential administrations has generally been that such third-party diversions run afoul of Subsection (a)(32) and related authorities.[26]

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[24] The wishes of certain third-party interests in receiving portions of providers' Medicaid payments are equally irrelevant to interpreting the statute today.

[25] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

[26] These documents were obtained by the Freedom Foundation from DSHS under the Washington State Public Records Act, Chapter 42.56 RCW.

While reviewing Washington's state plan amendment 08-009 in late 2008, CMS determined that a prior state plan amendment, 06-012, "was approved in error" in November 2007 because the state's "methodology for payment of personal care is out of compliance with Section 1905(a) of the Social Security Act [42 U.S.C. 1396d]."[27]

Nevertheless, because Washington was planning to implement a new provider payment system, CMS gave Washington until June 2011 to bring its personal care methodology into compliance along with the rollout of the new system.[28]

However, in April 2011, Washington requested an additional one-year extension to come into compliance because it had been informed by CMS that,

> "…even when the state gets the PCS [Provider Compensation System] implemented, our method of paying individual providers of personal care will not be acceptable to CMS because we pay for <u>training, health insurance and union dues</u> on behalf of the provider and outside of the provider's direct wage."[29]

(Emphasis added).

Washington also encouraged CMS to move ahead with the development of "regulations that would assist states with options for Medicaid payment to these types of providers."[30]

In its May 2011 reply, CMS approved a six-month extension of Washington's state plan, but explained,

> "During the Centers for Medicare & Medicaid Services (CMS) review of Washington State Plan Amendment (SPA) Transmittal Number 08-009, CMS determined the reimbursement methodology for Personal Care Services (PCS) was not in compliance with Section 1905(a) of the Social Security Act [42 U.S.C. 1396d] which states that Medicaid can only pay for Medicaid-covered services. The State of Washington was paying for

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[27] *See* letter from Stan Marshburn, interim secretary of DSHS, to Barbara Richards, associate regional administrator for the Centers for Medicare and Medicaid Services, Division of Medicaid and State Operations, Region X. April 24, 2009. Available online at: https://www.freedomfoundation.com/wp-content/uploads/2021/09/WA-DSHS-Personal-Care-Services.pdf

[28] Washington was not the only state that had to reconcile its Medicaid payment methodology with the direct payment requirement during this period. A 2008 bulletin prepared for Medicaid home care providers by Iowa's Department of Human Services stated, "AFSCME has informed us that if you have signed a green dues deduction card, you have agreed to have dues deducted from your Medicaid payments. In addition you may have authorized AFSCME to make other deductions. Due to Federal Medicaid rules, the Iowa Medicaid Enterprise is not able to deduct the dues." (Emphasis added). *See* Informational Letter 696. Iowa Department of Human Services. April 1, 2008. Available online at: http://dhs.iowa.gov/sites/default/files/696_DuesDeductionforAFSCME.pdf

[29] *See* letter from Susan Dreyfus, DSHS secretary, to Carol Peverly, acting associate regional administrator, Centers for Medicare and Medicaid Services, Division of Medicaid and State Operations, Region X. April 27, 2011. Available online at: https://www.freedomfoundation.com/wp-content/uploads/2021/09/WA-DSHS-Personal-Care-Services.pdf

[30] *Ibid*.

> union dues, health insurance and training costs as a separate payment, not included in the PCS payment. Union dues, health insurance and training costs are not Medicaid-covered services when paid by themselves. States may develop rates that include considerations for costs related to health insurance and union dues; however, the entire rate must be 'paid' to the provider of personal care services and reported as income by that provider."[31]

(Emphasis added).

Washington expressed its displeasure with CMS' determination and pleaded with it in a July 2011 letter to "revisit this issue to allow states more flexibility regarding reimbursement for individual providers of personal care."[32]

Rather than enforce its own interpretation of statutory requirements, CMS published a proposed regulation in May 2012[33] — eventually adopted in January 2014 as 42 CFR § 447.10(g)(4)[34] — adding an additional exception to Subsection (a)(32), beyond the four recognized in statute, providing for third party payroll deductions.

And even in its 2012 proposed rule CMS was forced to acknowledge that "the statute does not expressly provide for additional exceptions to the direct payment principle."[35]

Because the regulation clearly contradicted the statutory direct payment requirement in Subsection (a)(32), CMS eventually reverted to its correct and historic understanding that union dues and similar third-party deductions from provider Medicaid payments are statutorily impermissible. In July 2018, CMS proposed to repeal 42 CFR § 447.10(g)(4)

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[31] *See* letter from Carol Peverly to Susan Dreyfus. May 25, 2011. Available online at: https://www.freedomfoundation.com/wp-content/uploads/2021/09/WA-DSHS-Personal-Care-Services.pdf

Note that this is remarkably similar to the way the instant NPRM describes CMS' interpretation of the statute from 2019 to the present:

> "States may develop state plan payment rates that include considerations for costs related to health and welfare benefits, training, and other benefits customary for employees. However, consistent with our previous interpretation of the statutory provision at section 1902(a)(32) of the Act, and reflected in regulations at § 447.10 under the 2019 final rule, the entire rate must be paid to the individual practitioner who provided the service, unless certain exceptions apply."

[32] *See* letter from MaryAnne Lindeblad, assistant secretary of DSHS, to Carol Peverly. July 12, 2001. Available online at: https://www.freedomfoundation.com/wp-content/uploads/2021/09/WA-DSHS-Personal-Care-Services.pdf
[33] *See* 77 FR 26361. Available online at: https://www.federalregister.gov/documents/2012/05/03/2012-10385/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider
[34] *See* 79 FR 2947. Available online at: https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider
[35] *See* 77 FR 26361. Available online at: https://www.federalregister.gov/documents/2012/05/03/2012-10385/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

in its entirety,[36] which it did effective July 2019.[37]

In its final rule, CMS explained the regulation was,

> "…neither explicitly nor implicitly authorized by [42 U.S.C. § 1396a(a)(32)], which… provides for a number of exceptions to the direct payment requirement that we believe constitutes an exclusive list of exceptions and does not authorize the agency to create new exceptions. The regulatory provision at § 447.10(g)(4) granted permissions that Congress has not expressly authorized, and in our interpretation, has foreclosed."[38]

Unfortunately, the instant NPRM seeks to reinstate the novel and erroneous interpretation of the Subsection (a)(32) originally advanced via the 2014 final rule.

II. The proposed regulation would enable coercive and exploitative practices harmful to HCAs.

A. Unions take advantage of existing third-party deductions from HCAs' Medicaid payments to engage in patterns of fraudulent and coercive behavior.

Notwithstanding Subsection (a)(32) and CMS' prior determinations that diversions of provider Medicaid payments to third parties are prohibited by the direct payment requirement,[39] at least eight states as of 2017 — including California, Connecticut, Illinois, Massachusetts, Minnesota, Oregon, Vermont and Washington — had elected to implement legally inappropriate deductions on behalf of labor unions and affiliated funds from Medicaid payments to HCAs.[40]

The continuing experience of HCAs in these states indicates that congressional concerns about fraud resulting from diversions of Medicaid funds to non-providers are neither out-of-date nor merely theoretical. In fact, states' decisions to administer deductions of union dues from HCAs' Medicaid payments, in contravention of federal law, have spawned additional illegal and unscrupulous activity.

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[36] *See* 83 FR 32252. Available online at: https://www.federalregister.gov/documents/2018/07/12/2018-14786/medicaid-program-reassignment-of-medicaid-provider-claims

[37] *See* 84 FR 19718. Available online: https://www.federalregister.gov/documents/2019/05/06/2019-09118/medicaid-program-reassignment-of-medicaid-provider-claims

[38] *Ibid.*

[39] The most recent warning from CMS came in the form of an informational bulletin in the fall of 2019. Calder Lynch. CMCS Informational Bulletin regarding the Medicaid Provider Reassignment Regulation Final Rule. Center for Medicaid and CHIP Services. September 13, 2019. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib091319.pdf

[40] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

Originally, these states generally processed the deductions even if providers never authorized them or objected to them. *Harris* ended these mandatory deductions on constitutional grounds, but states and unions have continued flouting the law to continue processing the deductions.[41]

Perhaps the most flagrant example comes from Washington state where, for years after *Harris,* officials continued to automatically deduct 3.2 percent of HCAs' Medicaid payments as union dues without any authorization from the provider, though they would stop the deductions if a provider objected. It took additional federal litigation to end the practice in August 2018.[42] Some HCAs are still involved in litigation to recover the union dues unconstitutionally deducted from their payments by the state.[43]

Even limiting third-party deductions to circumstances in which the provider "voluntarily consents to such payments," as CMS proposes to do, would not close the door to fraud and abuse.

Egregiously, some unions representing HCAs have taken advantage of state payroll deduction systems to forge providers' signatures on forms consenting to union membership and authorizing the state to deduct union dues and political contributions from the providers' payments.

- In California, the United Domestic Workers of America/American Federation of State, County, and Municipal Employees Local 3930 (UDW) is being sued in federal court by HCA Maria Quezambra in the state's In-Home Supportive Services (IHSS) program who alleges the union forged her signature on an assignment form to trigger nearly "irrevocable" UDW dues deductions from her Medicaid payments by the state.[44]
- Also in California, IHSS caregiver Kristina Semerjyan is in federal court against her union, Service Employees International Union (SEIU) Local 2015, alleging that it forged her signature on a membership form, triggering years of unauthorized and nearly "irrevocable" dues deductions from her payments by the state.[45]
- Cindy Ochoa, an HCA from Washington state, sued SEIU 775 in federal court in 2018 alleging the union had forged her signature on a union membership and dues

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[41] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

[42] *Routh, et al. v. SEIU Healthcare 775NW,* U.S. District Court for the Western District of Washington, Case No. 2:14-cv-00200.
Maxford Nelsen. "SEIU 775 To Pay Back Millions of Dollars in Dues Taken Illegally from Home Care Workers." Freedom Foundation. October 3, 2019. https://www.freedomfoundation.com/labor/seiu-775-to-pay-back-millions-of-dollars-in-dues-taken-illegally-from-home-care-workers/

[43] *Schumacher et al., v. Inslee and SEIU 775,* U.S. District Court for the Western District of Washington, Case No. 3:18-cv-5535.

[44] *Quezambra v. UDW AFSCME Local 3930,* Ninth Circuit Court of Appeals, Case No. 20-55643.

[45] *Semerjyan v. SEIU 2015*, Ninth Circuit Court of Appeals, Case No. 21-55104.

deduction authorization form. The union agreed to resolve the case via an offer of judgement in the spring of 2019, paying $28,000 to do so.[46]

- Also in Washington, HCA Sigifredo Araujo filed suit in federal court against his union, SEIU 775, in early 2020 alleging that the union forged his signature on a membership, dues deduction and political contribution authorization form. Mr. Araujo and the union eventually agreed to resolve the case via a confidential settlement.[47]
- Another Washington state HCA, Maria Gatdula, sued SEIU 775 in federal court for fabricating a membership and dues deduction authorization for her. In April of this year, the union agreed to resolve the case via a $17,180 offer of judgement.[48]
- HCAs in Minnesota have also reported unauthorized union deductions from their Medicaid payments.[49] At least one caregiver, Patricia Johansen, submitted a sworn statement to the state's Bureau of Mediation Services attesting and documenting that her signature had been forged on an SEIU Healthcare Minnesota membership form and dues subsequently deducted from her Medicaid payments as a result.[50]

In each of the Washington and California cases listed above, the plaintiffs were represented by Foundation attorneys and the forgeries were only discovered after the providers attempted to cancel the state's deduction of union dues from their Medicaid payments and were told by their respective unions that they signed authorizations that were "irrevocable" unless cancelled during arbitrary annual escape periods of 15 days or less, prompting additional investigation that uncovered the forgeries.

The insertion of such irrevocability clauses into the fine print of union membership forms is increasingly common, to the point of ubiquity.[51]

In Oregon, for instance, a group of 14 HCAs sued their union, SEIU 503, in federal court for refusing to honor their dues cancellation requests. One HCA, Bonita Entwistle, submitted dozens of dues cancellation requests to the union, to no avail.[52]

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[46] *Ochoa v. SEIU 775*, U.S. District Court for the Eastern District of Washington, Case No. 2:18-cv-297. Sydney Phillips. "Three Years Later, SEIU 775 Finally Pays for Its Fraud." Freedom Foundation. April 2, 2019. https://www.freedomfoundation.com/litigation/three-years-later-seiu-775-finally-pays-for-its-fraud/

[47] *Araujo v. SEIU 775*, U.S. District Court for the Eastern District of Washington, Case No. 4:20-cv-05012-TOR.

[48] *Gatdula v. SEIU 775*, U.S. District Court for the Western District of Washington, Case No. 2:20-cv-00476. Sydney Phillips. "Another day, another union forgery attempt foiled." Freedom Foundation. April 15, 2021. https://www.freedomfoundation.com/litigation/another-day-another-union-forgery-attempt-foiled/

[49] Kevin Mooney. "She Never Joined a Union. But Union Fees Got Deducted From Her Paycheck." *The Daily Signal.* March 30, 2017. https://www.dailysignal.com/2017/03/30/she-never-joined-a-union-but-union-fees-got-deducted-from-her-paycheck/

[50] Minnesota Bureau of Mediation Services. Case No. 17PDE0404. Affidavit of Patricia Johansen. January 6, 2017. https://www.freedomfoundation.com/wp-content/uploads/2018/05/Minnesota-PCA-forged-signature-affadavit.pdf

[51] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

[52] Aaron Withe. "SEIU 503 refuses to honor opt-out requests." Freedom Foundation. January 11, 2018. https://www.freedomfoundation.com/labor/seiu-503-refuses-honor-opt-requests/

Groups of HCAs in California are presently engaged in litigation against their unions, UDW and SEIU 2015, for similarly refusing to end unwanted dues deductions from their Medicaid payments due to similar irrevocability provisions in membership and dues deduction authorization forms.[53]

The HCAs in these cases were/are represented by Foundation attorneys. Additional, similar cases may have been filed elsewhere without Foundation involvement.

B. Some states permit unions to solicit membership from HCAs in coercive, captive-audience settings.

As a further way to promote union dues deductions after *Harris,* several states have implemented *de facto* mandatory orientations and/or trainings at which union organizers pressure HCAs to sign the "irrevocable" dues deduction authorizations, often without informing them of their rights under *Harris* to refrain from such deductions. All eight states deducting union dues from Medicaid payments to HCAs as of 2017 allow for some union access to employee orientation or training programs.[54]

The experience of HCAs in Washington state — who participate in two captive audience meetings with union organizers during the onboarding process and at least one per year thereafter as part of their continuing education — documents just how coercive these settings can be.

Documents obtained by the Foundation from DSHS in 2017 indicated that the union, SEIU 775, had complained to state officials about agency staff remaining in the room during the union portion of HCA orientations and occasionally correcting the union organizers or informing attendees that dues payment is optional. One DSHS supervisor wrote in an email to a colleague how one of her staff "spoke up in response to IPs [individual provider home care aides] who were looking at her for help when they were being pushed into signing up" for membership by union representatives, triggering a union complaint.

In response, DSHS leadership directed field staff to "not be present during union presentation that way they don't feel compelled to ask questions or provide

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[53] *Quirarte v. United Domestic Workers of America, AFSCME Local 3930,* Ninth Circuit Court of Appeals, Case No. 20-55266.
National Right to Work Legal Defense Foundation. "California Homecare Providers File Class Action Lawsuit Challenging Union 'Escape Period' Scheme Used to Unlawfully Seize Dues." July 15, 2019. https://www.nrtw.org/news/california-homecare-providers-07152019/
Polk v. Yee and SEIU 2015, Ninth Circuit Court of Appeals, Case No. 20-17095.
National Right to Work Legal Defense Foundation. "
CA Home Healthcare Providers Appeal Suit Against SEIU for Skimming Dues from Medicaid Payments." October 23, 2020. https://www.nrtw.org/news/ca-home-care-providers-seiu-10232020/
[54] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

clarification."[55]

Additional documents obtained by the Foundation from DSHS in early 2018 shed further light on what happens during the HCA orientations. In the records, DSHS frontline staff describe SEIU 775 organizers presenting at the IP contracting appointments as, "aggressive," "forceful," "rude," "unprofessional," "coercive," "demanding," and "bullying." These same staff report caregivers feeling, "pressured," "misled," "tricked," "coerced," "intimidated" and "forced" into signing SEIU membership forms. In one case, DSHS staff report a caregiver being reduced to tears by the high-pressure tactics of two SEIU organizers.[56]

Another DSHS employee wrote in an email to their superiors that HCAs "express feelings of being pressured to sign the union card right away and lack of full disclosure" and explained that,

> "…after receiving the SEIU presentation it is not unusual for IPs to express frustration, confusion and sometimes anger at the contracting process, etc. which is then often directed at our staff. Staff have indicated concerns about what SEIU reps may be communicating to IPs that frequently results in IPs responding in a hostile or negative way…"[57]

In another email, a DSHS employee recounted how an SEIU organizer treated an HCA "rudely" at an orientation and how "a fair amount" of the information he provided "was incorrect."[58]

Finally, additional DSHS documents obtained by the Foundation in mid-2018 contained still more examples, with one DSHS employee writing about how HCAs were "poorly treated" and "bullied" by union organizers at the orientations and how they had heard of "horror stories" about HCAs "running out of the room when the Union reps were trying to 'force them to sign up to have extra money taken out of their checks and or donate.'"[59]

HCAs have even testified before the Washington State Legislature regarding the poor treatment and misinformation perpetuated by SEIU representatives at the orientations.[60]

The coercive nature of these captive-audience union presentations is enabled and

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[55] Maxford Nelsen. "DSHS Aiding SEIU Misinformation Of Home Care Workers." Freedom Foundation. February 8, 2017. https://www.freedomfoundation.com/labor/dshs-aiding-seiu-misinformation-of-home-care-workers/

[56] Maxford Nelsen. "DSHS allowing SEIU to continue exploiting caregivers." Freedom Foundation. January 29, 2018. https://www.freedomfoundation.com/labor/dshs-allowing-seiu-continue-exploiting-caregivers/

[57] *Ibid.*

[58] *Ibid.*

[59] Maxford Nelsen. "Records show continued SEIU harassment of caregivers." July 25, 2018. https://www.freedomfoundation.com/labor/records-show-continued-seiu-harassment-of-caregivers/

[60] Andrea Vangor. Testimony on Senate Bill 6229 before the Washington State Senate Labor and Commerce Committee. January 24, 2018. https://www.tvw.org/watch/?clientID=9375922947&eventID=2018011337&eventID=2018011337&startStreamAt=879&stopStreamAt=1028&autoStartStream=true

enhanced by the fact that these states have chosen to collect union dues and political contributions from HCA's Medicaid payments in violation of Subsection (a)(32) and without any intervention from CMS, since all unions need do to secure a nearly irrevocable right to a percentage of HCA's Medicaid payments is obtain or manufacture a provider's affirmative authorization.

Absent such deductions, unions could solicit membership and dues payments from providers directly — to be paid via check, credit card, electronic funds transfer, or other similar means — but would have no means to coercively or fraudulently access providers' Medicaid payments. By the same token, providers would have greater control over their decision to join and financially support a labor union or contribute to its political fund.

As CMS itself explained when it repealed 42 CFR § 447.10(g)(4) in 2019 and concluded Subsection (a)(32) "forecloses the ability of a practitioner to assign a portion of his or her Medicaid payment to a union," nothing prevents a provider from "voluntarily [agreeing] to automatic credit card or bank account deductions to pay for union dues once 100 percent of reimbursement has been received…"[61]

CMS should abandon the instant NPRM and instead move to protect HCAs from fraud and victimization by returning to the historic and correct understanding of Subsection (a)(32) as prohibiting any non-excepted diversions of Medicaid funds to third parties like labor unions.

<u>III. CMS' policy goals as stated in the NPRM do just justify the proposed regulation.</u>

In the NPRM, CMS points out that "Some states have sought methods to improve and stabilize the [personal care] workforce by offering health and welfare benefits to such practitioners, and by requiring that such practitioners pursue periodic training."

CMS reasons that allowing states to administer third party deductions from providers' Medicaid payments may help "[ensure] that the workforce has provisions for basic needs and is adequately trained for their functions, thus ensuring that beneficiaries have greater access to such practitioners and higher quality services," and assist states in countering high turnover among HCAs "by addressing training, wages and benefits." According to CMS, the proposed regulation "will ensure many of the country's most vulnerable workers, who care for the country's most vulnerable individuals, retain benefits which help them support themselves and their families."

While these stated goals are admirable, they fail to provide sufficient justification for CMS' proposed regulation, for three reasons.

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[61] *See* 84 FR 19718. https://www.federalregister.gov/documents/2019/05/06/2019-09118/medicaid-program-reassignment-of-medicaid-provider-claims

A. CMS' objectives for the regulation, even if laudable, are insufficient to overcome the statutory direct payment requirement.

Federal agencies may pursue policy changes, both praiseworthy and detrimental, only to the extent Congress has legislatively authorized them to do so. As the U.S. Supreme Court recently reaffirmed,

> "…our system does not permit agencies to act unlawfully even in pursuit of desirable ends. Cf. *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U. S. 579, 582, 585–586 (1952) (concluding that even the Government's belief that its action 'was necessary to avert a national catastrophe' could not over-come a lack of congressional authorization)."[62]

Subsection (a)(32), and other aspects of Medicaid's statutory and legal framework, simply do not permit the types of third-party deductions proposed by CMS in the NPRM.

B. Third-party deductions are unnecessary to achieve CMS' stated goals.

Legal issues aside, the regulation proposed by CMS in the instant NPRM is not necessary to increase HCAs' access to additional benefits or training.

As CMS informed DSHS officials in 2011,

> "Union dues, health insurance and training costs are not Medicaid-covered services when paid by themselves. States may develop rates that include considerations for costs related to health insurance and union dues; however, the entire rate must be 'paid' to the provider of personal care services and reported as income by that provider."[63]

If a state wishes to increase HCAs' Medicaid rates and HCAs decide to use the additional funds to purchase health insurance benefits, contribute to a retirement fund, pursue additional skills, complete mandatory training, pay for union membership, or contribute to a political funds, they are free to do so.

CMS offers no documentation in the NPRM supporting its speculative assertions about the necessity of payroll deduction. At most, CMS muses that allowing third-party payments may assist an HCA in maintaining "continuous health care coverage because the state automatically deducts funds for health insurance premiums on behalf of the practitioner."

The regularity of payroll deductions may have been distinctive in previous decades but, in the 21st century, the ease of arranging automatic, recurring payments via credit or debit

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[62] *Alabama Assn. of Realtors v. Department of Health and Human Servs.,* ___ S.Ct. ___, 2021 WL 3783142, *4 (August 26, 2021).

[63] *See* letter from Carol Peverly to Susan Dreyfus. May 25, 2011. Available online at: https://www.freedomfoundation.com/wp-content/uploads/2021/09/WA-DSHS-Personal-Care-Services.pdf

card or bank withdrawal provides a perfectly viable alternative.

Some may point out, correctly, that not everyone has access to financial services, potentially leaving some HCAs without the ability to arrange recurring third-party payments absent payroll deduction. However, according to the Federal Deposit Insurance Corporation (FDIC), 94.6 percent of American households were "banked" as of 2019, having access to a checking or savings account. Further, the percentage of "unbanked" households steadily declined from 8.2 percent in 2011 to 5.4 percent in 2019. The FDIC also reports that 56 percent of the remaining "unbanked" households reported having no interest in obtaining a bank account.[64]

Admittedly, the FDIC report does indicate that inability to meet minimum balance requirements was cited as a barrier to banking services by about half of unbanked households, a fact which some could use to argue the necessity of making payroll deduction available as a means of processing regular third-party payments for things like health insurance or union dues.

However, many states presently administering illegal payroll deduction arrangements for third parties have already moved to either facilitate or require HCAs to receive their Medicaid payments electronically.[65]

In Washington, for instance, HCAs can arrange electronic deposit of their payments. Further, the state is required to issue a debit card to any provider requesting one and to deposit the HCAs' payments on the card.[66] There's no reason such a debit card could not be used to arrange recurring payments for third-party payments desired by an HCA.

And in Connecticut, HCAs are required to receive payment electronically. Those who lack the ability to receive payments via electronic funds transfer are required to obtain a payment card from the state as a means of receiving their payments.[67]

Abiding by the statutory direct payment requirement allows HCAs the ability to better control how they spend their payments and shields them from the fraudulent and coercive behavior of third parties enabled by payroll deduction. As CMS explained when it repealed 42 CFR § 447.10(g)(4) in 2019, abiding by the direct payment requirement "puts Medicaid providers back in control of their reimbursements."[68]

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[64] Federal Deposit Insurance Corporation. "How America Banks: Household Use of Banking and Financial Services, 2019 FDIC Survey." October 2020. https://www.fdic.gov/analysis/household-survey/2019report.pdf

[65] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

[66] *See* Article 12.6 of the 2021-23 collective bargaining agreement currently in effect between the State of Washington and SEIU Local 775. Available online at: https://ofm.wa.gov/sites/default/files/public/labor/agreements/21-23/nse_homecare.pdf

[67] *See* Article 15 of the collective bargaining agreement currently in effect between the PCA Workforce Council and SEIU District 1199NE. Available online at: https://portal.ct.gov/-/media/Malloy-Archive/Personal-Care-Attendant-Workforce-Council/PCAWC-Doc---Collective-Bargaining-Agreement-2018.pdf

[68] *See* 84 FR 19718. https://www.federalregister.gov/documents/2019/05/06/2019-09118/medicaid-program-reassignment-of-medicaid-provider-claims

If CMS is correct when it argues in the instant NPRM that HCAs' ability to control payments to third parties "is critically important to improvements in workforce standards," then it should abandon the proposed regulation altogether.

C. There is little evidence that training provided by third parties meaningfully enhance the HCA workforce in a way that materially affects client care.

There is a lack of empirical evidence documenting that additional certification or training requirements for HCAs are effective at improving client care or even boosting workforce recruitment and retention.

For instance, CMS cites only a single study[69] to support its speculation that allowing states to divert Medicaid funds from providers to third parties may help ensure that "the workforce has provisions for basic needs and is adequately trained for their functions, thus ensuring that beneficiaries have greater access to such practitioners and higher quality services." But the study lends little support to CMS' position:

- The study sought to determine whether training and certification requirements increase direct care workers' total earnings or the likelihood that they work full-time or have access to employer-sponsored health insurance or retirement. This is decidedly different than measuring turnover rates or quality of care. Further, the study found that the improvements in designated job qualities were "quite modest."
- The study analyzed a sample including three kinds of direct care workers — home health aides, nurse aides, and psychiatric aides — without the ability to differentiate between them. Some, if not most, of these direct care workers were formally employed by home health agencies, nursing homes or other employers, and would not be subject to the proposed rule as "individual practitioners… for which the Medicaid program is the primary source of revenue."
- The study did not attempt to measure and reached no conclusions about the effect of additional training on the quality of care provided to clients.

Washington state's experience

In 2011, Washington voters approve Initiative 1163,[70] a union-backed ballot measure which created what are, to the best of this author's knowledge, the most robust training requirements for HCAs in the country, with most providers required to obtain and maintain a home care aide certificate by completing 75 hours of initial training and 12 hours of annual continuing education.[71] Washington state's experience with mandated

[69] Jeounghee Kim. "Occupational Credentials and Job Qualities of Direct Care Workers: Implications for Labor Shortages." *Journal of Labor Research*, 41, 403–420 (2020). https://link.springer.com/article/10.1007%2Fs12122-020-09312-5

[70] Bailey Ludlam. "Washington Long-Term Care, Initiative 1163 (2011)." Ballotpedia. Accessed September 28, 2021. https://ballotpedia.org/Washington_Long-Term_Care,_Initiative_1163_(2011)

[71] Washington State Department of Health and Human Services. "Individual providers." Accessed September 28, 2021. https://www.dshs.wa.gov/altsa/home-and-community-services/individual-providers

training requirements for HCAs serving Medicaid clients has produced, at best, mixed results.

As a result of the initiative, all training for independent HCAs must be provided by a single "training partnership" selected by the HCAs' union, SEIU 775.[72] Unsurprisingly, the training partnership selected by SEIU 775 was one that it created and that it claims is now the largest such training operation for HCAs in the country.

Under the terms of the union's collective bargaining agreement, the State of Washington currently pays the SEIU Training Partnership $0.44 for every hour worked by an HCA.[73] The Partnership reported total revenue of $42.3 million on its tax return for FY 2019-20.[74] SEIU 775 and the Training Partnership share officers, office space and a call center. And the state's financial obligations towards the Training Partnership have proven lucrative for SEIU 775 as well. In calendar year 2020, SEIU 775 was paid $3.2 million by the Training Partnership for services the union provided.[75]

The state's statutorily required financial obligation to the Training Partnership as the monopoly provider of mandated training to independent HCAs has, predictably, limited providers' choices, resulted in substandard customer service, and has made it difficult for some rural providers to access required training. After all, the Training Partnership's revenue is completely untethered from its performance.

And alternatives are available. In fact, over 50 other entities are certified by DSHS to offer the same 75-hour long-term care training provided by the Training Partnership — they just can't service the independent HCAs SEIU 775 represents.[76]

Despite the hundreds of millions of Medicaid dollars paid to the Training Partnership since passage of I-1163 in 2011, recruitment and retention challenges continue to plague the state, and a series of audits conducted by the Washington State Auditor suggests the stringent training requirements bear at least part of the blame.

A 2014 audit found that, despite efforts in prior years to improve the completion rate, only one-third of persons seeking a home care aide certification completed the training and were certified within required deadlines. The auditor noted that, "Program managers told us they believe that the failure of workers to complete the certification has resulted in

[72] *See* RCW 74.39A.360.
[73] *See* Article 15 of the 2021-23 collective bargaining agreement currently in effect between the State of Washington and SEIU Local 775. Available online at: https://ofm.wa.gov/sites/default/files/public/labor/agreements/21-23/nse_homecare.pdf
[74] The most recent Form 990 filed by the Training Partnership with the Internal Revenue Service is available online at: https://apps.irs.gov/pub/epostcard/cor/510673005_202006_990_2021052618210524.pdf
[75] *See* Schedule 14 of SEIU 775's LM-2 report to the U.S. Department of Labor for 2020. Available online at: https://olmsapps.dol.gov/query/orgReport.do?rptId=747518&rptForm=LM2Form
[76] Washington State Department of Social and Health Services. "Find a Training Class." Accessed September 28, 2021. https://fortress.wa.gov/dshs/adsaapps/Professional/training/training.aspx

a higher turnover rate, which can affect continuity of care for clients."[77]

The audit further reported that,

> "Program managers recognize that both completion rates and timeliness need to be improved, but point out that some factors are outside their control. For example, some people caring for a family member might decide not to pursue the 75 hours of required training needed to gain the certificate. Agency officials suggested that some workers leave the home care aide certificate program to pursue other types of certifications. For example, becoming a certified nursing assistant requires about 10 additional training hours but may lead to greater employment opportunities. Some people simply change their minds about working in the field, and others fail background checks. All these reasons affect home care aide certificate completion rates."[78]

In other words, the training requirements themselves were problematic.

A subsequent audit in 2016 found that the home care aide "certification completion rates have remained flat" despite efforts to increase passage, including by lowering exam passing scores.[79] Of course, the Training Partnership gets paid the same regardless of the success or failure of its trainees in passing the state home care aide certification exam.

Finally, the most recent state audit from 2019 examined reducing training requirements for certain caregivers as a way to boost recruitment:

- "Broad demographic trends and various studies suggest a growing need for long-term care, though it is difficult to quantify. Those trends and studies also suggest there will be an insufficient number of caregivers to meet that need."
- "The expected shortages in long-term care workers mean that families of people with disabilities, including those who are eligible for Medicaid, will likely face challenges in finding qualified caregivers. One possible way to address future unmet need is to expand training and certification exemptions beyond those currently afforded to parents and adult children."
- "By reducing the training requirements and offering the flexibility of online training, extended family members may be more inclined to become individual providers and be paid for their services."

Overall, the auditor concluded with no recommendations given the lack of hard data

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[77] Washington State Auditor's Office. "Initiative 1163: Long-Term Care Worker Certification Requirements." December 18, 2014. https://portal.sao.wa.gov/ReportSearch/Home/ViewReportFile?arn=1012952&isFinding=false&sp=false
[78] *Ibid.*
[79] Washington State Auditor's Office. "I-1163: Long-term Care Worker Certification Requirements 2016." August 4, 2016. https://portal.sao.wa.gov/ReportSearch/Home/ViewReportFile?arn=1017262&isFinding=false&sp=false

about the effect broadening exemptions would have.[80]

Despite repeated studies by the auditor, no empirical evidence to-date suggests that Washington's state's training requirements have measurably improved client care.

To the extent training requirements for HCAs are valuable, Washington states experience suggests that more is not always better. Further, HCAs should have access to multiple training providers, a choice they likely will not have in the event the state selects a preferred or required training provider to be funded via payroll deductions.

IV. If CMS proceeds with the rule, it should modify it to require written consent from practitioners for any third-party deductions

CMS notes in the NPRM that it "considered but did not propose to require explicit written provider consent for deductions out of concern that codifying a requirement for written consent could unintentionally result in a conflict with state law." Nonetheless, CMS solicited comments addressing "whether to include a CMS requirement for written provider consent or to remain silent on the form such consent must take and to defer to existing state law and regulation."

As explained above, the proposed regulation is legally at odds with Subsection (a)(32)'s direct payment requirement and other aspects of Medicaid's legal framework. These infirmities would not be cured by the addition of a written authorization requirement to the proposed regulation. Similarly, state laws permitting such deductions at all, no matter how authorized, are already in conflict with federal law.

However, if CMS is to proceed with promulgation of the proposed rule, it should incorporate a written authorization requirement for third-party deductions from providers' payments, which would discourage some of the coercive behavior perpetrated by labor unions against HCAs.

In Washington state, for instance, union deductions may be initiated from an HCA's paychecks upon the provider's "written, electronic, or recorded voice authorization."[81] In practice, this means that the union may solicit membership telephonically, a practice that has proven to be particularly deceptive.

Over the years, the SEIU 775 Benefits Group — a nonprofit affiliated with the union representing HCAs — has taken over management of state-funded benefits for HCAs, including health insurance, training and retirement. SEIU 775's "member resource center" (MRC) serves as the call center both for the union and for the Benefits Group. Consequently, any HCA with a question about his or medical benefits or training must phone the union's call center.

HCAs report that, before MRC staffers answer any questions, they will pressure the HCA to orally reauthorize their union membership over the phone. An anonymous letter sent to the

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[80] Washington State Auditor's Office. "Assessing Extended Family Exemptions for Individual Providers." February 21, 2019. https://sao.wa.gov/wp-content/uploads/Tabs/PerformanceAudit/PA_I-1163-Extending_Family_Exemptions_ar1023358.pdf

[81] See RCW 41.56.113.

Foundation by a person claiming to work in the MRC detailed how staffers are directed, "under the threat of being fired, to solicit and lie to members, to record membership messages and obtain signature over the phone using deceptive way"[82] (errors in original).

One HCA took legal action against the union after he agreed to membership over the phone under the mistaken belief he had to do so to address an issue with his state-funded medical benefits.[83]

SEIU 775's current membership form is nearly 2,000 words of legalese. The form not only authorizes the state to deduct 3.2 percent of the IPs' wages for SEIU 775 but makes the deductions "irrevocable" for at least one year. The terms also waive the IP's right to sue the union for certain illegal dues collections and gives the union authorization to obtain the caregiver's personal bank account and credit card information from the state for the purpose of collecting dues if necessary.[84]

In other words, properly understanding a *written* copy of SEIU 775's membership form is difficult. It is impossible to meaningfully understand over the phone.

Requiring that states first secure written authorization from HCAs before implementing third-party deductions from their paychecks would better ensure that HCAs have a chance to review the terms to which they are agreeing in writing and would make it more difficult to mislead HCAs into oral agreements they may not fully understand or intend.

V. The NPRM is procedurally deficient

A. CMS failed to properly solicit stakeholder input prior to publication of the NPRM.

Executive Order 13563, Sec. 2(c) requires that,

> "Before issuing a notice of proposed rulemaking, each agency, where feasible and appropriate, shall seek the views of those who are likely to be affected, including those who are likely to benefit from and those who are potentially subject to such rulemaking."

In this case, affected stakeholders would include at least state Medicaid agencies, Medicaid providers and advocates, client advocacy groups and the third parties that would benefit from the deductions. As an organization that has spent years working with thousands of HCAs, litigating on their behalf, and engaging in writing and research on the subject, the Foundation could reasonably expect to have been included in such agency

[82] A copy of the letter is available online at: https://www.freedomfoundation.com/wp-content/uploads/2016/05/SEIU-staff-letter-to-FF-March-19-2016.pdf
[83] Maxford Nelsen. "Freedom Foundation challenges SEIU 775's telemarketing campaign." Freedom Foundation. March 12, 2019. https://www.freedomfoundation.com/labor/freedom-foundation-challenges-seiu-775s-telemarketing-campaign/
[84] A copy of SEIU 775's current membership form is available online at: https://www.freedomfoundation.com/wp-content/uploads/2018/07/SEIU-775-membership-form-version-6-clean.pdf

outreach. However, nothing in the NPRM indicates that CMS conducted any intentional public outreach to stakeholders prior to publication of the NPRM.

Further, given that, at least as of January 2021, CMS itself contended that non-excepted third-party deductions from providers' payments were statutorily impermissible, Secretary of the Department of Health and Human Services Xavier Becerra wasn't confirmed by the Senate until March 18, and CMS administrator Chiquita Brooks-LaSure was not sworn in until May 27, there is no reason to believe that CMS had time to evaluate and revise its position, conduct intentional stakeholder outreach, and process related feedback prior to the publication of the NPRM on August 3.

Finally, reference to CMS' prior rulemaking regarding the creation of 42 CFR § 447.10(g)(4) is insufficient. Not only did the promulgation of the rule occur nearly eight years ago, but CMS received only seven public comments regarding its proposal.[85]

In its haste to reinstate a legally impermissible, unnecessary regulation that subjects HCAs to fraud and coercion while benefitting third-party groups with a financial interest in the illegal payroll deductions, CMS has failed to properly engage with the regulated community in violation of its procedural obligations. No additional rulemaking should occur until the required stakeholder engagement has taken place.

B. The proposed rule is a "significant regulatory action" requiring a regulatory impact analysis.

As CMS notes in the NPRM, agencies are required to conduct a regulatory impact analysis (RIA) of any "significant regulatory action," defined by Executive Order 12866 as one that "is likely to result in a rule that may… [h]ave an annual effect on the economy of $100 million or more…"

CMS claims such an analysis of the proposed rule is unnecessary, estimating that the rule "will be budget neutral or have a minimal economic impact that is unlikely to have an annual effect on the economy in excess of the $100 million threshold of Executive Order 12866."

"State budgets will not likely be significantly affected," CMS reasons, "because the operational flexibilities in the proposed rule would only facilitate the transfer of funds between participating entities, rather than the addition or subtraction of new funds."

At the same time, however, CMS also claims in the NPRM that the proposed rule is necessary because it would increase "benefits that provide the workforce with freedom to advocate for higher wages and career advancement, access necessary trainings, and options for other customary employee benefits."

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[85] *See* 79 FR 2947. https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

Both cannot be true at once. Either (1) the rule is budget neutral, allowing CMS to forgo an RIA, and the agency's stated policy justification of increasing wages, benefits, training and stability of the HCA workforce will be unrealized, or (2) the rule will advance CMS' stated goals but increase federal and state costs of procuring HCA services, requiring an RIA that has not been conducted.

The contradictions do not end there.

CMS claims in the NPRM that the rule will have "no impact on individual practitioners" as justification for forging an RIA. At the same time, CMS admits the proposed regulation "would allow states to deduct payments from provider's payment with their consent" under enumerated circumstances, that it lacks any "substantive analysis of the economic impact of this rule," and invites public comments estimating the "types and amounts deducted from individual providers for payment to third parties, broken down by benefit that may be included under § 447.10(i)."

In reality, the best available evidence indicates that third-party deductions from HCAs' Medicaid payments well exceed the $100 million threshold for an RIA.

Relying on public sources, union financial reports and FOIA-type requests to state governments, a comprehensive, 117-page Foundation research paper documented that, in 2017 alone, the states of California, Connecticut, Illinois, Massachusetts, Minnesota, Oregon, Vermont and Washington deducted $146.6 million in union dues from the Medicaid payments of 358,000 HCAs, well above the threshold to trigger an RIA.[86]

The report did not attempt to document the amount deducted by these states for political contributions, health insurance, or other benefits.

Additionally, the total amount of dues so deducted has likely continued to increase in the years since 2017. According to the annual LM-2 forms submitted to the U.S. Department of Labor by SEIU Local 2015, one of the two large unions representing Medicaid-paid HCAs in California, its revenue from dues — collected by the state via payroll deduction — increased 13 percent, from $78.8 million in 2017[87] to $89.1 million in 2020.[88]

UDW, the other union representing California's Medicaid paid HCAs, reported a more moderate increase in revenue, from $25.8 million in 2017[89] to $26.6 in 2020.[90]

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[86] Maxford Nelsen. "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity." Freedom Foundation. July 18, 2018. https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf

[87] *See* Statement B, line 36 of SEIU 2015's 2017 Form LM-2. Available online at: https://olmsapps.dol.gov/query/orgReport.do?rptId=668930&rptForm=LM2Form

[88] *See* Statement B, line 36 of SEIU 2015's 2020 Form LM-2. Available online at: https://olmsapps.dol.gov/query/orgReport.do?rptId=750539&rptForm=LM2Form

[89] *See* Statement B, line 36 of UDW's 2017 Form LM-2. Available online at: https://olmsapps.dol.gov/query/orgReport.do?rptId=670792&rptForm=LM2Form

[90] *See* Statement B, line 36 of UDW's 2020 form LM-2. Available online at: https://olmsapps.dol.gov/query/orgReport.do?rptId=752424&rptForm=LM2Form

Nevertheless, the two California unions alone cumulatively collected $115.7 million in dues from HCA's Medicaid payments in 2020, enough of a redistributive "effect on the economy" to exceed the threshold for an RIA without even taking other states, unions or deduction types into account.

The fact that these deductions are already occurring in defiance of the statutory direct payment requirement should have no bearing on estimates of the economic impact of the proposed rule, which attempts to legalize such deductions. Further, it is possible that additional states will implement additional types of deductions if CMS sanctions their ability to do.

VI. Conclusion

The Foundation appreciates the opportunity to submit comment on the NPRM. Unfortunately, however, we must respectfully urge CMS to abandon the proposed regulation, which would conflict with the statutory direct payment requirement in Subsection (a)(32), undermine the legal framework governing Medicaid, depart from CMS past interpretation of the law, and subject HCAs to continued fraud and coercion at the hands of third parties like labor unions with a financial interest in accessing providers' payments via payroll deduction. Further, CMS has failed to prove that the regulation is necessary to advance the goals of a more stable, better trained HCA workforce, or that it would even materially contribute to those goals. Finally, the NPRM is premature given CMS' failure to consult with stakeholders before publishing the proposed rule and its decision to forgo an RIA despite the best available evidence indicating the rule would have an economic impact of greater than $100 million.

Respectfully,

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