August 5, 2021

The Honorable Charles Schumer
United States Senate
Washington, D.C. 20510

The Honorable Bob Casey
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
United States Senate
Washington, D.C. 20510

The Honorable Tammy Duckworth
United States Senate
Washington, D.C. 20510

The Honorable Maggie Hassan
United States Senate
Washington, D.C. 20510

The Honorable Sherrod Brown
United States Senate
Washington, D.C. 20510

The Honorable Debbie Dingell
United States House of Representatives
Washington, D.C. 20510

The Honorable Frank Pallone
United States House of Representatives
Washington, D.C. 20510

The Honorable Jan Schakowsky
United States House of Representatives
Washington, D.C. 20510

The Honorable Doris Matsui
United States House of Representatives
Washington, D.C. 20510

RE: Better Care Better Jobs Act (S. 2210/HR 4131)
ANCOR Written Comments

Dear Leader Schumer, Chairman Casey, Chairman Wyden, Senators Duckworth, Hassan and Brown and Representatives Dingell, Pallone, Schakowsky, and Matsui,

On behalf of the American Network of Community Options and Resources ("ANCOR"), thank you for the opportunity to provide feedback on the Better Care Better Jobs Act ("BCBJA"), S. 2210/HR 4131. The BCBJA highlights crucial services and a dedicated direct care workforce which supports seniors and people with disabilities to remain in their own homes and communities. Dependent on states to set reimbursement, the direct care workforce has been decimated by the economic impact of the COVID-19 pandemic leaving American families without critical support and people with disabilities at increased risk of hospitalization and institutionalization.

ANCOR is a national, nonprofit trade association representing more than 1,600 private community providers of services to people with intellectual and developmental disabilities ("I/DD"). Combined, we support over one million individuals with disabilities and work collaboratively to shape policy, share solutions, and strengthen community. Our members assist people with I/DD to live full and independent lives by providing services and support for

instrumental activities of daily living. Home and community-based services is the heart of our efforts, as our members rely almost exclusively on Medicaid funding.

We are grateful for your insight and leadership in the development of the BCBJA which gives hope to providers, direct care workers, and American families to secure meaningful access to home and community-based services with a sustainable workforce. The effects of underinvestment in the direct care workforce can be seen in turnover rates among direct support professionals that hover near 50 percent nationally. The resulting inaccessibility of home and community-based services for people with disabilities is evidenced by the nearly 600,000 people with IDD waiting for authorization to receive services and countless more waiting for available providers to provide them.

The proposed $400B for states to develop and implement sustainable infrastructure improvement plans is critical to ensuring a foundational and demonstrable path forward for states to address sustainable solutions to the access and workforce crisis. Without full investment, states and community stakeholders will continue to scramble with scarce resources for stop-gap approaches to access barriers and workforce shortages. This legislation's two-part method to fund plans and require reportable data and quality metrics will not only give states the tools necessary to substantively address the access and workforce crisis, but the framework to independently continue building sustainability.

ANCOR offers the following comments, suggestions, and requests for clarification in overwhelming support for the BCBJA and its intended purpose. The investments we make in our home and community-based services infrastructure now will sustain an industry of caring and hardworking professionals while ensuring access to home and community. The resulting economic impact from expanding meaningful employment opportunities and offsetting expensive hospitalization and crisis services will positively impact the nation.

We have organized our feedback by section below, touching upon broad themes and specific recommendations that arose within those topics.

Engagement Generally

ANCOR applauds the BCBJA for prioritizing transparency and stakeholder engagement in expanding access to home and community-based services and strengthening the direct care workforce.

Full inclusion of stakeholder voices is necessary to inform policy of quality and practical application. Requiring engagement with eligible families, providers, and other relevant stakeholders is critical to the success of home and community-based services programs. For further clarification, we recommend inclusion of family and provider engagement in the following sections:

"[A] description of barriers to accessing home and community-based services identified by eligible individuals, families of such individuals, and providers of home and community-based services."[1] Pg. 8 line 14.

"A description of how the quality of home and community-based services is measured and monitored, including how the State uses provider, family caregiver, and beneficiary experience of care surveys to assess the quality of home and community-based services provided by the state."[2] Pg. 9 line 24.

Sec. 2. Definitions

Direct Care Worker/Direct Care Workforce

ANCOR recommends further clarification to the term "direct care worker; direct care workforce" and removal of "a direct care worker"[3] from the definition as duplicative.

We appreciate the broad definition of home and community-based services[4] which demonstrates the extensive landscape contributing to community access and required descriptions for eligibility, access, utilization, structures, payment rates, and corresponding demographics. Clarifying the direct care workforce within that structure will target strategy to stabilize workforce shortages necessary to prevent unnecessary hospitalizations or institutionalizations from the community. Moreover, it may encourage overwhelmed states to participate in planning grants which address immediate need.

As the broad definition includes a wide variety of services with differing delivery models, it becomes critically important to target the BCBJA's intended workforce infrastructure. Further defining direct care worker to identify individuals providing support services necessary for activities of daily living and promoting independence will assist states in addressing areas of extreme workforce shortages with high turnover and vacancy rates. This may also assist states in acknowledging home and community-based services positions not traditionally understood as direct care, including but not limited to, employment services and transportation.

As the workforce shortages have reached crisis level, providers are forced to pull from other designated positions to cover direct care worker vacancies. Qualified administrative and managerial staff routinely provide direct care in addition to their normal duties to ensure continuity of care. This has led to similar vacancies and turnover in supervisory positions holding the frontline during times of extreme and unanticipated shortages. ANCOR recommends the definition focus on the services performed in lieu of titled positions to be inclusive of all workers providing direct care during these unprecedented times.

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[1] Section 101(b)(1)(B)(v)
[2] Section 101(b)(1)(G)
[3] Section 2(2)(C); Pg. 3, line 3.
[4] Section 2(6); Pg. 3, line 23

Competitive Wages and Benefits

We strongly recommend further definition of "competitive wages and benefits"[5] and direction to the Director of the Office of Management and Budget to revise the Standard Occupational Classification system to establish a separate code for direct support professionals as a healthcare support occupation as a subset of 31-1120.

1. Direction to establish a Standard Occupational Classification

ANCOR consistently advocates for the inclusion of a Standard Occupational Classification ("SOC") for direct support professionals for collecting, calculating, and disseminating data specific to demographics and wages and benefits. Currently, the Bureau of Labor Statistics informally categorizes direct support professionals under the broader category of "home health care aides", making it impossible to accurately track workforce trends. Without specific classification, states are left to independently determine what is "competitive" within direct care often through blending and piecemealing unrelated statistics. This has allowed wages to remain low and stagnant with unrelated entry-level industries when compared against other healthcare positions.

We recommend inclusion of the following section to provide this direction:

<u>REVISION OF STANDARD OCCUPATIONAL CLASSIFICATION SYSTEM. The Director of the Office of Management and Budget shall, not later than 30 days after the date of enactment of this Act, revise the Standard Occupational Classification system to establish a separate code (31-1123) for direct support professionals as a healthcare support occupation.</u>

2. Definition of competitive wage and benefits

Requiring evidence that direct care workers receive competitive wages and benefits without further definition may inadvertently incentivize states to continue utilizing inappropriately low benchmarks. Home and community-based services providers across the country are reducing services and foregoing basic benefits striving to match wage with retail, convenience, and fast food offering permanent hazard pay. Even so, direct care workers that remain in the field are still working extreme overtime with second and third jobs to make ends meet. Direct care workers are dedicated, trained, and qualified professionals delivering life sustaining supports and services and deserve a living wage[6] competitive with positions which require the same skill, training, and experience.

Though the BCBJA offers hope to stabilize the industry, we understand that undoing decades of damage to the workforce will take time and intentional focus. We request that quality benchmarks, such as competitive wage and benefits, be clearly defined with value for the position direct care workers hold in the healthcare industry. We also request the competitive wages benchmark require states to comprehensively report and determine methodology for

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[5] Section 102(a)(2); Pg. 34, line 15, Pg. 38, line 9.

[6] <u>See</u> Glasmeier, Amy K. Living Wage Calculator. 2020. Massachusetts Institute of Technology: livingwage.mit.edu.

calculating competitive wage and benefits through a transparent engagement process with community stakeholders.

Existing Medicaid HCBS Landscape

Access

The requirement to define and assess access to services[7] is key to addressing the existing home and community-based services landscape.

Though access is required under the Social Security Act, states have little obligation to demonstrate compliance with this provision and provide access to home and community-based services. For stakeholders in states with access concerns, requiring an assessment and ongoing reporting is instrumental to defining and demonstrating meaningful expansion of that access. The factors included in the assessment are vital to building a foundation for growth.

As home and community-based services founded in community integration, we recommend including a requirement to assess the extent to which home and community-based services are available through enrolled providers to beneficiaries in each geographic area of their community. We also recommend a corresponding description of home and community-based services not available in each geographic area due to provider capacity.[8] Finally, we request a transparent input process for stakeholders to identify other key factors for defining access specific to their state and service delivery model.

Utilization

Similarly, we request further clarification that the assessment of utilization[9] is not limited to a binary assessment of whether an individual is receiving services. The assessment must be comprehensive and able to identify when partial services are received due to lack of provider capacity. As further illustration, the utilization assessment must be able to capture if an individual requires seven (7) hours of in-home support per day and is only able to access four (4) due to short staffing.

Maintenance of Effort Requirements

ANCOR appreciates the maintenance of effort requirements which protect beneficiaries from losing further access to critical home and community-based services by a narrowing scope of eligibility and authorization. We request the addition of a prohibition against reimbursement rate reductions with respect to the period for which the State is awarded a planning grant. As addressed above, access to services is significantly impacted by the availability of services through provider capacity. If providers continue to lose workforce and capacity through reduced

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[7] Section 101(b)(1)(B); Pg. 7, line 19.

[8] For example, while there may be an enrolled home and community-based services' provider within a given town, that enrollment is meaningless to the beneficiary if the provider does not have workforce to provide the required services.

[9] Section 101(b)(1)(C); Pg. 8, line 18.

reimbursement, beneficiaries will in turn lose access and choice of provider regardless of eligibility and authorization.

Strengthened and Expanded Workforce

ANCOR is supportive and appreciative of the provisions addressing insufficient reimbursement rates with update at least every two (2) years through a transparent process[10].

The nationwide direct care workforce crisis is directly attributable to providers' inability to maintain workforce with stagnant reimbursement rates left unadjusted for inflation, rising costs, and increased industry standards for decades at a time. To maintain minimum staffing, providers are forced to make cuts to programs, training, and quality standards to shift funding to meet minimal wages. With consistent underfunding and increased expenses, providers have limited options left to further cut employees, programs, and general administrative expenses to remain operational.

With this in mind, we request further clarification of the use of the term "proportionately" with respect to passing increases through to direct care workers. We have concerns that if the intent is to pass the entirety of increase through to wage this may inadvertently continue other quality shortfalls. In order to increase wages for direct care workers, providers have already reduced or terminated programs, services, and benefits. It is critical that reimbursement rates consider the necessity of rebuilding quality services and employee retention of which wage is one crucial component.

We recommend the following edits to provide this clarification:

> *(aa) ~~at minimum, proportionately~~ passed through to direct care workers with consideration for employee and program related expenses and in a manner that is determined with input from the stakeholders described in subclause (II).*[11]

Similarly, the description of payment rates be revised to "A description of the payment rates for home and community-based services, including when such rates were last updated, an assessment of the extent to which authorized services are not delivered as a result of such rates being insufficient, the extent to which payment rates are passed through to direct care workers' wages, and the impact of such rates on provider capacity."[12]

We also recommend clarifying reference to updating payment rates to specify updating *each* payment and reimbursement rate for home and community-based services. Though we acknowledge the process of reviewing and updating reimbursement rates may be lengthy, we believe requiring a two-year schedule is necessary to prioritize and build necessary infrastructure within state systems to address rising costs in service delivery. Allowing reimbursement rates to languish from neglect and long wait times has created and contributed to the direct care workforce crisis.

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[10] Section 102(a)(2); Pg. 27, line 12.
[11] Section 102(a)(2); Pg. 28, line 4.
[12] Section 101(b)(1); Pg. 9, line 26.

HCBS Improvement to Support Self-Directed Models for the Delivery of Services

ANCOR understands and appreciates provisions to ensure an adequate number of direct care workers are available to assist beneficiaries to choose and utilize self-directed models.

We seek clarification that funding to contract with a third-party entity to register, recruit, train, etc. direct care workers[13] is limited to self-directed services through independent practitioners. Though we appreciate building further infrastructure into self-directed services, much of these requirements are already state and federally mandated through provider agencies. Duplication of this effort outside of self-directed services may inadvertently create competing systems with additional administrative barriers and requirements further disincentivizing direct care workers from the field.

We have also heard concern from ANCOR members that requiring this type of registration may have a chilling effect on direct care workers providing self-directed services. Many direct care workers providing self-directed services have prior-established familial or other relationships with the person receiving services. In these cases, those direct care workers are more often motivated by the relationship and not open to coordination with other services or beneficiaries. By requiring their participation in a broader registry, we may unintentionally further dissuade their participation in the program.

For these reasons, we recommend clarifying self-directed direct care worker participation in a separate registration process as optional with opt-in consent required. As some states have already moved forward in establishing directories for similar purposes, we also recommend restating use of the term "registering" to "supporting voluntary participation in directories established to assist beneficiaries in finding direct care workers."[14]

Quality, Reporting, and Oversight

We request further clarity to distinguish the activity of the HCBS ombudsman office[15] from current required oversight entities.

ANCOR supports all measures to improve core quality measures for home and community-based services. Our concern is the potential for duplication of effort and administrative response to individual and systemic issues repeatedly identified in reports, surveys, and the BCBJA itself. There are numerous entities currently required to independently provide direct assistance and identify systemic problems including Protection and Advocacy agencies, councils, and program integrity systems.

With this comment, we seek to emphasize the necessity of directing funding to address the systemic issues currently within home and community-based services systems without further administrative delay restating the concerns.

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[13] Section 102(a)(2); Pg. 28, line 22
[14] Section 102(a)(2); Pg. 29, line 5
[15] Section 102(a)(2); Pg. 31, line 15

Permanent Extension of Money Follows the Person Rebalancing Demonstration

We wish to express our sincerest gratitude and appreciation for the inclusion of a permanent extension of Money Follows the Person. The funding and corresponding programs have been instrumental in supporting individuals with disabilities to transition from institutional care into their own homes and community. The funding flexibility in Money Follows the Person has allowed focus on the global needs of the individual in transition unburdened by Medicaid limitations supporting a true person-centered approach to community care.

Thank you for this opportunity to provide comment and please reach out to me at ldawson@ancor.org if we can provide further clarification or information to the above.

Sincerely,

Lydia Dawson, J.D.
Director of Policy, Regulatory, and Legal Analysis