SB197 Testimony.pdf
Uploaded by: Alex Berezin
Position: FAV

COMPLETE HOME CARE
90 Painters Mill Rd, Suite 215
Owings Mills, MD 21117
Ph: (410) 343-4353 Fax: (410) 343-4393

Dear Members of the Senate Finance Committee,

I am writing to express my strong support for SB0197. As CEO of Complete Home Care and someone who has been in the home and community based service industry for over 14 years, I believe it is important to ensure that personal care aides who work under Medicaid programs are properly classified as employees and not misclassified as independent contractors.

It is unacceptable that, despite enforcement efforts by the U.S. Department of Labor and guidance from the Office of the Attorney General, many home care agencies continue to misclassify these workers. As someone who has seen the effects of misclassification, I understand the harm it can cause to both the workers and the consumers. This misclassification affects not only the workers, who are denied benefits and face a higher tax burden, but also the clients who depend on them for their independence, the law-abiding home care agencies that face unfair competition, and the state of Maryland, which is deprived of critical revenue. It is unacceptable that the current system allows for such widespread misclassification, leading to a decline in job quality and a reduction in the social safety net for the workers.

I am grateful that SB197 offers a solution to this long-standing problem. By requiring the Maryland Department of Health to only reimburse residential service agencies if the personal care aides are classified as employees, this bill will level the playing field for law-abiding agencies, professionalize the workforce, improve the quality of care, and ensure that public dollars are not used to violate the law.

One issue that has been brought up by agencies not in support of this bill are family caregivers that work overtime. Even with overtime pay, agencies are still able to pay at or above the minimum wage and be in compliance with all labor laws, including but not limited to carry workers compensation coverage. If the FLSA law states that all caregivers, regardless of relationship, should be classified as employees and required to receive all employee benefits, why would Medicaid not want to make sure that all agencies are complying with labor standards?

In conclusion, I urge you to support SB0197 and ensure that personal care aides are properly classified as employees. This bill would provide a simple solution that will benefit all parties involved. Thank you for your time and consideration.

Sincerely,

Alex Berezin

Oral Testimony SB197 Misclassification.docx.pdf
Uploaded by: Allison Yunda
Position: FAV

NATIONAL DOMESTIC WORKERS ALLIANCE

Comments in Support of SB197
Homecare Worker Rights Act of 2024
Residential Service Agencies - Reimbursement - Personal Assistance Services

February 5, 2024

Submitted via:
https://mgaleg.maryland.gov/mgawebsite/MyMGATracking/WitnessSignup

The National Domestic Workers Alliance ("NDWA") submits this testimony in support of SB197, *Homecare Worker Rights Act of 2024*.

My name is Allison Yunda and I am the Maryland Lead Organizer for the National Domestic Workers Alliance, otherwise known as NDWA. We are the leading voice for the estimated 2.2 million domestic workers who work as direct care workers, nannies , and house cleaners in private homes providing essential care and supportive services to children, aging adults, and family members with disabilities. While we are a national organization, our DMV chapter is a locally operated, membership-based organization covering the area of Washington DC, Maryland, and Virginia and is staffed by several local organizers.

Domestic and care workers comprise a growing workforce that has been historically excluded from basic workplace protections such as minimum wage, overtime, anti-discrimination protections, health and safety, and the right to organize. NDWA has led the movement both at the federal and state level to pass legislation to eliminate the exclusions. Unfortunately, the rampant misclassification in the home care industry undermines these efforts and enables employers to evade minimum wage, overtime, and other labor laws that home care workers have fought for.

NDWA supports this bill to specifically protect direct care workers employed by agencies in the home care industry who are regularly misclassified as independent contractors and subsequently denied their critical workplace rights, including the right to overtime, earned sick leave as well as coverage under worker's compensation, and unemployment insurance.

More than 750 Residential Service Agencies or RSA's provide care for beneficiaries of Medicaid's Home and Community Based Programs and are paid through public funds. Because of the structure of Maryland's Medicaid program, all personal care aides this bill covers are already employees under the law. This bill would prevent

misclassification by providing that RSAs will only be reimbursed for in-home personal care under certain Medicaid programs if those who do the work are classified as employees. It is a simple solution to a serious problem. Maryland must ensure that residential services agencies receiving public dollars are abiding by tax and labor laws and this measure would protect the direct care workforce from exploitation.

Domestic and direct care workers have for too long been excluded from core workplace protections, which stems from the racist and sexist devaluing of household and caregiving work. Misclassification is another tool for employers to utilize to evade the critical benefits they need to provide a sense of dignity on the job.

For these reasons, the National Domestic Workers Alliance (NDWA) fully supports HB39/SB197 Homecare Worker Rights Act of 2024.

Sincerely,

Allison Yunda
Maryland Lead Organizer
DMV Chapter
National Domestic Workers Alliance (NDWA)
ayunda@domesticworkers.org

Reena Arora, Esq.
Director of Care Policy

NDWA
reena@domesticworkers.org

SB197 Misclassification Written Testimony.docx.pdf
Uploaded by: Allison Yunda
Position: FAV

Comments in Support of SB197
Homecare Worker Rights Act of 2024
Residential Service Agencies - Reimbursement - Personal Assistance Services

February 7, 2024

Submitted via:
https://mgaleg.maryland.gov/mgawebsite/MyMGATracking/WitnessSignup

The National Domestic Workers Alliance ("NDWA") submits this testimony in support of SB197, ***Homecare Worker Rights Act of 2024***.

NDWA is the leading voice for the estimated 2.2 million domestic workers who work as direct care workers, nannies , and house cleaners in private homes providing essential care and supportive services to children, aging adults, and family members with disabilities every day. Founded in 2007, NDWA works to raise wages and strengthen industry standards to ensure that domestic and direct care workers achieve economic security and protection, respect, and dignity in the workplace. NDWA reaches and engages over 400,000 domestic workers on a regular basis through our 68 affiliate organizations in 50 cities and 19 states, our state and local chapters in the DMV (Washington D.C., Virginia & Maryland), North Carolina, Georgia, New York, Houston (TX), San Jose (CA), and Philadelphia (PA) through our digital platforms. While the National Domestic Workers Alliance is a national organization, our DMV chapter is a locally operated, membership-based organization covering the geographical area of Washington DC, Maryland, and Virginia and is staffed by several local organizers.

Domestic and care workers comprise a growing workforce that has been historically excluded from basic workplace protections such as minimum wage, overtime, anti-discrimination protections, health and safety, and the right to organize. NDWA has led the movement both at the federal level and in numerous states to pass legislation to eliminate the exclusions. Unfortunately, the rampant misclassification in the home care industry undermines these efforts and enables employers to evade minimum wage, overtime, and other labor laws that domestic and home care workers have fought to secure.
NDWA supports this bill to specifically protect direct care workers employed by agencies in the home care industry who are regularly misclassified as independent

contractors and subsequently denied their critical workplace rights, including the right to overtime, earned sick leave as well as coverage under worker's compensation, and unemployment insurance. These workers already earning poverty level wages are also forced to pay their employers' share of taxes for social security and medicare. Until 2016, a number of home care workers were unable to avail themselves of basic rights under the federal Fair Labor Standards Act (FLSA), due to the "companionship exemption," which was applied to a majority of home care work. When the federal Department of Labor (DOL) narrowed the exemption, home care workers significantly won the right to overtime. However, many home care agencies have chosen to misclassify their home workers as independent contractors in order to continue to avoid paying them overtime and for all hours worked, including travel time. In 2022, the US Department of Labor determined that the Maryland agency "A Plus Personal Home Care" had misclassified 193 workers and denied overtime wages, ordering payment of $1.13 million in back wages and damages[1].

More than 750 Residential Service Agencies provide care for beneficiaries of Medicaid's Home and Community Based Programs and are paid through public funds. Because of the structure of Maryland's Medicaid program, all personal care aides this bill covers are already employees under the law. Residential Service Agencies are necessarily employers of personal care aides; they set their pay, enforce their schedules, and ensure they comply with Medicaid rules. Despite being illegal, the problem of misclassification persists. Enforcement authorities such as the U.S. Department of Labor and the Maryland Office of the Attorney General do not have adequate resources to bring the industry into compliance through litigation – and most workers do not know their rights. This bill would prevent misclassification by providing that RSAs will only be reimbursed for in-home personal care under certain Medicaid programs if those who do the work are classified as employees. It is a simple solution to a serious problem. Maryland must ensure that residential services agencies receiving public dollars are abiding by tax and labor laws and this measure would protect the direct care workforce from exploitation.

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[1] US DOL News Release, "US Department Of Labor Seeking Maryland Home Healthcare Workers Who May Be Owed Back Wages, Damages In $1.13m Recovery," available at: https://www.dol.gov/newsroom/releases/whd/whd20221110-1

All workers who are misclassified suffer from a lack of workplace protections, but women, people of color, and immigrants face unique barriers to economic security and disproportionately must accept low-wage, unsafe, and insecure working conditions. Domestic and direct care workers have for too long been excluded from core workplace protections, which stems from the racist and sexist devaluing of household and caregiving work. Misclassification is another tool for employers to utilize to evade the critical benefits they need to provide a sense of dignity on the job.

For these reasons, the National Domestic Workers Alliance (NDWA) fully supports SB197 Homecare Worker Rights Act of 2024.

Sincerely,

Allison Yunda
Maryland Lead Organizer
DMV Chapter
National Domestic Workers Alliance (NDWA) NDWA
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Reena Arora, Esq.
Director of Care Policy
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SB 197 - WLCMD - FAV.pdf
Uploaded by: Andrea Rafter
Position: FAV

Women's Law Center of Maryland
JUSTICE FAIRNESS EQUALITY
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phone 410-321-8761 fax 410-321-0462 www.wlcmd.org

BILL NO:	Senate Bill 197
TITLE:	Residential Service Agencies - Reimbursement - Personal Assistance Services (Homecare Worker Rights Act of 2024)
COMMITTEE:	Finance
HEARING DATE:	February 08, 2024
POSITION:	**SUPPORT**

Senate Bill 197 seeks to address the illegal practice of misclassification of employees of residential service agencies as independent contractors rather than employees. Misclassification of employees denies those workers of benefits they are entitled to under the law, including overtime pay, minimum wage, and workers' compensation. It also leads to substantial losses to the state, of funds that should have been paid into unemployment insurance and workers' compensation funds[1].

This is particularly troubling as women continue to be disproportionately represented within the care service industry. Black women, in particular, are more widely represented, yet they are concentrated in the most dangerous and lowest wage jobs. Women of color are also more likely to be misclassified as independent contractors, particularly in residential care facilities, nursing facilities, and home health providers[2]. Thus it is critical that Maryland address this practice. SB 197 does so by requiring the Maryland Department of Health only reimburse residential service agencies for in-home personal care provided under certain Medicaid waiver programs if the aides who do the work are classified as employees.

The truth is, residential care workers are just not operating as independent contractors. They do not set their own schedules, hours, or wages. Nor do they utilize their own tools, maintain control of where or how they work, or any of the other factors the IRS considers when determining independent contractor status[3]. Instead, care workers perform work that is an integral part of the residential service agency, and therefore must be categorized as employees. Yet, because they are often amongst the most vulnerable workers, they are frequently misclassified without their knowledge and in violation of the law.

This bill will level the playing field for law-abiding home care agencies, professionalize a marginalized workforce, improve quality of care, and ensure that public dollars are not used to violate the law. As such, the Women's Law Center of Maryland urges a favorable report on Senate Bill 197.

The Women's Law Center of Maryland is a non-profit legal services organization whose mission is to ensure the physical safety, economic security, and bodily autonomy of women in Maryland.
Our mission is advanced through direct legal services, information and referral hotlines, and statewide advocacy.

[1] https://blog.dol.gov/2021/05/06/the-true-cost-of-misclassification

[2] https://www.dol.gov/newsroom/releases/whd/whd20221116

[3] https://www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee

SB197_Marylanders for Patient Rights_fav.pdf
Uploaded by: Anna Palmisano
Position: FAV

MARYLANDERS FOR PATIENT RIGHTS REQUESTS A FAVORABLE REPORT ON SB197 Residential Service Agencies – Reimbursement -- Personal Assistance Services

Marylanders for Patient Rights is a leading advocacy group for patients in our state. We strongly believe that SB197 is critically important to ensuring that we maintain and build a workforce of personal care aides that is so essential to Maryland patients as our population ages. We urge you to provide a favorable report.

The caregiver workforce continues to decline in alarming numbers, leaving many vulnerable patients without the help they need. It is very difficult for patients to have a revolving group of caregivers while those workers, understandably, seek better employment situations. That is why it is vital to ensure that this important workforce is treated fairly and attracts qualified and caring workers.

Basically, SB197 will ensure that personal care aides who work under certain Medicaid programs are properly classified as employees, rather than as independent contractors. The current misclassification of thousands of these essential workers has created harm by cutting workers out of ready access to benefits and imposing a higher self-employment tax burden.

The bill would address the misclassification problem by requiring that the Maryland Department of Health only reimburse Residential Service Agencies for in-home personal care under certain Medicaid waiver programs if the personal care aides are properly classified as employees.

Personal care aides have been treated as marginalized workers for too long. Please provide a favorable report on SB197, and support Maryland caregivers and their patients.

Thank you,

A C Palmisano

Anna C. Palmisano, Ph.D
Director, Marylanders for Patient Rights
palmscience@verizon.net

LATE_SB197_WomensCaucus_Support
Uploaded by: Ariyana Ward
Position: FAV

February 12, 2024

The Honorable Pamela Beidle
Chair, Health and Government Operations Committee
East Miller Senate Office Building
6 Bladen St
Annapolis, MD 21401

Dear Chair Pamela Beidle,

On behalf of the majority of the Women Legislators of Maryland members, we are writing to support **SB197 Residential Service Agencies – Reimbursement – Personal Assistance Services**. This legislation has been identified as one of our priorities for the 2024 legislative session.

This bill authorizes the Maryland Department of Health to reimburse a residential service agency for personal assistance services only if the personal assistance services are provided by an individual classified as an employee. This legislation improves the employment conditions of home healthcare workers. The Women Legislators of Maryland fully support this bill because we recognize that women make up a majority of home healthcare workers and therefore, are largely impacted by this legislation.

Sincerely,

Delegate Edith J. Patterson
President

Signed Testimony SB 197.pdf
Uploaded by: Arthur Ellis
Position: FAV

Arthur Ellis, CPA
Legislative District 28
Charles County

Assistant Deputy Majority Leader

Finance Committee

Senate Chair
Joint Committee on the
Management of Public Funds

Chair, Charles, St. Mary's and Calvert
Counties' Senate Delegation

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District Office
3261 Old Washington Road
Waldorf, Maryland 20602

February 7, 2024

Testimony of Senator Arthur Ellis in Support of Senate Bill 59: Safe Sleep for Infants – Awareness and Certification

Dear Chair Beidle, Vice Chair Klausmeier, and the Members of the Finance Committee:

Senate Bill 59 requires the Maryland Department of Health to develop and implement a public awareness campaign to promote education regarding safe sleep for infants; establish the Maryland Safe Sleep Certification Program and requiring child care centers to be certified by the Program; and requires hospitals and freestanding birthing centers to be certified by the Cribs for Kids' National Safe Sleep Hospital Certification program.

I urge your favorable report on Senate Bill 200.

Yours in Service,

Arthur Ellis – District 28

ARTHUR ELLIS, CPA
Legislative District 28
Charles County

ASSISTANT DEPUTY MAJORITY LEADER

Finance Committee

Senate Chair
Joint Committee on the
Management of Public Funds

Chair, Charles, St. Mary's and Calvert
Counties' Senate Delegation

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February 7, 2024

Testimony of Senator Ellis in Support of Senate Bill 197: Residential Service Agencies – Reimbursement – Personal Assistance Services

Dear Chair Beidle, Vice Chair Klausmeier, and the Members of the Finance Committee:

Senate Bill 197 authorizes the Maryland Department of Health to reimburse a residential service agency for personal assistance services only if the personal assistance services are provided by an individual classified as an employee.

I urge your favorable report on Senate Bill 197.

Yours in Service,

Arthur Ellis – District 28

ILN Written Testimony - SB 197 of 2024.pdf
Uploaded by: Chris Kelter
Position: FAV

SB 197: Residential Service Agencies - Reimbursement - Personal Assistance Services (Homecare Workers Employment Act of 2024)

Testimony of the Maryland Centers for Independent Living

SUPPORT

Senate Finance, February 8, 2024

The seven Centers for Independent Living (CILs) in Maryland were established by federal law and work to ensure the civil rights and quality services of people with disabilities in Maryland. CILs are nonprofit disability resource and advocacy organizations located throughout Maryland operated by and for people with disabilities. CIL staff and Boards are at least 51% people with disabilities. The seven Maryland CILs are part of a nationwide network which provides Information and Referral, Advocacy, Peer Support, Independent Living Skills training, and Transition Services.

The Independent Living Network submits this written testimony in strong **support** of SB 197.

Many individuals with disabilities depend on personal assistance services to support activities of daily living and to live safely and fully participate in our communities. Individuals with disabilities requiring personal assistance know their personal care assistants (PCAs) well and know how essential PCAs are to their well-being. Individuals with disabilities depend on a strong PCA workforce.

The shortage of PCAs has been acutely felt in the community of individuals with disabilities. Without PCAs, individuals with disabilities struggle with activities of daily living and are unable to fully participate in the communities in which they live. Without PCAs it is a struggle and sometimes impossible for individuals with disabilities to transfer from a wheelchair to beds and washrooms. Without PCAs it may be impossible for individuals with disabilities to get nourishing meals and necessary medications. PCAs offer care for individuals with disabilities in the most personal and intimate manner. PCAs assist individuals with disabilities to attend family gatherings, participate in community events and functions, and shopping. Throughout the pandemic, and even now, PCAs have been essential workers.

Individuals with disabilities depend on PCAs and how the PCAs improve activities of daily living and participation in the community. PCAs have the support of individuals with disabilities for the essential work that they do, and the improved job benefits they deserve. A stronger workforce, with better protections, is better for all Marylanders.

SB 197 will improve job quality for PCAs and will ensure that Medicaid dollars are well spent. The Maryland Independent Living Network **supports** SB 197 and **urges** a favorable report.

Thank you for your consideration and anticipated support.

Contact Information:
Chris Kelter, Executive Director
Accessible Resources for Independence
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ckelter@arinow.org

SB197_Maryland Center on Economic Policy_FAV.pdf
Uploaded by: Christopher Meyer
Position: FAV

MDCEP
MARYLAND CENTER ON ECONOMIC POLICY

FEBRUARY 8, 2024

State-Funded Home Care Agencies Must Follow Labor Law

Position Statement in Support of Senate Bill 197

Given before the Senate Finance Committee

Home care workers are a vital part of the social infrastructure that keeps Maryland going. These workers provide essential services to aging Marylanders and Marylanders with disabilities. They provide long-term care in the community, rather than in residential facilities, which brings many documented benefits. But today we are failing to ensure that home care jobs are good jobs, and the result is a severe and growing labor shortage in the industry. Senate Bill 197 would strengthen Maryland's home care workforce by requiring that the state reimburse Medicaid-funded home care agencies only if they properly classify their workers as employees as required under Maryland labor law. **For these reasons, the Maryland Center on Economic Policy supports Senate Bill 197.**

Maryland already has a serious shortage of home care and other direct care workers.[i] If current practices continue, this shortage will only grow in coming years as our state's population continues to age. Maryland's 65+ population grew by 18% from 2015 to 2021, while the 20–64 population increased by only 0.2%.[ii] By 2030, our 65+ population is projected to grow by another 29% as the 20–64 population slightly declines.[iii] We will be increasingly unable to meet the need for home care if we do not make the occupation significantly more attractive to workers.

The current shortage of home care workers is due in large part to paltry wages and dangerous working conditions.[iv] As of 2022, home health and personal care aides in Maryland typically took home only $15.26 per hour.[v] However, this statistic *overstates* home care workers' true earnings because of the too-common practice of private home care agencies misclassifying workers as independent contractors rather than employees.[vi] According to the Department of Legislative Services, Medicaid-funded home care agencies classify about 2,000 home care workers as independent contractors.[vii] **This misclassification violates federal and state labor law, strips workers of wage and hour protections, and shifts tax responsibilities from employers to workers.**

Because of the tax-shifting worker misclassification enables, a home care worker who is labeled an independent contractor can expect to take home the equivalent of only **$14.00 per hour** paid to an employee.[viii]

Home care agencies' refusal to abide by labor law disproportionately harms women of color, who constitute the bulk of this workforce:[ix]

- 84% of home care workers in Maryland are women.
- 60% of home care workers in Maryland are Black, and 74% are workers of color.
- 61% of home care workers in Maryland are women of color.

- 42% of home care workers in Maryland were born outside the United States.

Lawmakers have taken limited steps to combat misclassification and strengthen worker protections in recent years. These include requiring management at home care agencies to read and acknowledge a clear explanation of employee classification law and requiring agencies to report to the state the number of workers they label as independent contractors. These are meaningful steps in the right direction. Senate Bill 197 presents a more comprehensive solution, requiring the state to reimburse Medicaid-funded home care agencies only if they properly classify their workers as employees.

The Maryland Attorney General's guidance document for home care agencies makes clear why this requirement is appropriate:[x]

- While several areas of labor law use slightly different definitions of employment, common themes include the payment of hourly wages, managerial control over the way work is performed, and the relationship between the work performed and the employer's core business.
- Home care agencies typically pay hourly wages rather than a negotiated fee for service; agencies exercise significant control over workers' performance, such as by enforcing compliance with state rules for long-term care providers; and home care workers' jobs are *precisely* the core business of home care agencies.

Moreover, even if a few atypical cases may currently exist where independent contractor classification satisfies the letter of the law, requiring that Medicaid-funded home care agencies classify workers as employees advances several important policy goals:

- Most state and federal worker protection laws apply to employees. These include bedrock wage and hour law, the Healthy Working Families Act, and worker's compensation and unemployment insurance coverage. When agencies misclassify workers, they are denying them these basic protections. **An industry without basic worker protections cannot recruit and retain a robust workforce**, and the resulting labor shortage is already harming Marylanders.
- Because Medicaid is by far the largest home care payer, the state has substantial power to set norms in the industry. For this reason, the most likely outcome of Senate Bill 197 is to incentivize home care agencies to properly classify workers as employees and thereby **improve access to care**.
- How we invest our shared resources reflects what we value as a state. Our current practice creates low-quality jobs and asks the people who take them to provide some of the most important care work for Maryland communities. Investing our shared resources to create good jobs benefits all of us, strengthening our labor market and improving the quality of public services.

We should measure the health of our economy not simply by the number of dollars exchanged or the number of people who go to work each day, but by its ability to raise all families' standard of living. Strengthening protections to ensure workers are properly classified would directly benefit workers and would also reduce barriers to maintaining a sufficient home care workforce to provide essential supports to aging Marylanders and Marylanders with disabilities.

For these reasons, the Maryland Center on Economic Policy respectfully requests that the Senate Finance Committee make a favorable report on Senate Bill 197.

Equity Impact Analysis: Senate Bill 197

Bill summary

Senate Bill 197 would require that the state reimburse Medicaid-funded home care agencies only if they classify their workers as employees.

Background

Researchers have documented a trend of private home care agencies classifying home care workers as independent contractors in spite of working conditions consistent with employment, such as significant managerial control.[xi] According to the Department of Legislative Services, Medicaid-funded home care agencies classify about 2,000 home care workers as independent contractors.[xii] This misclassification violates federal and state labor law, strips workers of wage and hour protections, and shifts tax responsibilities from employers to workers.

Maryland currently faces a shortage of long-term care workers.[xiii] As the state's population continues to age in coming years, the needs for these services will grow significantly. Absent a substantial increase in the supply of long-term care workers, the shortage will become more severe.

Lawmakers in 2021 (Chapter 775) and 2022 (Chapters 673, 674) enacted laws strengthening communication between the state and home care agencies regarding employee classification. However, the laws do not strengthen the state's ability to enforce existing labor law.

Equity Implications

House Bill 498 would strengthen protections for home care workers who face dangerous working conditions, often take home low wages, and are disproportionately women of color.[xiv] It would also benefit Marylanders with disabilities by increasing the long-term supply of workers available to provide necessary supports.

- 84% of home care workers in Maryland are women.
- 60% of home care workers in Maryland are Black, and 74% are workers of color.
- 61% of home care workers in Maryland are women of color.
- 42% of home care workers in Maryland were born outside the United States.
- Home health and personal care aides in Maryland typically took home only $15.26 per hour in 2022.[xv] For a misclassified worker, this is equivalent to $14.00 paid to an employee.

Impact

Senate Bill 197 would likely **improve racial, gender, disability, and economic equity** in Maryland.

---

[i] "The Direct Services Workforce in Long-Term Services and Supports in Maryland and the District of Columbia," PHI, 2018, https://phinational.org/wp-content/uploads/2018/09/DSWorkers-Maryland-2018-PHI.pdf
Christopher Meyer, "Budgeting for Opportunity Case Study: A Racial Equity Analysis of Medicaid-Funded Home- and Community-Based Services," Maryland Center on Economic Policy, 2023, https://www.mdeconomy.org/budgeting-for-opportunity-case-study/

[ii] MDCEP analysis of U.S. Census Bureau Population Estimates.

[iii] MDCEP analysis of U.S. Census Bureau Population Estimates and Maryland Department of Planning population projections.

[iv] "The Direct Services Workforce," 2018; Meyer, 2023.

[v] May 2021 BLS Occupational Employment and Wage Statistics. Throughout this document, statistics about "home care workers" refer to home health aides and personal care aides.

[vi] Caitlin Connolly, "Independent Contractor Classification in Home Care," National Employment Law Project, 2015, https://www.nelp.org/publication/independent-contractor-classification-in-home-care/

[vii] Senate Bill 197 Fiscal and Policy Note, https://mgaleg.maryland.gov/2024RS/fnotes/bil_0007/sb0197.pdf

[viii] Calculated based on the 12.4% total Social Security tax and the 2.9% total Medicare tax, with the misclassified worker paying the full tax and the properly classified worker paying only the employee side. This does not take income tax into account – doing so would make the true equivalent wage even lower.

[ix] MDCEP analysis of 2017–2021 IPUMS American Community Survey microdata. See Meyer, 2023.

[x] "Understanding How Maryland's Employee Protection Laws Apply to Residential Service Agencies (RSAs) and Personal Care Aides (PCAs)," Maryland Office of the Attorney General, https://health.maryland.gov/ohcq/docs/RSA-PCA%20Guidance%20Document.pdf

[xi] Connolly, 2015

[xii] Senate Bill 197 Fiscal and Policy Note, https://mgaleg.maryland.gov/2024RS/fnotes/bil_0007/sb0197.pdf

[xiii] "The Direct Services Workforce," 2018.

[xiv] "The Direct Services Workforce," 2018.

[xv] Bureau of Labor Statistics, May 2021 Occupational Employment and Wage Statistics for Maryland

Testimony - Absolute Home Health Care.pdf
Uploaded by: Daniel Trosman
Position: FAV

Honorable Finance Committee members,

I am writing to express my wholehearted support for the bill authorizing the Maryland Department of Health to reimburse a residential service agency for personal assistance services only if the services are provided by an individual classified as an employee. This crucial legislation not only recognizes the value of personal assistance services but also emphasizes the importance of fair employment practices within the healthcare sector.

Personal assistance services play a vital role in enhancing the quality of life for individuals who rely on them for daily activities and support. By ensuring that reimbursement is contingent on the classification of service providers as employees, the bill establishes a foundation for fair labor practices and promotes job stability within the healthcare workforce.

This legislation reflects a commitment to acknowledge the dedication and hard work of individuals who provide essential personal assistance services. By classifying these service providers as employees, the bill extends crucial employment benefits and protections, fostering a healthier and more sustainable work environment.

Moreover, this bill aligns with broader efforts to prioritize the well-being of those in need of personal assistance services while simultaneously recognizing the rights and contributions of the healthcare workforce. Other states already follow this commendable standard and promote fair labor practices. Ensuring that those who provide essential services are treated with the dignity and respect they deserve.

Our RSA switched over our staff from contractor to employee status in 2019. It was an involved and multi-step process. However, it did not result in any undue financial hardship for our company and brought nothing but a wealth of additional benefits and stability to our staff. Employee turnover went down, and overall job satisfaction went up. In other words, it was a resounding success.

I urge you to consider the positive impact that this bill will have on both service recipients and healthcare workers in Maryland. By supporting this legislation, we can contribute to the creation of a more just and equitable healthcare system that benefits everyone involved.

Thank you for your attention to this matter, and I hope to see the successful passage of this bill for the betterment of our community.

Respectfully,

Daniel Trosman
Owner/President
Absolute Home Health Care Inc
410-580-9100 office
410-580-9101 fax

PJC - SB197 - FAV - with attachments.pdf
Uploaded by: David Rodwin
Position: FAV

David Rodwin, Attorney
Public Justice Center
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SB197: Residential Service Agencies - Reimbursement - Personal Assistance Services

Hearing of the Senate Finance Committee, Feb. 8, 2024

Position: FAVORABLE

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Workplace Justice Project works to expand and enforce the right of low-wage workers to receive an honest day's pay for an honest day's work. **The PJC supports SB197, which would end the illegal misclassification of home care workers as independent contractors under certain Medicaid home care programs, improve the quality of home care jobs, and help address Maryland's home care workforce crisis at $0 cost to the State of Maryland. The Maryland Department of Health is supporting the bill.**

Summary: SB197 will ensure that personal care aides (also known as home care workers) who work for home care agencies (called "residential service agencies" – RSAs – by the Health Code) under certain Medicaid programs are properly classified as employees and not illegally misclassified as independent contractors.

Combatting the illegal misclassification of employees as independent contractors—also known as "workplace fraud"—is a priority for Governor Moore, Comptroller Lierman, and Attorney General Brown.

- Real independent contractors have their own businesses, while employees do not. Calling an employee an "independent contractor" to avoid paying employment taxes and providing employee benefits like sick leave is called "misclassification" or "workplace fraud."
- Just weeks ago, Governor Moore issued an executive order establishing a task force to combat this harmful practice. As the Governor's press release noted, "Workplace fraud deprives workers of basic protections such as rights to minimum wage and overtime pay, health insurance coverage, and access to unemployment benefits. Businesses may also be put at a disadvantage when competitors misclassify workers. As a result, required taxes may be unpaid, which lowers state revenue and impacts funding to pay for critical public services."[1]
- As Gov. Moore noted, ending misclassification is "an important step toward a more equitable, competitive, and prosperous economy that lifts all Marylanders."
- The press release also quotes Comptroller Lierman and Attorney General Brown, both of whom explained that misclassification hurts workers and law-abiding businesses alike.

[1] https://governor.maryland.gov/news/press/pages/governor-moore-issues-executive-order-establishing-crossgovernmental-task-force-to-combat-workplace-fraud.aspx The press release is also attached to this testimony.

When personal care aides are misclassified as independent contractors, it is both illegal and harmful.

- It is already illegal for the RSAs this bill covers[2] to classify personal care aides as independent contractors. If a worker's pay rate and schedule are set by an employer, and the employer can control how the work is done, that worker is an employee. Because of the structure of Maryland's Medicaid program, *all personal care aides this bill covers are already employees under the law*: RSAs set their pay, enforce their schedules, and ensure they comply with Medicaid rules.
- Misclassification hurts Maryland's personal care aides, those they care for, and law-abiding RSAs. These workers are not tax experts: they earn about $15/hour and do the jobs available to them. When they are misclassified, they are cut out of the social safety net and lose protections like *sick leave*, *workers' compensation*, *health insurance*, and more – and they face a higher "self-employment" tax when they should be getting a tax refund. Misclassification also hurts those they care for by shrinking the size of the workforce. And it hurts law-abiding RSAs by forcing them to compete on an uneven playing field with RSAs that save money by misclassifying their workers.

SB197 is needed to stop the problem on the front end.

- Despite being illegal, the problem persists. More than 550 RSAs currently provide care through these Medicaid programs. Despite enforcement by the U.S. Department of Labor and guidance[3] from the Maryland Office of the Attorney General, many RSAs still misclassify personal care aides as independent contractors. State and federal labor agencies do not have the resources bring so many RSAs to court, and most workers do not know their rights.
- This bill would fix the problem by providing that RSAs will only be reimbursed for in-home personal care under certain Medicaid programs if those who do the work are classified as employees. It is a simple solution to a serious problem.
- The bill does *not* prevent a home care worker from working as an independent contractor. Rather, the bill provides that if certain Medicaid programs are funding the work, the worker must be properly classified as an employee as the law requires.
- The bill's scope is limited. It does not apply to care paid out of pocket, by long-term care insurance, or under the Developmental Disabilities Administration.
- Most of the affected workers are already classified as employees. The bill's fiscal note shows that more than 80% of Medicaid-funded personal care aides are already classified as employees. The bill would not rock the industry – it would get the industry all the way to where it needs to be.
- MDH already has the classification data it needs to measure compliance. 2022's SB 600 / HB 544 – codified at § 19-4A-11(c) of the Health code – already provides the Maryland Department of Health with the information on worker classification that the Department needs to ensure compliance.

There is extraordinarily broad agreement that SB197 is the best way to tackle the problem.

- Most Maryland home care agencies support the bill. Most Maryland home care agencies support the bill because it would eliminate unfair competition.

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[2] The bill covers personal care aides working for home care agencies and whose work is funded by Medicaid through the Maryland Department of Health's Office of Long Term Services and Supports.

[3] https://health.maryland.gov/ohcq/docs/Residential%20Service%20Agency%20Documents/2022-11-01%20RSA-PCA%20Guidance%20Document%20%281%29.pdf The guidance document is also attached to this testimony.

- The Maryland Department of Health Supports the bill. For 2023's bill, MDH filed a letter of interest making clear that its only initial objection was an early effective date, but the agency supported the bill once its effective date was extended by a year. This year's bill reflects that agreement, and MDH is supporting it again this year.
- There is very broad support for the bill from other stakeholders. Supporters include *consumer groups* like AARP and Disability Rights Maryland, *worker groups* like 1199SEIU and the National Domestic Worker Alliance, *legal experts* like the National Women's Law Center and Women's Law Center of Maryland, and numerous *home care agencies*.

Improving home care job quality is a race equity issue and a gender equity issue.

- Maryland's home care workers are mostly Black women. About 90% are women and about 70% are Black. This majority women-of-color workforce deserves employee protections.
- The bill will decrease worker turnover and increase retention. The turnover rate for home care workers ranges between 60% and 80%. This extremely high turnover is traumatizing for those who rely on home care because of the intimacy of the work, involving help with bathing, toileting, dressing, etc.
- Home care workers and RSAs alike say employee status reduces turnover. During the 2023 hearings on this bill and the 2024 hearings in the House, multiple home care workers testified to this. Home care agencies also testified that transitioning from an independent contractor model to an employee model decreases turnover and does not cause workers to leave home care.

For these reasons, the PJC **SUPPORTS SB197** and urges a **FAVORABLE** report. Should you have any questions, please call David Rodwin at 410-625-9409 ext. 249.

Governor Moore Issues Executive Order Establishing Cross-Governmental Task Force to Combat Workplace Fraud

Published: 1/11/2024

ANNAPOLIS, MD — Governor Wes Moore this week signed an executive order to renew and expand a cross-governmental task force dedicated to strengthening investigations and enforcement of laws regarding workplace fraud. The nine-member Joint Enforcement Task Force on Workplace Fraud, chaired by Maryland Department of Labor Secretary Portia Wu, includes Maryland Attorney General Anthony G. Brown and Comptroller Brooke E. Lierman.

"We will never tolerate the exploitation of Maryland workers," **said Gov. Moore.** "This order will help ensure that employees receive the pay and benefits they've earned while driving fair competition in the private sector. Today, we take an important step toward a more equitable, competitive, and prosperous economy that lifts all Marylanders."

Workplace fraud deprives workers of basic protections such as rights to minimum wage and overtime pay, health insurance coverage, and access to unemployment benefits. Businesses may also be put at a disadvantage when competitors misclassify workers. As a result, required taxes may be unpaid, which lowers state revenue and impacts funding to pay for critical public services.

“Companies that hire workers and misclassify them to circumvent our tax and labor laws are committing serious fraud that erodes basic rights and benefits, saddles workers with an undue financial burden, and undermines the economic well-being of our state,” **said Comptroller Brooke E. Lierman.** “This executive order expands our ability to share information, coordinate resources, and investigate suspected workplace fraud to protect Marylanders and their families. We should all stand against this form of egregious theft. I thank Governor Moore for prioritizing this issue and I look forward to working as a partner in this initiative to build a stronger and fairer Maryland.”

As outlined in the executive order, the task force will collaborate to share information and data across agencies and drive strategic and effective enforcement. It will identify industries where workplace fraud is more prevalent and focus efforts to address the problem, including stronger outreach to businesses and workers. The task force will also make recommendations on where regulations and laws may be strengthened.

“I commend Governor Moore’s work to combat workplace fraud and protect Maryland workers and their families,” **said Attorney General Anthony G. Brown.** “The reestablishment of the Joint Enforcement Task Force on Workplace Fraud is an important effort, along with our work with the Department of Labor to improve and enhance the role of my office and our resources to advance this critical priority. I look forward to continuing our work with the administration to ensure the relationship between Maryland employers and their employees remains fair and equitable.”

The task force will advance the Moore-Miller Administration’s efforts to make Maryland a fair and equitable place to work and do business. Studies have shown that workers of color, immigrants, young workers and those in low-wage employment are most at risk for exploitation, including misclassification and wage theft.

"This is a win for both businesses and workers,” **said Maryland Department of Labor Secretary Portia Wu**. “Employees need to be classified correctly and paid fairly, and this keeps our businesses on a level-playing field in the competitive

Understanding how Maryland's employee protection laws apply to residential service agencies (RSAs) and personal care aides (PCAs)

Maryland's RSAs sometimes wrongly classify PCAs (that is, anyone paid to provide personal care services) as independent contractors rather than employees.[1] When this happens, it is called *worker misclassification* and it is illegal. Pursuant to Health General §19–4A–11, this guidance document explains (1) some differences between employees and independent contractors in the context of personal care, (2) worker misclassification and how it can cost RSAs money and hurt PCAs, and (3) some steps RSAs can take to ensure that their classification policies comply with Maryland's Labor and Employment Code.

1. What is the difference between "employees" and "independent contractors"?

- **There are two kinds of workers under Maryland's employment laws: employees and independent contractors.** In general, independent contractors are in business for themselves, while employees are not. If an RSA pays a PCA an hourly wage to perform personal care and oversees the PCA's work, the worker should usually be classified as an employee. A worker can sometimes be an "employee" under one law and an "independent contractor" under another, because different laws have different purposes and define these terms differently. Even if the IRS has accepted the classification of PCAs as independent contractors, you should not assume that a court would reach the same conclusion under Maryland's employee protection laws, which are humanitarian statutes designed to broadly protect workers and are therefore more favorable to employees.

- **Maryland's wage laws and sick leave law—including the Wage and Hour Law, Wage Payment and Collection Law, and Healthy Working Families Act—have a very broad definition of employee.** Most workers are employees, not independent contractors, under these laws. A worker's status as an employee cannot be changed by a contract or other document (like an "independent contractor agreement") that labels the worker as an independent contractor. To determine a worker's proper classification, courts consider factors related to whether workers are in business for themselves. When the employer exercises, or has the right to exercise, direction and control over the performance of an individual's work, the worker is an employee and not an independent contractor. The Maryland Labor and Employment Code defines the term "employ" broadly as "to engage an individual to work," and expressly includes "allowing an individual to work" and "instructing an individual to be present at a work site."

[1] Maryland law defines "personal care" as "a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation." Md. Code Ann., Health – Gen. Article § 19-301(n)(1). Personal care includes help in walking, getting in and out of bed, bathing, dressing, feeding, and general supervision and help in daily living. *Id.* § 19-301(n)(2)(i)-(vi).

- Applying these factors to RSAs and PCAs, (1) RSAs typically have authority to set and enforce conduct policies, including policies designed to ensure that workers comply with the Maryland Department of Health's rules for Medicaid providers; (2) RSAs typically pay PCAs an hourly wage, which means that PCAs have no opportunity for profit or loss dependent on any managerial skill; (3) PCAs typically do not invest in their own equipment and cannot hire others to do the work instead of them; (4) personal care does not require advanced certifications and does not involve business-like skill; (5) PCAs typically have a working relationship with RSAs that is at least several months long; and (6) RSAs are typically in the business of providing personal care. Therefore, PCAs are more likely to be RSAs' employees than independent contractors within the meaning of Maryland's wage and sick leave laws. In cases where PCAs recruit their own clients, that fact alone does not make them independent contractors if factors otherwise suggest the existence of an employment relationship.

- **Maryland's unemployment insurance law also has a broad definition of employee.** Under this law, a PCA is presumed to be an employee, not an independent contractor, unless the RSA can satisfy a test called the "ABC test." Applying this test to RSAs and PCAs, (1) RSAs typically have the ability to control or direct PCAs' work, (2) PCAs do not customarily have their own business, and (3) although the work is typically performed in individuals' homes, personal care is typically the type of work that RSAs perform. Therefore, PCAs are more likely to be employees than independent contractors within the meaning of Maryland's unemployment insurance law. For illustrations of how Maryland's unemployment insurance law applies to workers like PCAs, see the Code of Maryland Regulations (COMAR) 09.32.01.18-3.

- **Maryland's workers' compensation law also defines employee broadly.** Under this law, a worker is presumed to be an employee unless the employer can show that the worker is an independent contractor under the "common law" test. Applying this test to RSAs and PCAs, (1) RSAs typically have the power to hire PCAs, (2) RSAs typically pay wages to PCAs, (3) RSAs typically have the power to fire PCAs, (4) RSAs typically have the power to control PCAs' conduct, and (5) personal care is typically part of the regular business of RSAs. Therefore, in the context of RSAs, PCAs are more likely to be employees than independent contractors within the meaning of Maryland's workers' compensation law.

2. How can misclassification of PCAs as independent contractors hurt RSAs and PCAs?

- **Misclassification hurts RSAs because it is illegal and can lead to costly investigations and lawsuits.** The Maryland Department of Labor or U.S. Department of Labor may investigate, require payment of unpaid wages and money damages to workers, and even get a court order requiring the RSA to change its classification and compensation practices. In addition, PCAs may sue an RSA for unpaid wages that they should have been paid as employees. PCAs may bring these cases individually or, in some circumstances, as class actions on behalf of other workers. A court may order the RSA to pay workers damages up to three times the wages they should have been paid. An RSA held liable under Maryland's Wage and Hour Law and Maryland's Wage Payment and Collection Law may also be

responsible for the attorneys' fees of PCAs who sue them. Under these laws, individual owners of a corporation (including an RSA) may also be held personally liable for unpaid wages and attorneys' fees, putting their personal assets at risk.

- **Misclassification can also have severe tax consequences for RSAs.** If the Maryland State Department of Assessments and Taxation (SDAT) or U.S. Internal Revenue Service (IRS) finds that an RSA has failed to pay employment taxes for PCAs who should have been classified as employees, SDAT and/or the IRS may require that the RSA pay tens of thousands of dollars—or more—in back taxes and penalties.

- **Misclassification also hurts PCAs by denying them important legal protections.** These include unemployment benefits, workers' compensation, sick leave, and the right to overtime pay (for hours worked beyond 40 in a workweek) and travel-time pay (for time spent traveling from one client's home to another client's home).

3. What steps can an RSA take to ensure it follows Maryland's employee protection laws?

- **Do: Talk to a lawyer.** Employment law can be complicated. Lawyers who practice employment law can help ensure that your RSA follows Maryland law. While it may cost money to ask a lawyer about your RSA's worker classification policies, a labor investigation or a lawsuit could cost far more.

- **Do:** Visit the Maryland Department of Labor's website for guidance and to learn about various outreach programs offered by the Department to employers.

- **Do not: Assume something is legal just because others do it.** People sometimes assume a business practice is legal just because other businesses do it. Some rely on advice from friends when establishing their business's worker classification policies. But this can be dangerous, especially in industries where legal violations are common. And in Maryland, "industry practice" is not a defense to a suit for unpaid wages.

- **Do not:** Assume that if you employ a PCA on a salary basis that you don't have to pay overtime pay. PCAs are entitled to overtime wages.

- **Do: Take action to correct your RSA's employment classification policies if you believe they may be incorrect.** Changing the classification of your RSA's PCAs from independent contractors to employees does not mean you will automatically be subjected to lawsuits or liability. The best way to protect your business—and your own assets—is to make sure your RSA follows the law.

SB 197 - Residential Service Agencies - Reimbursem

Uploaded by: Donna Edwards

Position: FAV

MARYLAND STATE & D.C. AFL-CIO

AFFILIATED WITH NATIONAL AFL-CIO

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Secretary-Treasurer
Gerald W. Jackson

SB 197 - Residential Service Agencies - Reimbursement - Personal Assistance Services
(Homecare Worker Rights Act of 2024)
Senate Finance Committee
February 8, 2024

SUPPORT

Donna S. Edwards
President
Maryland State and DC AFL-CIO

Madame Chair and members of the Committee, thank you for the opportunity to provide testimony in support of SB 197. My name is Donna S. Edwards, and I am the President of the Maryland State and DC AFL-CIO. On behalf of the 300,000 union members in the state of Maryland, I offer the following comments.

SB 197 prohibits the Maryland Department of Health from reimbursing a residential service agency for home health care services unless the care was provided by workers classified as employees and not independent contractors. The home health care industry is rampant with mistreatment and misclassification. SB 197 helps discourage bad behavior by limiting the potential fraudulent business opportunities for bad actors that cost the state thousands of dollars.

On January 9, Governor Wes Moore issued Executive Order 01.01.2024.04 which re-established the Joint Enforcement Task Force on Workplace Fraud. The Order recognizes that misclassification and workplace fraud are ongoing problems in Maryland. The order further reads, “Combating these practices effectively requires a whole of government approach, involving multiple different agencies and authorities within State government.” We fully agree and encourage Maryland’s medical assistance program to do its part by banning the reimbursement of residential service agencies that contribute to this problem.

In November 2022, the U.S. Department of Labor (DOL) announced it had reached a settlement against A Plus Personal Home Care, based in Pikesville, Maryland. The DOL announced that the residential service agency had stolen overtime wages from over 193 home healthcare workers by illegally categorizing them as independent contractors. DOL was able to recover over $1.13 million in stolen wages, but is having difficulty locating all of the impacted workers that may be entitled to backpay. The Economic Policy Institute published a report that found some consulting firms, like Contractor Management Services, specialize in advising residential service agencies on how to reclassify their workers as independent contractors. Stories like this are far too common in the industry and only state intervention can help root out these bad actors

The Internal Revenue Service is very clear on the differences between an employee and independent contractor, stating, “The general rule is that an individual is an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done.” This does not apply to the home health care industry where residential service agencies still maintain a large degree of control over when and how their employees carry out their tasks. Employers are committing payroll fraud by misclassifying their workers as independent contractors, denying the state its share of unemployment insurance, state and local taxes, and workers compensation.

The State of Maryland must stop rewarding companies that are misclassifying their workers and defrauding the public. We urge the committee to issue a favorable report for SB 197.

SB197 -FIN - MDH - LOS (1).pdf
Uploaded by: Jason Caplan
Position: FAV

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 8, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 197 – Residential Service Agencies – Reimbursement – Personal Assistance Services – Letter of Support

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of support for Senate Bill (SB) 197 – *Residential Service Agencies – Reimbursement – Personal Assistance Services*. SB 197 requires MDH to reimburse a Residential Service Agency (RSA) for personal assistance services only when they are provided by an individual classified as an employee of the RSA. Currently, Maryland Medicaid has 920 Medicaid enrolled RSAs providing personal assistance services. In FY 2022, MDH reimbursed RSAs $394,351,407 for personal assistance services provided to 14,230 Medicaid participants.

The Department relies heavily on this group of providers to serve participants receiving long term services and support in the community as an alternative to nursing home placement. RSAs are often minority-owned small businesses that provide services in impoverished areas. MDH is responsible for determining the reimbursement rates for the services rendered by an RSA. The Department has consistently implemented the rate increases for Medicaid long-term services and supports programs as required by legislation and the Governor's budget from FY 2017 through FY 2024. Most recently, this includes a 12% increase in FY 2023 and another 8% increase in FY24.

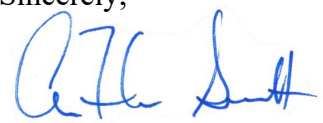
The Department supports the implementation timeline included in SB 197 as it permits RSAs until October 1, 2025 to come into compliance with the requirements to shift to billing for only those services delivered by employees. The Department is in support of this phase-in approach as it will help mitigate the potential impact on Medicaid's RSA provider network and Medical Assistance participants' ability to access services.

There are currently 2,323 licensed RSAs in Maryland. Two years ago, SB 600 – *Health Facilities – Residential Service Agencies – Reporting Requirement (Ch. 674 of the Acts of 2022)* required OHCQ to estimate new reporting requirements for the RSAs regarding their use of employees and independent contractors. Out of the currently 2,323 licensed RSAs in Maryland, 1,348 (58%) have completed an RSA certification. Of the respondents, 579 receive Medicaid

funds and 61 hire PCAs only as independent contractors, 396 hire PCAs only as an employee, and 122 RSAs hire PCAs as either employees or independent contractors. These 579 RSAs that receive Medicaid funds employ 12,363 PCAs, including 10,330 employees and 2,033 independent contractors.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron at sarah.case-herron@maryland.gov or (410) 260-3190.

Sincerely,



Laura Herrera Scott, M.D., M.P.H.
Secretary

HB39_SB0197 Testimony Doc.pdf
Uploaded by: Jason Hafer
Position: FAV

Supporting Testimony for HB39/SB0197

As an RSA operator who works hard to make sure that we deliver quality care to our customers I strongly support this bill.

- It Protects Consumers
  - Ensures properly trained caregivers.
    - Independent contractors can't be required to be trained.
  - Ensures caregivers are supervised.
    - Independent contractors self-supervise.
  - Allows agency to enforce policy and ensure quality.
    - Independent contractors can't be disciplined.
  - Protects from client being considered the employer.
    - Potential legal implications for workers compensation and employer portions of payroll taxes.
  - Ensures adequate back-up coverage
    - Independent contractors can set their own schedule and do not have back-ups for illness or other scenarios that might cause them to miss a shift.
- Protects the Caregiver
  - Ensures proper pay especially over time
    - Independent contractors are often taken advantage of because they are not entitled to overtime protections.
  - Ensures Sick and Safe leave
    - This legislature did the right thing for employees and made sick and safe leave (Maryland Health Families Act) mandatory but it only applies to employees. independent contractors do not receive this protections.
  - Ensures all appropriate insurances are in place
    - Workers Comp, Unemployment, Liability, etc.
  - Ensures access to benefits.
  - Makes the employer responsible for their share of income taxes
- Protects the Taxpayer

- Ensures that tax dollars are being spent in a way that minimizes risk and potential for fraud while maximizing quality

In conclusion the 1099 model is a dangerous model that removes the agency from a position where they can ensure qualified caregivers deliver quality care in an environment that protects both the consumer and the caregiver. To continue to spend taxpayer dollars propping up the clearly illegal misclassification of caregivers as independent contractors is irresponsible. This legislation rights this wrong and that is why HomeCentris, and I personally, support this legislation.

Sincerely,

Jason Hafer
HomeCentris Healthcare
443-218-4036 – Direct Phone
Jason.Hafer@homecentris.com - Email

Home Address
2106 Sterling Ct.
Hampstead, MD 21074

Written Testimony MDOA SB197 - Homecare Worker Rig
Uploaded by: Jennifer Crawley
Position: FAV

Date: February 7, 2024

Bill Number: **SB197**

Bill Title: Residential Service Agencies - Reimbursement - Personal Assistance Services (Homecare Worker Rights Act of 2024)

Committee: Senate Finance

MDOA Position: FAVORABLE

The Department of Aging (MDOA) thanks the Chair and Committee members for the opportunity to testify in support of Senate Bill (SB) 197 - Residential Service Agencies - Reimbursement - Personal Assistance Services (Homecare Worker Rights Act of 2024).

The Maryland Department of Aging (MDOA) serves as Maryland's State Unit of Aging, administering federal funding for core programs, overseeing the Area Agency on Aging (AAA) network at the local level that provides services, and planning for Maryland's older adult population. Pursuant to a recent Executive Order, in January 2024, MDOA launched the Longevity-Ready Maryland Initiative,[1] which will build upon existing efforts across state agencies, private and philanthropic sectors and other stakeholders to tackle real-life challenges throughout the lifespan, taking a whole-of-life and whole-of-government approach. Key goals of Longevity-Ready Maryland are for all Marylanders to afford their longer lives by investing in a multigenerational workforce and improving access to healthcare and retirement needs. The Governor's Longevity-Ready Maryland Executive Order confirmed explicitly that the workforce in Maryland that cares for older adults is disproportionately women and people of color who earn below a living wage.

According to the Public Justice Center and other groups representing these workers directly, Maryland's home care workforce is about 90% women and about 70% Black, and earn on average $14-15 per hour. The Public Justice Center asserts that a significant number of home

[1] More on Longevity-Ready MD Initiative available at: https://aging.maryland.gov/Pages/LRM.aspx

care workers in Maryland who provide direct care services that are reimbursed by Medicaid[2] are misclassified as independent contractors by residential service agencies.

Prior state legislation requires Residential Service Agencies getting reimbursed by Medicaid to acknowledge and sign off on plain-language guidance reinforcing when home care workers must be classified as employees from the Maryland Attorney General, Departments of Labor and Health;[3] clarifying for any reluctant or confused business operators their actual obligations under federal and state law. When workers are misclassified as contractors, they lose access to sick leave, health insurance, workers' compensation and unemployment insurance - while the state loses out on required employer contributions to unemployment insurance. The majority of law-abiding home care businesses in Maryland that classify workers as employees are also harmed, reducing our statewide economic competitiveness. Home care workers and the services they provide are the backbone to aging in community and vital to the long term care infrastructure for older adults. Maintaining the status quo, allowing some homecare agencies to continue to misclassify workers with public funds, will continue to perpetuate systemic racism against the large number of women of color who work as home care aides and contribute to high worker turnover. Failing to lift home care workers out of poverty and into financial self-sufficiency will increase harm to the homecare businesses classifying workers correctly and jeopardize publicly-funded, community-based care for older Marylanders. For Maryland to be longevity-ready, we must swiftly and permanently improve job quality for home care workers.

SB197's approach aligns with the recently published National Strategy on Caregivers and President Biden's subsequent Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers, in April, 2023. Both underscore the need for comprehensive government action to support and enhance job quality for all types of care workers. The National Strategy on Caregivers recommends numerous specific tactics to states, including "increas[ing] wages, benefits and training for direct care workers under Medicaid that provides for a livable income.[4]

[2] Maryland Medical Assistance Program (Medicaid) pays for a significant amount of direct care for older Marylanders, both in skilled nursing facilities and home-based settings.
[3] MD Attorney General, Department of Labor, Department of Health Guidance Document: "Understanding how Maryland's employee protection laws apply to residential service agencies and personal care aides," *available at:* https://health.maryland.gov/ohcq/docs/Residential%20Service%20Agency%20Documents/2022-11-01%20RSA-PCA%20Guidance%20Document%20%281%29.pdf
[4] "2022 National Strategy to Support Family Caregivers: Actions for States, Communities and Others," Developed by: The Recognize, Assist, Include, Support, and Engage (RAISE) Act Family Caregiving Advisory Council & The

For these reasons, the Department of Aging respectfully urges a favorable report for SB197. If you have any questions, please contact Andrea Nunez, Legislative Director, at andreah.nunez@maryland.gov or (443) 414-8183.

Sincerely,

Carmel Roques
Secretary
Maryland Department of Aging

Advisory Council to Support Grandparents Raising Grandchildren, with technical assistance provided by the Administration for Community Living, Sept. 21, 2022, p. 19, *available at:* https://acl.gov/sites/default/files/RAISE_SGRG/NatlStrategyFamCaregivers_ActionsSCO.pdf (accessed Jan. 21, 2024).

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MLAW Testimony - SB197 - Residential Service Agenc

Uploaded by: Jessica Morgan

Position: FAV

Bill No:	SB197
Title:	Residential Service Agencies - Reimbursement - Personal Assistance Services
Committee:	Finance
Hearing:	February 8, 2024
Position:	SUPPORT

The Maryland Legislative Agenda for Women (MLAW) is a statewide coalition of women's groups and individuals formed to provide a non-partisan, independent voice for Maryland women and families. MLAW's purpose is to advocate for legislation affecting women and families. To accomplish this goal, MLAW creates an annual legislative agenda with issues voted on by MLAW members and endorsed by organizations and individuals from all over Maryland. **SB197 - Residential Service Agencies - Reimbursement - Personal Assistance Services** is a priority on the **2024 MLAW Agenda** and we urge your support.

SB197 will guarantee that home care workers, the majority of whom are women, employed by agencies receiving Medicaid reimbursements, are properly classified and granted essential benefits such as overtime pay, sick and safe leave, unemployment insurance, and workers' compensation.

Many personal care aides who provide vital in-home care under Medicaid programs are misclassified as independent contractors, denying them access to the social safety net and reducing job quality when Maryland faces a shortage of these important workers. This large workforce consists of between 20,000 and 30,000 workers, who are vastly women -- about 90% are women and about 70% are Black. This majority women-of-color workforce deserves employee protections.

Currently, many of the agencies that employ these workers illegally misclassify them as independent contractors. When they are misclassified, they are cut out of the social safety net and lose protections like sick leave, workers' compensation, health insurance, and more – and they face a higher "self-employment" tax when they should be getting a tax refund. Misclassification also hurts those they care for by shrinking the size of the workforce. And it hurts law-abiding RSAs by forcing them to compete on an uneven playing field with RSAs that save money by misclassifying their workers.

Workers lose safety net protections when they are classified as independent contractors, and often cite lack of these benefits a reason for leaving the field of home care. By classifying these workers as the employees they are, they will receive all of these protections, which they should be receiving but are not due to illegal misclassification by their agencies.

For these reasons, MLAW strongly urges the passage of SB197.

Maryland Legislative Agenda for Women
102 W. Pennsylvania Avenue, Suite 100 ▪ Towson, MD 21204 ▪ 443-519-1005 phone/fax
mdlegagenda4women@yahoo.com ▪ www.mdlegagendaforwomen.org

MLAW 2024 Supporting Organizations

The following organizations have signed on in support of our 2024 Legislative Agenda:

1199 SEIU United Healthcare Workers East
AAUW Anne Arundel County
AAUW Garrett Branch
AAUW Kensington-Rockville Branch
AAUW Maryland
Adolescent Single Parent Program (PGCPS)
Anne Arundel County Commission for Women
Anne Arundel County NOW
Baltimore County Commission for Women
Black Women for Positive Change, Baltimore Chapter
Bound for Better, Advocates for Domestic Violence
Bound for Better, advocates for Domestic Violence
Business & Professional Women/Maryland
Center for Infant & Child Loss
Child Justice, Inc.
Church Women United, Inc.
Climate XChange Maryland
Court Watch Montgomery
CTLDomGroup Inc
DABS Consulting, LLC
Engage Mountain Maryland
Frederick County Commission For Women
If/When/How at University of Baltimore School of Law
Lee Law, LLC
Les Etoiles in Haiti
Maryland Coalition Against Sexual Assault
Maryland Legislative Coalition
Maryland Network Against Domestic Violence
Maryland WISE Women
Miller Partnership Consultants
MomsRising
Montgomery County Alumnae Chapter, Delta Sigma Theta Sorority, Inc.
Montgomery County NOW
National Coalition of 100 Black Women, Inc., Anne Arundel County Chapter
National Organization for Women, Maryland Chapter
Rebuild, Overcome, and Rise (ROAR) Center at UMB
REHarrington Plumbing and Heating
Reproductive Justice Maryland
Stella's Girls Inc
The Federation of Jewish Women’s Organizations of Maryland
The Hackerman Foundation
The Relentless Feminist
The Salvation Army Catherine’s Cottage
Top Ladies of Distinction, Inc., Patuxent River
Top Ladies of Distinction, Prince George's County
TurnAround Inc.
University System of Maryland Women's Forum
Women of Action Maryland
Women's Equity Center and Action Network (WE CAN)
Women's Law Center of Maryland
Zeta Phi Beta Sorority, Incorporate - Alpha Zeta Chapter
Zonta Club of Annapolis

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NASW Maryland - 2024 SB 197 FAV - Home Care Worker

Uploaded by: Karessa Proctor

Position: FAV

5750 Executive Drive, Suite 100, Baltimore, MD 21228
410.788.1066 » nasw-md.org

NASW MARYLAND CHAPTER
National Association of Social Workers

House Health & Government Operations Committee

Senate Bill 197
Residential Service Agencies - Reimbursement - Personal Assistance Services
(Homecare Worker Rights Act of 2024)
February 8, 2024

*****SUPPORT*****

The Maryland Chapter of the National Association of Social Workers supports Senate Bill 197 Residential Service Agencies - Reimbursement - Personal Assistance Services. As social workers, we are in favor of this bill because it strengthens the workforce that cares for vulnerable older adults and persons with disabilities. This bill will ensure that personal care aides who work under certain Medicaid programs are properly classified as employees and not misclassified as independent contractors. It will authorize the Maryland Department of Health to reimburse a residential service agency for personal assistance services only if the personal assistance services are provided by an individual classified as an employee, guaranteeing fair and equitable wages and benefits, such as worker compensation and lower tax rates for these invaluable workers who administer care for some of our most vulnerable citizens.

Most personal care aides are employed less than full time, have hours that change frequently, and do not receive health benefits, worker's compensation, or paid leave due to their classification as independent contractors. Under Maryland's Medicaid program, between 15,000 and 20,000 personal care aides provide care under programs operated by the Office of Long-Term Services and Supports. By classifying personal care aides as independent contractors, it worsens job quality by removing the social safety net (making it harder for them to get benefits like workers' compensation when they're injured) and imposing on them a higher "self-employment" tax burden when they should be getting a tax refund. It hurts consumers by shrinking the size of the workforce they depend on for their independence and increasing worker turnover, which – given the intimate nature of the work – can be traumatizing to care recipients. Classifying personal care aides as independent contractors hurts law-abiding RSAs that face unfair competition from RSAs that save money by shirking their obligations as workers' employers.

Currently, older Marylanders and those with disabilities rely on personal care aides to administer bedside and personal care, to perform housekeeping duties, and to transport them to physicians' offices or other locations. Assistance with these tasks allows care recipients to remain in their homes rather than having to enter institutional care. Most of these individuals would prefer to remain in their local community, where they can maintain vital social

connections with family, friends, and neighbors. Furthermore, living in the community is less costly for the state of Maryland.

Requiring the classification of personal care aides as employees would make these jobs more appealing, grant equity in pay and benefits, and increase safety for both personal care aides and older adults. This requirement would lead to a more secure workforce and more consistent care for community-dwelling older Marylanders and those with disabilities.

We ask that you give a favorable report on Senate Bill 197.

Respectfully,

Karessa Proctor, BSW, MSW
Executive Director, NASW-MD

SB 197 - Home Care Misclassification - 1199SEIU.pd
Uploaded by: Loraine Arikat
Position: FAV

Testimony for **SB 197**

Residential Service Agencies – Reimbursement – Personal Assistance Services

Position: **FAV**

To Chair Beidle and members of the Senate Finance Committee:

My name is Ricarra Jones, and I am the Political Director of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the nation – representing 10,000 healthcare workers in long-term care facilities and hospitals across Maryland. 1199 SEIU is a proud partner of the Caring Across Maryland coalition which consists of direct care workers, patients, loved ones, and advocates who are committed to improving the long-term care infrastructure in Maryland through bolstering job quality for care workers, protecting quality of care, and increasing access to affordable long-term care.

HB 39 ensures that the Department of Health only reimburses residential service agencies that are classifying their workers as employees. Many of our members interact with home care aides who help some residents in the facilities. Home care workers are an important part of the patient care team. Often, home care workers have no idea they are being cut out of the social safety net that employees receive and are struggling to pay bills and keep a roof over their heads. Given the high demand of home care workers, HB 39 is an important solution to addressing retention of home care workers.

1199 SEIU represents healthcare workers across the care continuum – long term care, hospitals, and clinics – and we know how our broken long term care infrastructure impacts our state's unique Total Cost of Care healthcare model and our already burdened emergency rooms. Ensuring we have the care force in Maryland to let residents age safely in their homes will positively impact the entire care system.

The widespread misclassification of these workers hurts everyone. It hurts workers by worsening job quality, cutting them out of the social safety net (making it harder for them to get benefits like workers' compensation when they're injured) and imposing on them a higher "self-employment" tax burden when they should be getting a tax refund. Patient quality of care is negatively impacted by high turnover when home care workers are misclassified. It hurts law-abiding RSAs that face unfair competition from RSAs that save money by shirking their obligations as workers' employers. It hurts the State of Maryland by depriving the unemployment insurance trust fund (among other things) of critical revenue that Maryland and its workers depend on.

1199 SEIU believes that care work is essential work. Our public dollars should be going to law-abiding home care agencies not those who undercut essential staff. For those reasons and more, we urge a favorable report on HB 489.

In unity,

Ricarra Jones
Political Director, 1199 SEIU
Ricarra.jones@1199.org
www.caringacrossmaryland.org

SB 197 - Vivian.pdf
Uploaded by: Loraine Arikat
Position: FAV

Testimony for SB 197

Position: Favorable

Dear Chair Beidle and members of the Senate Finance Committee:

My name is Vivian Boone and I am a home care worker in Baltimore City. As someone with over 35 years of experience caring for the state's most vulnerable and being underpaid as a misclassified worker, I support HB 39 to ensure the end of illegal misclassification of home care workers. Home care workers need more support and protection.

Many of us do not even know that we are misclassified until we start sharing our experiences of not getting paid overtime or for the time we spend commuting between homes. I have to work two jobs just to make ends meet. Because of low pay and poor benefits, many of my colleagues leave the field for more stable, less stressful jobs. The patients I take care of need a great deal of support and I can't imagine what would happen to them if they were not able to find a home care worker to take care of them. By preventing worker misclassification, this legislation would reduce turnover and improve the quality of care.

I work hard for my money, but I am not getting what I work for. It hurts me, my family, my home. I work to pay my bills but when my agency misclassifies me. I work weekly to pay for my monthly bills and I still can't meet it. It's hard to make ends meet when we are not compensated justly.

This is a widespread issue, and it needs to be prevented. The state's public dollars are being used by agencies who are breaking the law and undercutting their staff.

Our governor, Wes Moore, said that no one will get left behind. Home care workers continue to be left behind because of lack of state oversight. We call on this committee to stand with home care workers. I respectfully urge a favorable report on SB 197.

Sincerely,

Vivian Boone

Vivian.boone@yahoo.com

SB-197 Testimony 2.8.24.pdf
Uploaded by: Matthew Auman
Position: FAV

Senate Bill 197 Testimony

Good afternoon, Chairman Beidle and Committee members.

My name is Matt Auman, and I am an owner of HomeCentris Healthcare, a Maryland RSA. HomeCentris has five offices in Maryland and is one of the largest providers of Medicaid waiver services with approximately 1,300 employees. I am also a Board Member of MNCHA, the trade association for the homecare industry.

I am testifying today in favor of SB-197 which would tie Medicaid reimbursement to the correct and compliant classification of personal care givers as W2 employees.

I would like to open my remarks by referencing the Guidance Document which was required by the General Assembly in 2021 and issued in the fall of 2022. The Guidance Document was written by The Maryland Department of Labor, The Attorney General's office, and the Department of Health. The first two sentences of this document read, "Maryland's RSAs sometimes wrongly classify PCAs (that is, anyone paid to provide personal care services) as independent contractors rather than employees. When this happens, it is called worker misclassification, and it is illegal." In addition, on January 9th of this year, the US Department of Labor issued its final rule on independent contractors which solidifies that these caregivers should be classified as employees.

At this time, there is no longer a question as to the correct classification of these workers. SB-197 simply says that in order for an RSA to receive Maryland Medicaid funds, it must follow the law. Despite this guidance, I have spoken to multiple 1099 agencies who have told me that until the Department of Labor sues them for non-compliance, they will continue with the 1099 model. This non-compliant viewpoint is why the sponsors of this bill rightly believed that without tying reimbursement to labor law compliance, change will not happen.

WHY DOES SB 197 MATTER?

1. <u>The first reason is protection to workers via compliance with labor laws</u>. Allowing a 1099 model to continue negates the employment-related legislation passed by the General Assembly. Laws and regulations that state, "An employer shall…" is immediately disregarded by many 1099 based RSAs as they simply say, "this legislation doesn't apply to me, I don't have any employees." This interpretation by the 1099 agencies immediately wipes out any employee protection laws and benefits for a class of workers that desperately needs them. An example arose at the MNCHA Legislative Reception on January 30, 2024 at the Calvert House. During a presentation by the Maryland Department of Labor on the FAMLI law providing family leave to Maryland employees, an audience member asked whether the law applied to agencies using the 1099 model. The answer was "no." Not only is this bad for the neediest of employees, but it is another indication of the unlevel playing field between compliant and non-compliant agencies.
2. <u>The second reason is the improvement of quality of care and patient safety</u>. By definition, a 1099 model does not allow agencies to provide any training to their independent contractors or control their schedules. This might be okay for highly educated consultants who may be legitimate 1099 contractors. However, our caregiver workforce is not in that category and desperately needs training to help keep Maryland's citizens safe at home. Without this needed

training, a 1099 agency is simply sending out an untrained, unskilled worker to provide care for somebody's mother or grandmother. This is not what our frail elderly citizens deserve. In addition, it is a reasonable assumption that agencies which openly choose to not comply with labor laws may also choose not to comply with healthcare regulations designed to protect patients.

POSSIBLE OBJECTIONS:

1. A conversion will be too difficult. Some 1099 agencies may tell you that a conversion to a W2 model will be too difficult and therefore will cause a loss of providers to Medicaid recipients. I disagree with this objection. Our company converted approximately 1,100 caregivers in a six-month period in 2018. Most Maryland RSAs have fewer than 20 caregivers. Second, there will be no loss of services. If some RSAs decide to close rather than convert, the caregivers and clients can easily switch to a W2 agency.
2. It is going to cost my agency more to use this model. This objection is correct, and this is the crux of the fairness argument. The employer model is more expensive because it includes taxes and fees for needed employee protection programs. For example, under a 1099 independent contractor model, an agency is generally not paying for:
    a. Overtime wages
    b. Payroll taxes
    c. Unemployment insurance
    d. Maryland Sick and Safe Leave
    e. Workers compensation insurance
    f. Health insurance (if over 50 employees)
    g. Maryland FAMLI paid leave law.

    This totals approximately $2.00 per hour in worker protections that these agencies are not paying. Not only is this bad for the caregivers who need these protections, but also immediately disadvantages compliant W2 agencies by driving caregivers and clients from law-abiding agencies to non-compliant agencies which may offer higher hourly wages. By not requiring a consistent model, Maryland is incentivizing non-complaint agencies while penalizing compliant agencies with significant extra costs.
3. Eliminates flexibility for these caregivers to work in multiple agencies. This is incorrect. Many of these caregivers already work for multiple agencies and are free to move from agency to agency as a W2 employee. There is absolutely no loss of flexibility for these caregivers as W2 employees.

Passing SB-197 is very important to Maryland's seniors and to the caregivers who provide these vital services. I ask the committee to recommend SB-197.

Understanding how Maryland's employee protection laws apply to residential service agencies (RSAs) and personal care aides (PCAs)

Maryland's RSAs sometimes wrongly classify PCAs (that is, anyone paid to provide personal care services) as independent contractors rather than employees.[1] When this happens, it is called *worker misclassification* and it is illegal. This guidance document explains (1) some differences between employees and independent contractors in the context of personal care, (2) worker misclassification and how it can cost RSAs money and hurt PCAs, and (3) some steps RSAs can take to ensure that their classification policies comply with Maryland's Labor and Employment Code.

1. What is the difference between "employees" and "independent contractors"?

- **There are two kinds of workers under Maryland's employment laws: employees and independent contractors.** In general, independent contractors are in business for themselves, while employees are not. If an RSA pays a PCA an hourly wage to perform personal care and oversees the PCA's work, the worker should usually be classified as an employee. A worker can sometimes be an "employee" under one law and an "independent contractor" under another, because different laws have different purposes and define these terms differently. Even if the IRS has accepted the classification of PCAs as independent contractors, you should not assume that a court would reach the same conclusion under Maryland's employee protection laws, which are humanitarian statutes designed to broadly protect workers and are therefore more favorable to employees.

- **Maryland's wage laws and sick leave law—including the Wage and Hour Law, Wage Payment and Collection Law, and Healthy Working Families Act—have a very broad definition of employee.** Most workers are employees, not independent contractors, under these laws. A worker's status as an employee cannot be changed by a contract or other document (like an "independent contractor agreement") that labels the worker as an independent contractor. To determine a worker's proper classification, courts consider factors related to whether workers are in business for themselves. When the employer exercises, or has the right to exercise, direction and control over the performance of an individual's work, the worker is an employee and not an independent contractor. The Maryland Labor and Employment Code defines the term "employ" broadly as "to engage an

[1] Maryland law defines "personal care" as "a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation." Md. Code Ann., Health – Gen. Article § 19-301(n)(1). Personal care includes help in walking, getting in and out of bed, bathing, dressing, feeding, and general supervision and help in daily living. *Id.* § 19-301(n)(2)(i)-(vi).

individual to work," and expressly includes "allowing an individual to work" and "instructing an individual to be present at a work site."

- Applying these factors to RSAs and PCAs, (1) RSAs typically have authority to set and enforce conduct policies, including policies designed to ensure that workers comply with the Maryland Department of Health's rules for Medicaid providers; (2) RSAs typically pay PCAs an hourly wage, which means that PCAs have no opportunity for profit or loss dependent on any managerial skill; (3) PCAs typically do not invest in their own equipment and cannot hire others to do the work instead of them; (4) personal care does not require advanced certifications and does not involve business-like skill; (5) PCAs typically have a working relationship with RSAs that is at least several months long; and (6) RSAs are typically in the business of providing personal care. Therefore, PCAs are more likely to be RSAs' employees than independent contractors within the meaning of Maryland's wage and sick leave laws. In cases where PCAs recruit their own clients, that fact alone does not make them independent contractors if factors otherwise suggest the existence of an employment relationship.

- **Maryland's unemployment insurance law also has a broad definition of employee.** Under this law, a PCA is presumed to be an employee, not an independent contractor, unless the RSA can satisfy a test called the "ABC test." Applying this test to RSAs and PCAs, (1) RSAs typically have the ability to control or direct PCAs' work, (2) PCAs do not customarily have their own business, and (3) although the work is typically performed in individuals' homes, personal care is typically the type of work that RSAs perform. Therefore, PCAs are more likely to be employees than independent contractors within the meaning of Maryland's unemployment insurance law. For illustrations of how Maryland's unemployment insurance law applies to workers like PCAs, see the Code of Maryland Regulations (COMAR) 09.32.01.18-3.

- **Maryland's workers' compensation law also defines employee broadly.** Under this law, a worker is presumed to be an employee unless the employer can show that the worker is an independent contractor under the "common law" test. Applying this test to RSAs and PCAs, (1) RSAs typically have the power to hire PCAs, (2) RSAs typically pay wages to PCAs, (3) RSAs typically have the power to fire PCAs, (4) RSAs typically have the power to control PCAs' conduct, and (5) personal care is typically part of the regular business of RSAs. Therefore, in the context of RSAs, PCAs are more likely to be employees than independent contractors within the meaning of Maryland's workers' compensation law.

2. **How can misclassification of PCAs as independent contractors hurt RSAs and PCAs?**

- **Misclassification hurts RSAs because it is illegal and can lead to costly investigations and lawsuits.** The Maryland Department of Labor or U.S. Department of Labor may investigate, require payment of unpaid wages and money damages to workers, and even get a court order requiring the RSA to change its classification and compensation practices. In addition, PCAs may sue an RSA for unpaid wages that they should have been paid as employees. PCAs may bring these cases individually or, in some circumstances, as class actions on behalf of other workers. A court may order the RSA to pay workers damages up to three times the wages they should have been paid. An RSA held liable under Maryland's Wage and Hour Law and Maryland's Wage Payment and Collection Law may also be responsible for the attorneys' fees of PCAs who sue them. Under these laws, individual owners of a corporation (including an RSA) may also be held personally liable for unpaid wages and attorneys' fees, putting their personal assets at risk.

- **Misclassification can also have severe tax consequences for RSAs.** If the Maryland State Department of Assessments and Taxation (SDAT) or U.S. Internal Revenue Service (IRS) finds that an RSA has failed to pay employment taxes for PCAs who should have been classified as employees, SDAT and/or the IRS may require that the RSA pay tens of thousands of dollars—or more—in back taxes and penalties.

- **Misclassification also hurts PCAs by denying them important legal protections.** These include unemployment benefits, workers' compensation, sick leave, and the right to overtime pay (for hours worked beyond 40 in a workweek) and travel-time pay (for time spent traveling from one client's home to another client's home).

3. **What steps can an RSA take to ensure it follows Maryland's employee protection laws?**

- **Do: Talk to a lawyer.** Employment law can be complicated. Lawyers who practice employment law can help ensure that your RSA follows Maryland law. While it may cost money to ask a lawyer about your RSA's worker classification policies, a labor investigation or a lawsuit could cost far more.

- **Do:** Visit the Maryland Department of Labor's website for guidance and to learn about various outreach programs offered by the Department to employers.

- **<u>Do not</u>: Assume something is legal just because others do it.** People sometimes assume a business practice is legal just because other businesses do it. Some rely on advice from friends when establishing their business's worker classification policies. But this can be dangerous, especially in industries where legal violations are common. And in Maryland, "industry practice" is not a defense to a suit for unpaid wages.

- **<u>Do not:</u>** Assume that if you employ a PCA on a salary basis that you don't have to pay overtime pay. PCAs are entitled to overtime wages.

- **<u>Do</u>: Take action to correct your RSA's employment classification policies if you believe they may be incorrect.** Changing the classification of your RSA's PCAs from independent contractors to employees does not mean you will automatically be subjected to lawsuits or liability. The best way to protect your business—and your own assets—is to make sure your RSA follows the law.

CERTIFICATION

To obtain an initial license from the Maryland Department of Health to operate as an RSA and every 3 years thereafter, an individual with authority over the RSA's pay or employment practices must complete the following certification.

I, _____ [print your name], certify that (1) I have read and understood the above guidance and (2) _____ [name of RSA] will comply with the Maryland Labor and Employment Code's requirements concerning the classification of employees.

If the RSA receives payments from the Maryland Department of Health for the provision of home care, personal care, or similar services through any Medicaid program (CFC, CO, CPAS, ICS, CP, or similar): I certify that _____ [name of RSA] ☐ does / ☐ does not [check one box] use personal care aides who have been classified as independent contractors.

_____ _____

Signature of individual with authority over RSA's pay or employment practices

Date

Wage and Hour Division

Small Entity Compliance Guide

On January 10, 2024, the U.S. Department of Labor published a final rule, Employee or Independent Contractor Classification Under the Fair Labor Standards Act, revising the Department's guidance on how to analyze who is an employee or independent contractor under the Fair Labor Standards Act (FLSA). This final rule rescinds an earlier rule published on January 7, 2021 (2021 Independent Contractor Rule) and replaces it with an analysis for determining employee or independent contractor status that is more consistent with the FLSA as interpreted by decades of court decisions. The Department believes that this final rule will reduce the risk that employees are misclassified as independent contractors, while providing added certainty for businesses that engage (or wish to engage) with individuals who are in business for themselves.

The final rule is scheduled to take effect on March 11, 2024.

Overview of The Final Rule: Employee or Independent Contractor Classification Under the Fair Labor Standards Act

To Whom Does the FLSA Apply?

The FLSA is a federal law that establishes minimum wage, overtime pay, recordkeeping, and child labor standards affecting full-time and part-time employees in the private sector and in federal, state, and local governments. For example, the FLSA generally requires covered employers to pay nonexempt employees at least the federal minimum wage for all hours worked and overtime pay of at least one and one-half times the employee's regular rate of pay for every hour worked over 40 in a workweek. The FLSA also regulates the employment of children, prohibits employers from taking employee tips, and requires employers to provide reasonable break time and a place for covered nursing employees to express breast milk at work. Finally, the FLSA requires covered employers to maintain certain records about their employees and prohibits retaliation against employees who attempt to assert their rights under the Act. The FLSA's protections do not apply to independent contractors.

The FLSA does not define "independent contractor." Courts have held that, under the FLSA, the question is whether, as a matter of economic reality, the worker is economically dependent on the employer for work (and is thus an employee) or is in business for themself (and is thus an independent contractor). Independent Contractors play an important role in the economy and are commonly referred to by different names, including independent contractors, self-employed individuals, and freelancers.

What determines whether a worker is an employee or independent contractor under the FLSA?

There is no single rule for determining whether an individual is an independent contractor or an employee for purposes of the FLSA. Rather, an "economic reality test" looks to the facts of a situation, rather than assuming that a written label, contractual arrangement, or form of business decides if a worker is economically dependent on an employer. In assessing economic dependence, courts and the Department have historically analyzed the circumstances of the employment relationship, considering multiple factors to analyze whether a worker is an employee or an independent contractor, with no factor or factors having predetermined weight.

To analyze if a worker is an employee or independent contractor, the final rule provides six factors that businesses and workers should consider when analyzing the economic realities of the working relationship. These factors, described in the economic reality test of the final rule, are:

(1) opportunity for profit or loss depending on managerial skill;

(2) investments by the worker and the potential employer;

(3) degree of permanence of the work relationship;

(4) nature and degree of control;

(5) extent to which the work performed is an integral part of the potential employer's business; and

(6) skill and initiative.

No one factor or subset of factors determines if a worker is an employee or independent contractor. Rather, all the circumstances of the relationship should be examined. The weight given to each factor may depend on the facts and circumstances of the particular relationship. Also, additional factors may be relevant if they in some way indicate if the worker is in business for themself as opposed to being economically dependent on the employer for work.

The Six Factors of The Economic Reality Test

To analyze if a worker is an independent contractor or employee under the FLSA, the final rule considers the six factors listed below.

Factor One: Opportunity for Profit or Loss Depending on Managerial Skill

Does the worker have opportunities for profit or loss based on managerial skill that affect the worker's economic success or failure? Managerial skill can include initiative or business expertise or judgment. The following facts, among others, can be relevant in the determination:

- Whether the worker determines or can meaningfully negotiate the charge or pay for the work provided;
- Whether the worker accepts or declines jobs or chooses the order and/or time in which the jobs are performed;
- Whether the worker engages in marketing, advertising, or other efforts to expand their business or secure more work; and
- Whether the worker makes decisions to hire others, purchase materials and equipment, and/or rent space.

If a worker has no opportunity for a profit or loss, then this factor suggests that the worker is an employee. Some decisions by a worker that can affect the amount of pay that a worker receives, such as the decision to work more hours or take more jobs when paid a fixed rate per hour or per job, generally do not reflect the exercise of managerial skill indicating independent contractor status under this factor.

Examples: Opportunity for Profit or Loss Depending on Managerial Skill

- **Example 1**: A worker for a landscaping company performs assignments only as decided by the company for its corporate clients. The worker does not independently choose assignments, ask for additional work from other clients, advertise the landscaping services, or try to reduce costs. The worker regularly agrees to work additional hours to earn more money. In this example, the worker does not exercise managerial skill that affects their profit or loss. Rather, their earnings may change based on the work available and their willingness to work more. Because of this lack of managerial skill affecting their opportunity for profit or loss, these facts indicate employee status under the opportunity for profit or loss factor.
- **Example 2**: In contrast, a worker provides landscaping services directly to corporate clients. The worker produces their own advertising, negotiates contracts, decides which jobs to perform and when to perform them, and decides when and whether to hire helpers to assist with the work. This worker exercises managerial skill that affects their opportunity for profit or loss. These facts indicate independent contractor status under the opportunity for profit or loss factor.

Factor Two: Investments by the Worker and the Potential Employer

Are any investments by a worker capital or entrepreneurial in nature? The following facts, among others, can be relevant in that determination:

- Costs to a worker of tools for a specific job and costs that the employer imposes on the worker are not capital or entrepreneurial investments that indicate independent contractor status. Investments that are capital or entrepreneurial in nature and indicate independent contractor status generally support an independent business and serve a business-like function, such as increasing the worker's ability to do different types of or more work, reducing costs, or extending market reach.
- Additionally, the worker's investments should be considered on a relative basis with the potential employer's investments in its overall business. The worker's investments do not have to be equal to the potential employer's investments and should

not be compared only in terms of the dollar values of the investments. The focus should be on whether the worker makes similar types of investments as the employer (even if on a smaller scale) or investments of the type that would allow the worker to operate independently in the worker's industry or field. Such investments by the worker in comparison to the employer weigh in favor of independent contractor status, while a lack of investments that support an independent business indicate employee status.

Examples: Investments by the Worker and the Potential Employer

- **Example 1**: A graphic designer provides design services for a commercial design firm. The firm provides software, a computer, office space, and all the equipment and supplies for the worker. The company invests in marketing and finding clients and maintains a central office from which to manage services. The worker occasionally uses their own preferred drafting tools for certain jobs. In this scenario, the worker's relatively minor investment in supplies is not capital in nature and does little to further a business beyond completing specific jobs. These facts indicate employee status under the investment factor.
- **Example 2**: A graphic designer occasionally completes specialty design projects for the same commercial design firm. The graphic designer purchases their own design software, computer, drafting tools, and rents their own space. The graphic designer also spends money to market their services. These types of investments support an independent business and are capital in nature (e.g., they allow the worker to do more work and find new clients). These facts indicate independent contractor status under the investment factor.

Factor Three: Degree of Permanence of the Work Relationship

Is the work relationship indefinite in duration, continuous, or exclusive of work for other employers? That would weigh in favor of the worker being an employee. Is the work relationship indefinite in duration, non-exclusive, project-based, or sporadic based on the worker being in business for themself and marketing their services or labor to multiple businesses? That would weigh in favor of the worker being an independent contractor.

- This may include regularly occurring fixed periods of work, although the seasonal or temporary nature of work by itself would not necessarily indicate independent contractor classification.
- Where an individual cannot perform work on a permanent basis due to operational characteristics that are unique or intrinsic to particular businesses or industries and the workers they employ, then this factor would not necessarily indicate independent contractor status unless the worker is exercising their own independent business initiative.

Examples: Degree of Permanence of the Work Relationship

- **Example 1**: A cook has prepared meals for an entertainment venue continuously for several years. The cook prepares meals as decided by the venue, depending on the size and specifics of the event. The cook only prepares food for the entertainment venue, which has regularly scheduled events each week. The relationship between the cook and the venue is characterized by a high degree of permanence and exclusivity as the cook does not cook for other venues. These facts indicate employee status under the permanence factor.
- **Example 2**: A cook has prepared specialty meals intermittently for an entertainment venue over the past three years for certain events. The cook markets their meal preparation services to multiple venues and private individuals and turns down work from the entertainment venue for any reason, including because the cook is too busy with other meal preparation jobs. The cook has a sporadic or project-based nonexclusive relationship with the entertainment venue. These facts indicate independent contractor status under the permanence factor.

Factor Four: Nature and Degree of Control

Does the potential employer have control, including reserved control over the performance of the work and the economic aspects of the working relationship?Reserved control means the employer has the right to control even if they do not actually exercise the control. An example of reserved control is if an employer reserves the right to discipline a worker for declining assignments.

Facts relevant to the potential employer's control over the worker include whether the potential employer:

- sets the worker's schedule;
- supervises the performance of the work;
- explicitly limits the worker's ability to work for others, or places demands or restrictions on workers that do not allow them to work for others or work when they choose;
- uses technological means to supervise the performance of the work (such as by means of a device or electronically);
- reserves the right to supervise or discipline workers; or

- controls economic aspects of the working relationship, such as the prices or rates for services and the marketing of the services or products provided by the worker.

Actions taken by the potential employer for the sole purpose of complying with a specific, applicable federal, state, tribal, or local law or regulation are not indicative of control. However, actions taken by the potential employer that go beyond compliance with a specific, applicable federal, state, tribal, or local law or regulation and instead serve the potential employer's own compliance methods, safety, quality control, or contractual or customer service standards may be indicative of control. More facts that show control by the potential employer indicate employee status; more facts that show control by the worker indicate independent contractor status for this factor.

Examples: Nature and Degree of Control

- **Example 1**: A registered nurse provides nursing care for Alpha House, a nursing home. The nursing home sets the work schedule with input from staff regarding their preferences and determines the staff assignments. Alpha House's policies prohibit nurses from working for other nursing homes while employed with Alpha House to protect its residents. In addition, the nursing staff are supervised by regular check-ins with managers, but nurses generally perform their work without direct supervision. While nurses at Alpha House work without close supervision and can express preferences for their schedule, Alpha House maintains control over when and where a nurse can work and whether a nurse can work for another nursing home. These facts indicate employee status under the control factor.
- **Example 2**: Another registered nurse provides specialty movement therapy to residents at Beta House. The nurse maintains a website and was contacted by Beta House to assist its residents. The nurse provides the movement therapy for residents on a schedule agreed upon between the nurse and the resident, without direction or supervision from Beta House, and sets the price for services on the website. In addition, the nurse provides therapy sessions to residents at Beta House as well as other nursing homes in the community at the same time. These facts—that the nurse markets their specialized services to obtain work for multiple clients, is not supervised by Beta House, sets their own prices, and has the flexibility to select a work schedule—indicate independent contractor status under the control factor.

Factor Five: Extent to Which the Work Performed is an Integral Part of the Potential Employer's Business

Is the work performed an integral part of the potential employer's business?

- If the work performed by a worker is critical, necessary, or central to the potential employer's principal business, then this factor indicates that the worker is an employee.
- If the work performed by a worker is not critical, necessary, or central to the potential employer's principal business, then this factor indicates that the worker is an independent contractor.

This factor does not depend on whether any individual worker is an integral part of the business, but rather whether the function they perform is an integral part of the business.

Examples: Extent to Which the Work Performed is an Integral Part of the Potential Employer's Business

- **Example 1**: A large farm grows tomatoes that it sells to distributors. The farm pays workers to pick the tomatoes during the harvest season. Because a necessary part of a tomato farm is picking the tomatoes, the tomato pickers are integral to the company's business. These facts indicate employee status under the integral factor.
- **Example 2**: Alternatively, the same farm pays an accountant to provide non-payroll accounting support, including filing its annual tax return. This accounting support is not critical, necessary, or central to the principal business of the farm (farming tomatoes), thus the accountant's work is not integral to the business. Therefore, these facts indicate independent contractor status under the integral factor.

Factor Six: Skill and Initiative

Does the worker use specialized skills to perform the work and do those skills contribute to business-like initiative?

- This factor indicates employee status where the worker does not use specialized skills in performing the work or where the worker is dependent on training from the potential employer to perform the work.
- Where the worker brings specialized skills to the work relationship, this fact is not itself indicative of independent contractor status because both employees and independent contractors may be skilled workers. It is the worker's use of those specialized skills in connection with business-like initiative that indicates that the worker is an independent contractor.

Examples: Skills and Initiative

- **Example 1**: A highly skilled welder provides welding services for a construction firm. The welder does not make any independent decisions at the job site beyond what it takes to do the work assigned. The welder does not determine the sequence of work, order additional materials, think about bidding for the next job, or use their welding skills to obtain additional jobs, and is told what work to perform and where to do it. In this scenario, the welder, although highly skilled technically, is not using those skills in a manner that evidences business-like initiative. These facts indicate employee status under the skill and initiative factor.
- **Example 2**: A highly skilled welder provides a specialty welding service, such as custom aluminum welding, for a variety of area construction companies. The welder uses these skills for marketing purposes, to generate new business, and to obtain work from multiple companies. The welder is not only technically skilled, but also uses and markets those skills in a manner that evidences business-like initiative. These facts indicate independent contractor status under the skill and initiative factor.

Additional Factors

Additional factors that answer the question of whether a worker is economically dependent on an employer may be relevant. Factors that do not help answer this question, such as whether an individual has alternate sources of wealth or income, are not relevant.

Common Questions

1. **Can an employee waive their rights under the FLSA by signing an independent contractor agreement?**

   No. Under the FLSA, a worker is an employee and not an independent contractor if they are, as matter of economic reality, economically dependent on the employer for work—regardless of whether they sign an independent contractor agreement. While businesses are certainly able to organize their businesses as they prefer consistent with applicable laws, and workers are free to choose which work opportunities are most suitable for them, if a worker is an employee under the FLSA, then FLSA-protected rights (such as minimum wage and overtime pay) cannot be waived by the worker. The Supreme Court has explained that permitting employees to waive their FLSA rights would undermine the Act's goal of eliminating unfair methods of competition in commerce.

2. **Can an individual be an employee for FLSA purposes even if they are an independent contractor for tax purposes?**

   Yes. The Internal Revenue Service (IRS) applies its own test (a version of the common law control test) to analyze if a worker is an employee or independent contractor for tax purposes. While the Department of Labor considers many of the same factors as the IRS, the economic reality test for FLSA purposes is based on a specific definition of "employ" in the FLSA, which provides that employers "employ" workers if they "suffer or permit" them to work. Courts have interpreted this language to be broader than the common law control test. This means that some workers who may be classified as independent contractors for tax purposes may be employees for FLSA purposes because, as a matter of economic reality, they are economically dependent on an employer for work.

3. **If an individual is an employee, are they entitled to minimum wage and/or overtime pay?**

   Yes, unless an exemption applies. The FLSA requires that most employees in the United States be paid at least the federal minimum wage for all hours worked and overtime pay at not less than time and one-half the regular rate of pay for all hours worked over 40 hours in a workweek. However, the FLSA includes numerous exemptions to the Act's minimum wage and/or overtime pay requirements. For example, section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as bona fide executive, administrative, or professional employees, as well as computer employees and outside sales employees. For this FLSA exemption to apply, an employee's specific job duties and earnings must meet all the requirements of the Department's regulations. For more information on the FLSA's white-collar exemptions, see Fact Sheet #17A: Exemption for Executive, Administrative, Professional, Computer & Outside Sales Employees Under the Fair Labor Standards Act (FLSA).

4. **What is an employer's liability for misclassifying an employee as an independent contractor?**

   If an employee is incorrectly classified as an independent contractor, the employer will be responsible for paying any unpaid wages owed to the employee under the FLSA. Additionally, the employer may have to pay liquidated damages in an amount equal to back wages, as well as civil money penalties. Employers may also have to pay attorneys' fees associated with litigation.

Additional Resources

- Final Rule
- Fact Sheet 13: Employment Relationship Under the Fair Labor Standards Act (FLSA)
- Frequently Asked Questions
- Compliance Assistance

Questions?

For questions about this final rule, you may call the Wage and Hour Division's (WHD) Division of Regulations, Legislation, and Interpretation at (202) 693-0406. For questions about the employment classification of a particular worker or group of workers, please contact your nearest WHD District Office, as found at https://www.dol.gov/agencies/whd/contact/local-offices.

Scroll to Top

SB 197 - FAV - ALZ Association Testimony.pdf
Uploaded by: Megan Peters
Position: FAV

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alzheimer's association®

Bill: SB 197 - Residential Service Agencies - Reimbursement - Personal Assistance Services
Committee: Senate Finance Committee
Position: Favorable
Date: February 8, 2024

On behalf of the more than 110,000 Marylanders living with Alzheimer's and the nearly 250,000 caregivers, the Alzheimer's Association supports *SB 197 - Residential Service Agencies - Reimbursement - Personal Assistance Services* and urges a favorable report.

SB 197 authorizes the Maryland Department of Health to reimburse a residential service agency for personal assistance services only if the personal assistance services are provided by an individual classified as an employee.

According to a study published in July 2023, Maryland is amongst the states with the highest prevalence for Alzheimer's dementia in people 65 and older.[1] Specifically, for U.S. counties with a population of 10,000 or more individuals age 65 and older, both Baltimore City and Prince George's County fall in the top 5 jurisdictions with the highest estimated prevalence rates, 16.6% and 16.1% respectively.[2]

As the prevalence of Alzheimer's disease increases, so does the demand for the workforce involved in caring for those living with the disease. Personal care aides are an essential part of our care ecosystem. Ensuring that their careers include social safety net benefits, such as sick leave, will not only benefit the individual but will ensure there are both consistent workers and a sufficient workforce to care for people living with dementia and other vulnerable adults.

The Alzheimer's Association is committed to strengthening the dementia care workforce and urges a favorable report on SB 197. Please contact Megan Peters, Director of Government Affairs at mrpeters@alz.org with any questions.

[1] Dhana K, Beck T, Desai P, Wilson RS, Evans DA, Rajan KB. Prevalence of Alzheimer's disease dementia in the 50 US states and 3142 counties: A population estimate using the 2020 bridged-race postcensal from the National Center for Health Statistics. *Alzheimer's Dement*. 2023; 19: 4388–4395. https://doi.org/10.1002/alz.13081
[2] Ibid.

SB0197-FIN-SUPP.pdf
Uploaded by: Nina Themelis
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB0197

February 8, 2024

TO: Members of the Senate Finance Committee

FROM: Nina Themelis, Director of Mayor's Office of Government Relations

RE: Senate Bill 197 – Residential Service Agencies - Reimbursement - Personal Assistance Services

POSITION: FAVORABLE

Chair Beidle, Vice Chair Klausmeier, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 197.

SB 197 mandates that the Maryland Department of Health prohibits reimbursement for services provided by a residential service agency unless the service was provided by workers classified as "employees," not "independent contractors." This bill will strengthen wage protection for home care workers, benefitting both those workers and the many people they serve.

SB 197 addresses a common practice in the home health industry: the illegal categorization of home health workers as independent contractors, which allows residential service agencies to avoid paying overtime, unemployment insurance, payroll taxes, and workers compensation. These workers are a vital part of the care workforce that supports the growing number of Maryland's frail elderly and persons with disabilities. Not compensating them equitably results in an unstable workforce and deteriorating and inconsistent care.

By mandating that the Department of Health address this issue, SB 197 will improve the quality of Medicaid-funded services and positively impact the home care industry in Maryland as a whole.

For these reasons, the BCA respectfully request a **favorable** report on SB 197.

Annapolis – phone: 410.269.0207 • fax: 410.269.6785
Baltimore – phone: 410.396.3497 • fax: 410.396.5136
https://mogr.baltimorecity.gov/

MSCAN SB197 Homecare Worker Rights Act of 2024).pd
Uploaded by: Sarah Miicke
Position: FAV

Maryland Senior Citizens Action Network

MSCAN

AARP Maryland

Alzheimer's Association, Maryland Chapters

Baltimore Jewish Council

Catholic Charities

Central Maryland Ecumenical Council

Church of the Brethren

Episcopal Diocese of Maryland

Housing Opportunities Commission of Montgomery County

Jewish Community Relations Council of Greater Washington

Lutheran Office on Public Policy in Maryland

Maryland Association of Area Agencies on Aging

Maryland Catholic Conference

Mental Health Association of Maryland

Mid-Atlantic LifeSpan

National Association of Social Workers, Maryland Chapter

Presbytery of Baltimore

The Coordinating Center

MSCAN Co-Chairs: Carol Lienhard

Testimony in Support of SB 197- Homecare Worker Rights Act of 2024

Finance Committee

February 8, 2024
Support

The Maryland Senior Citizens Action Network (MSCAN) is a statewide coalition of advocacy groups, service providers, faith-based and mission-driven organizations that supports policies that meet the housing, health and quality of care needs of Maryland's low and moderate-income seniors.

MSCAN supports SB197 which would ensure that home care works who work for residential service agencies (RSAs) are properly classified as employees, instead of independent contractors under certain Medicaid programs.

Homecare workers are often illegally classified as independent contractors under certain Medicaid programs. These important members of society, who generally make minimum wage, are left out of vital safety net programs and protections, like sick leave, health insurance and workers compensation when they are classified as independent contractors. In addition, these workers pay higher self-employment tax.

Even though this practice is illegal, it is a persistent problem in Maryland. This bill offers a simple fix, by providing that RSAs will only be reimbursed for in-home personal care under certain Medicaid programs if those who do the work are classified as employees.

For the reasons stated above, MSCAN urges a favorable report on SB197.

Thank you for your consideration.

Sarah Miicke
410-542-4850

SB 197 RSA_Reimbursement_Personal Assistance Servi
Uploaded by: Tammy Bresnahan
Position: FAV

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SB 197 Residential Service Agencies - Reimbursement - Personal Assistance Services
(Homecare Worker Rights Act of 2024)
Senate Finance Committee
FAVORABLE
February 8, 2024

Good afternoon, Chair Beidel and members of the Senate Finance Committee. My name Tammy Bresnahan, Senior Director of Advocacy for AARP Maryland. AARP Maryland is a proud member of the Caring Across Maryland coalition supporting a package of bills to bolster quality of care in long term care settings. We would like to thank you for the opportunity to speak in support with amendments of SB 197 Residential Service Agencies-Reimbursement-Personal Assistance Services (Homecare Worker Act of 2024). We thank Senator Ellis for sponsoring this vital piece of legislation.

SB 197 authorizes the Maryland Department of Health to reimburse a residential service agency for personal assistance services only if the personal assistance services are provided by an individual classified as an employee. This is a consumer-friendly policy for many reasons. As one example, employees receive more frequent and better-quality training from their employers than independent contractors receive. As another, employees are included in Maryland's employment-based safety net protections – including sick and safe leave – while independent contractors are not. When personal care workers are unable to take a paid sick day, they are more likely to come to work while sick, putting the client at risk.

Personal care workers who work for Maryland residential service agencies provide the bulk of paid long-term care. These paraprofessional workers hold a variety of job titles, including personal care assistants, home care aides, home health aides, and certified nursing assistants (CNAs). They work in diverse settings, including private homes, adult day centers, assisted living residences and other residential care settings, and nursing homes. More than a million direct care workers in the U.S. work at jobs that may include:

- assisting with personal care activities, such as bathing, dressing, toileting, transferring, and eating;
- providing comfort and companionship;
- observing and reporting changes in a client's condition;
- preparing meals and housekeeping;
- providing oversight for people with cognitive and mental impairments; and
- administering medications and measuring vital signs.

Although most personal care workers find their jobs intrinsically rewarding, they are often low paid with limited or no benefits, high workloads, unsafe working conditions, inadequate training,

a lack of respect from supervisors, lack of control over their jobs, and few opportunities for advancement, all of which contribute to high turnover.

To a large extent, the challenges facing the personal care workforce reflect nationwide realities. The workforce is comprised almost entirely of historically marginalized workers—including women, people of color, and/or immigrants—who face significant obstacles in education and employment. Despite the demands of the job and the unequivocal importance of their contributions, these workers still struggle to make a livable wage and achieve economic stability. SB 197 will ensure that personal care aides who work under Medicaid reimbursement programs are properly classified as employees and not misclassified as independent contractors.

For these reasons we respectfully ask the Committee for a favorable report on SB 197. For questions, please contact me at tbresnahan@aarp.org or by calling 410-302-8451.

SB197_LOS_MCC-signed.pdf
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Position: FAV

MARYLAND COMMISSION ON CAREGIVING

February 8, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: SUPPORT SB 197 - Residential Service Agencies - Reimbursement - Personal Assistance Services

Dear Chairwoman Beidle,

The Maryland Commission on Caregiving is pleased to submit this **letter of support for SB 197 - Residential Service Agencies - Reimbursement - Personal Assistance Services**. This bill will ensure that personal care aides (also known as home care workers) who work for home care agencies (called "residential service agencies" – RSAs – by the Health Code) under certain Medicaid programs are properly classified as employees and not illegally misclassified as independent contractors.

Many people with disabilities and older adults rely on Medicaid-funded personal care services to provide necessary supports to live safely and independently within their homes. As the population ages, people with disabilities live longer, and national policy shifts from institutional towards community-based care, there will need to be substantial improvements in the availability of personal care aides to meet the demand. This has only been exacerbated by the COVID-19 pandemic.

This workforce deserves employee protections and by misclassifying personal care aides who work under Medicaid-funded programs as "independent contractors", they are cut out of the social safety net and lose protections like sick leave, workers' compensation, health insurance, and more – and they face a higher "self-employment" tax when they should be getting a tax refund. This has an effect on employee turnover and retention and, ultimately, the availability of trained, consistent support for older adults and those with disabilities who need assistance in completing activities of daily living.

Serving as the 'voice of the Maryland family caregiver,' the Maryland Commission on Caregiving ("Commission") is a 14-member Governor-appointed body charged with recommending policies that positively impact family caregivers, soliciting and responding to their concerns and acknowledging their contributions. The Commission works to ensure that caregivers across the lifespan are equipped with the resources needed to provide safe care to their loved ones. Medicaid-funded personal care programs are essential to supporting family caregivers. **Passage of SB 197 would support such efforts which is why the Commission respectfully urges a favorable report**.

Sincerely,

Theresa Robertson

Theresa Robertson, Co-Chair, MD Commission on Caregiving

NWLC testimony - MD SB 197 (2.7.24).pdf
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Position: FAV

NATIONAL WOMEN'S LAW CENTER
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SB 197: Residential Service Agencies – Reimbursement – Personal Assistance Services

Senate Finance Committee | February 8, 2024

Position: SUPPORT

The National Women's Law Center (NWLC) submits this testimony in strong support of SB 197, which will better ensure that Maryland's Medicaid dollars support residential service employers who recognize that personal care aides—most of whom are women, disproportionately Black women—are employees who deserve all the benefits and protections of Maryland's labor and employment laws. In so doing, SB 197 will also curb abusive misclassification practices that are particularly prevalent in the home care industry and improve home care services for families throughout the state.

Since 1972, NWLC has fought for gender justice—in the courts, in public policy, and in our society—working across the issues that are central to the lives of women and girls. NWLC advocates for improvement and enforcement of our nation's employment and civil rights laws, with a particular focus on the needs of LGBTQI+ people, women of color, and women with low incomes and their families. Ensuring that working people who are in fact employees under our employment laws are entitled to a minimum wage, overtime pay, and other rights and protections associated with employee status is a critical way to advance higher wages and better working conditions, benefiting the communities we serve.

Misclassification harms workers, their families, and the families they serve.

As Maryland's Office of the Attorney General and the Department of Labor have explained, "[i]n general, independent contractors are in business for themselves, while employees are not."[1] Maryland's labor and employment laws define "employees" broadly,[2] and it is clear that personal care aides working for residential service agencies should fall within that definition because they do not operate their own businesses; instead, the agency pays them an hourly rate to perform specific duties for the agency's clients.[3] But misclassification persists: home care employers often view classifying their workers as independent contractors as a strategy to achieve "attractive financial returns," notwithstanding numerous court decisions affirming that home care workers are employees.[4]

Classification as an independent contractor requires workers to forego not only minimum wage and overtime protections, but also rights to important benefits, including paid sick days, travel time compensation, unemployment insurance, and workers' compensation under Maryland laws as well as employer-provided health insurance, retirement contributions, and more.[5] Misclassified home care

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[1] MD Office of the Attorney General, MD Dep't of Labor & MD Dep't of Health, *Understanding How Maryland's Employee Protection Laws Apply to Residential Service Agencies (RSAs) and Personal Care Aides (PCAs),* RSA-PCA Guidance Document.pdf (maryland.gov).

[2] *Id.*

[3] David J. Rodwin, *Independent Contractor Misclassification Is Making Everything Worse: The Experience of Home Care Workers in Maryland*, 14 ST. LOUIS U.J. HEALTH L. & POL'Y 47, 49-50 (2020), https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1249&context=jhlp.

[4] *Independent Contractor Misclassification in Home Care*, NELP 1-3 (May 2015), https://s27147.pcdn.co/wp-content/uploads/Home-Care-Misclassification-Fact-Sheet.pdf.

[5] *See id*. *See also, e.g.,* Sarah Leberstein & Catherine Ruckelshaus, *Independent Contractor vs. Employee: Why Independent Contractor Misclassification Matters and What We Can Do to Stop It*, NELP 3 (May 2016), https://s27147.pcdn.co/wp-content/uploads/Policy-Brief-Independent-Contractor-vs-Employee.pdf.

workers are thus deprived of the benefits and protections they are due under labor and employment laws, without additional compensation or autonomy in exchange.[6]

It is no coincidence that corporate misclassification is rampant in low-paid, labor-intensive industries in which women and people of color are overrepresented,[7] with home care being a prime example. Black women, Latinas, and other women of color make up the majority of home care workers and other direct care workers[8]—and they often are forced to work long hours at poverty-level wages, on average making $14.50 per hour.[9] In Maryland, 70 percent of home care workers are Black women, many of whom must hold multiple jobs in order to support their own families while providing critical in-home support for clients. Nearly half (46 percent) of home care workers in Maryland rely on means-tested public assistance.[10]

At the individual level, misclassification costs workers thousands of dollars a year,[11] causing stress and hardship for many home care workers and their families. And in the aggregate, these inequities exacerbate and perpetuate the racial and gender wage and wealth gaps that persist in Maryland and across the country. Moreover, the poor quality of home care jobs contributes to high turnover and an ongoing shortage of workers in the field[12]—making it even harder for Maryland's disabled community to secure the care they need.

SB 197 can help improve job quality and reduce misclassification, especially for women and people of color, and ensure that state Medicaid dollars are well spent.

Maryland has long sought to ensure that businesses receiving state money create decent jobs, as shown by Maryland's Prevailing Wage and Living Wage Laws. This legislature has also demonstrated a commitment to reducing race- and gender-based disparities and building an economy that works for all Marylanders. Enacting SB 197 will achieve all of these objectives, benefiting workers, consumers, and the state.

SB 197 will help combat abusive employer misclassification practices and ensure that more home care workers are correctly classified as employees, with the benefits and protections that status provides—which will particularly benefit the women of color who hold the majority of the affected jobs. And taxpayer dollars will go to support better quality home care jobs—and better quality care—for Maryland residents. **For all of these reasons, we urge the Committee to pass SB 197, and respectfully request a favorable report.**

* * *

Please do not hesitate to contact Veronica Faison at vfaison@nwlc.org if you have questions or require additional information. Thank you for your consideration.

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[6] *See, e.g.,* 87 Fed. Reg. 62,268 (Oct. 13, 2022) (citing 2017 Contingent Worker Supplement data indicating that independent contractors are more likely than employees to report earning less than the federal minimum wage and to work overtime hours).

[7] Charlotte S. Alexander, *Misclassification and Antidiscrimination: An Empirical Analysis*, 101 MINN. L. REV. 907, 924 (2017) (finding that "seven of the eight high misclassification occupations were held disproportionately by women and/or workers of color").

[8] *Direct Care Workers in the United States*, PHI 6 (Sept. 11, 2023), https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/#:~:text=Key%20Takeaways&text=Between%202021%20and%202031%2C%20the,care%20workers%20were%20only%20%2423%2C688.

[9] *Id*.

[10] Rodwin, supra note 3, at 54.

[11] *See id.* at 52.

[12] *See, e.g.,* Elizabeth Shwe, *Home Care for Older Adults Increased During COVID, but Direct Care Workers Remain Hard to Find*, MARYLAND MATTERS (Oct. 7, 2021), https://www.marylandmatters.org/2021/10/07/home-care-for-older-adults-increased-during-covid-but-direct-care-workers-remain-hard-to-find/.

SB 197 - Nadirah.pdf
Uploaded by: Wendy Wiley
Position: FAV

Testimony for SB 197

Homecare Workers Rights Act of 2024

Position: FAV

Dear Chair Beidle and members of the Senate Finance Committee:

My name is Wendy (I go by Nadirah) and I live in Baltimore City. I have been a home care aid on and off for 30 years now. I love my job because I believe that care is what keeps this world afloat. Since I was twelve years old when I started watching my mom and ever since then I knew that caregiving is my calling.

I am here today because just last month, I realized that my boss at the agency I work for has classified me as a 1099 “self employed” worker. I recently got into serious car accident that has left me with limited mobility and PTSD, but I do not have health insurance through my job nor do I have sick leave. I had no idea that for the past 5 years I could have had these benefits if I had not been misclassified by my employer. I am here to protect the thousands of other home care workers in the state working for residential service agencies working underpaid and without the benefits they deserve and, like me, may not even know.

For too long, home care workers have been invisible to society as we travel to people’s homes ensuring they can do their daily tasks safely and with support. I am here today to fight for home care workers in the state but also for my patients who deserve consistent caregivers. Because of low pay, I have colleagues jumping between agencies or sometimes leaving the field entirely to earn more in another industry.

I do this work because providing care is personal to me, but I am underpaid and burnt out trying to make ends meet for me and my family. The work that I do is emotional labor, but it also directly impacts my physical health as I go into people’s homes during this pandemic and when the condition of people's homes are unsafe. I had a brain tumor and survived a stroke. I suffered paralysis and when I could not walk, talk, or barely eat, I relied on a friend to care for me. Will the legislature wait until you or your loved ones experiences a health decline to invest in our care infrastructure? And by then, will it be too late?

Caregivers are the backbone of this economy. It’s long overdue for the state to invest in us care workers, and ensure our rights are protected. Because care can’t wait, I urge you to issue a favorable report on SB 197.

Sincerely,

Wendy (Nadirah) Wiley

Wendywiley101@gmail.com

Home Care of Baltimore Favorable Testimony.pdf
Uploaded by: Zinoviy Fradlin
Position: FAV

TESTIMONY IN SUPPORT OF SB 197

Home Care of Baltimore has been providing care for elderly Medicaid recipients for 13 years and has witnessed various trends in employment laws during this time. We initially structured our company as 1099, and we faced challenges with Unemployment, the Labor Department, and other regulatory bodies.

Some companies wrongly think that if a company pays Unemployment and Working compensation, they could consider workers as contractors that it is incorrect. A question arises: if you hire roofers or landscapers, do you pay them overtime or unemployment?

According to the IRS, labor, and unemployment departments, our caregivers should not consider an independent contractor. If the services performed can be controlled by an employer (defining what will be done and how it will be done). This holds true even if the worker is granted freedom of action. What matters is that the employer has the legal right and obligation to control the details of how the services are performed, as required by Comar 10.07.05.

Many employers commonly refer to independent contractors as "1099" and employees as "W-2" workers, based on the IRS forms used for reporting purposes. However, it's essential to note that simply providing a worker with a 1099 Form does not automatically classify them as an independent contractor. The classification must always be based on whether the worker meets federal and state tests for independent contractor status. Different tests are utilized to determine whether a worker is covered by a particular law or benefit.

Under federal nondiscrimination laws, a worker is presumed to be an employee.

" The employer has the right to control when, where, and how the worker performs the job.
" The work doesn't require a high level of skill or expertise.
" The employer furnishes the tools, materials, and equipment.
" The work is performed on the employer's premises.
" There is a continuing relationship between the worker and the employer.
" The employer has the right to assign additional projects to the worker.
" The employer sets the hours of work and the duration of the job.
" The worker is paid by the hour, week, or month rather than the agreed cost of performing a particular job.
" The worker does not hire and pay assistants.
" The work performed by the worker is part of the regular business of the employer.
" The worker is not engaged in their own distinct occupation or business.
" The employer provides the worker with benefits such as insurance, leave, or workers' compensation.
" The worker is considered an employee of the employer for tax purposes (i.e., the employer withholds federal, state, and Social Security taxes).
" The employer can discharge the worker.

Correct classification of workers is a sound fiscal policy and helps families, businesses, and our state.

Home care workers who provide care under Medicaid programs should be properly classified as employees and not misclassified as independent contractors.

Several years ago, before we voluntarily changed our caregivers from contractors to employees we had audited and paid a lot of money because we had not properly classified our workers.

I had many meetings with different lawyers, and everyone said that they could not defend us.

While it may cost money to ask a lawyer about RSA's worker classification policies, a labor investigation or a lawsuit could cost much more.

We participated in the Voluntary Classification Settlement Program (VCSP), an optional initiative allowing taxpayers to reclassify their workers as employees for future tax periods. This provides partial relief from federal employment taxes for eligible taxpayers who agree to prospectively treat their workers as employees.

Some persons who opposite the Bill saying that "We strongly believe this is a mistake that could lead to much lower caregiver shortages for our already underserved community"

But it is wrong, we did it and we survived, it only hurt owners of the companies financially, decreased their profit.

If contractors become employees, the company has to pay 50% of employees Social Security and Medicare, but it makes employees pay 50% less to Social Security and Medicare taxes.

Also, the company must pay (not voluntarily, but mandatory) Unemployment and working compensation Insurances.

The company has to offer and pay other benefits such as Health Insurance and Sick/Vocation time.

My company is paying the same rate to our Employees as other paying to Contractor, yes, it is much less profitable, but we fallow the law.

Changing the classification of your RSA's PCAs from independent contractors to employees is the best way to protect our business and to make sure your RSA follows the law.

I am confident SB197 as presented will ensure home care workers can comfortably continue providing quality in-home care.

We strongly believe that this is the correct path for the RSA.

Thank you for your consideration.

Zinoviy Fradlin

Home Care of Baltimore

410.978.8236

Testimony.pdf
Uploaded by: Jocelyn Buchanan
Position: FWA

Comprehensive Nursing Services, Inc.

Comprehensive Home Health Services

February 7, 2024

This testimony favors SB 197 with amendments - Residential Service Agencies - Reimbursement - Personal Assistance Services.

I am writing on behalf of Comprehensive Nursing Services, Inc. CNS, a licensed Residential Service Agency accredited by the Joint Commission.

CNS supports this bill as it justifies the unfairness that employees, patients, and the State of Maryland face, unlike RSAs that use subcontracted workers. However, we ask that the bill expand its definition of personal assistance services to include LPN and RN services. These licensed professionals contribute to the caregivers' population, and this bill should also apply to them.

Misclassification of the worker often causes the individual to have tax struggles because of the lack of withholding Federal and State taxes. Frequently, we have applicants call our office to confirm that we withhold these taxes before applying to our agency because of past work experience with 1099 agencies and digging themselves out of a financial hole. There is also the concern that the families being cared for may not be protected by workers' compensation or medical malpractice, as individuals working under 1099 may not carry the appropriate coverage.

Additionally, this is unfair to the agencies such as ours, which are responsible for FUTA, Maryland unemployment, and FICA. We also carry professional liability and workers' compensation insurance. Agencies that employ subcontractors do not have this overhead or have to pay overtime. Not paying overtime leads to nurses working more than the allowed 60 hours per COMAR regulations.

And finally, this practice is unfair to the State of Maryland because the State has lost revenue due to RSA's using subcontracted employees. The State of Maryland cannot collect State unemployment from these agencies. To give you a visual of how much misclassification of workers can cost the State, our agency that classifies its nursing staff as employees paid 24,500 dollars in Maryland unemployment tax in 2023.

Thank you for your time, and we appreciate your attention to this issue; we hope you consider expanding this bill to include LPN and RN services. If you have any additional questions, please get in touch with our office.

Thank you,

Jocelyn Buchanan MSN-Ed RN

Jocelyn Buchanan, MSN-Ed RN
Administrator/Co-Owner

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AgainstBill2:8:24.pdf
Uploaded by: Vickie Beard
Position: FWA

Dear Senators,

The proposed bill banning the use of 1099 contractors, presents some concerning issues, for CFC/CO Medicaid reimbursed RSA companies. It would add an additional burden to the family live in caregiver, who in my estimation outnumber all other caregivers in this state. Those that live where they work are expected to provide both formal and informal care hours. In other words, gratuitous care, free care, because according to Mark Leeds, “we don’t want to pay them for anything they might do for free.” Show me where employees work for free? It seems that this is a mistake that could lead to much more caregiver shortages for our already underserved community.

While there is complete agreement that those who do not live where they work are employees providing PAS, the same cannot be said for the live in caregiver. IRS Notice 2014-7 makes it clear that the live in caregivers Medicaid payment for difficulty of care is not taxable. While there may be some gray area as to FICA taxes, in most cases if the caregiver is a spouse, grandparent or parent there is not in these situations. Even if a POS calls for 12 hours of care per day that is the cut off. There are 168 hours in a week and many live in caregivers provide all those hours. Much like the EVV exemption for Live in caregivers could not the same apply here? It is understood that this bill looks to create jobs and treat employees fairly. Again, no argument. But don’t punish live in caregivers in the same brush stroke. If a parent is caring for their severely disabled child 84 hours per week, this bill would send them out looking for a job. What it misses, is if their child needs that much care a regular PAS will take a long time to train, CPR and simple first aid won’t get it. In most cases the parent ends up losing their job, due to a shortage of trained caregivers who sometimes just don’t show up or inflict harm upon the participant. It seems that the passage of this bill, could lead to exponentially even more caregiver shortages for our already underserved and vulnerable community, especially since COVID.

RSA's have been in business providing care for the elderly and disabled Medicaid recipients, many since the union was disbanded in 2015. They have seen many trends in employment laws over the years. There have been many that ignored such laws and misclassified workers on a regular basis. Casting a wide net and banning all use of 1099 contractors is unfair to the RSA's that have tried to make sure all caregivers and their clients, be it live in or W-2 followed state and federal regulations. Providing workers comp, unemployment compensation and all paid taxes to W-2 Employees. Banning 1099, controlling the time clock that is EVV or ISAS, makes the RSA more of an FSA all controlled by MDH and not the RSA owner.

With very low Medicaid reimbursements it is hard to be profitable already. If we are forced to meet CMS 80-20, as well as re-classify all our caregivers as a W2, there will be very few RSA's, MDH will be the employer once again. Especially, in light of the fact that, these programs have not been able to create a self-directed program in the last decade, leading many participants to be misclassified and in the wrong program altogether. The ability to use 1099 is embedded in the Community First Choice (CFC), Community Options (CO) and Community Personal Assistance (CPAS) programs especially for those who are live in caregivers.

The homecare industry is already struggling with caregiver retention and low reimbursement. Taking away the ability to use 1099 would greatly affect all.

Vickie Lee Beard

Business Operations Manager Courtney Cares

Mdlocal406@aol.com 301-312-0462

Hilltop study highlighted.pdf
Uploaded by: Alex Petukhov
Position: UNF

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

January 3, 2018

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
100 State Circle
Annapolis, MD 21401-1925

The Honorable Michael E. Busch
Speaker of the House of Delegates
H-101 State House
100 State Circle
Annapolis, MD 21401-1925

RE: HB 1696 (Ch. 798 of the Acts of 2018) – Report on Rare and Expensive Case Management Reimbursement Rates for Home- and Community-Based Care and the Costs Associated with Providing Service and Care Under Other Home- and Community-Based Programs

Dear President Miller and Speaker Busch:

Pursuant to the requirements in Section 2 of HB 1696 (Ch. 798 of the Acts of 2018), enclosed is a report on Rare and Expensive Case Management reimbursement rates for home- and community-based care and the costs associated with providing service and care under other home- and community-based programs. The Department posted a draft of this report for public comment on its website on October 24, 2018 and shared the draft report via email with service providers on October 26, 2018 (the comment period was open until November 9, 2018). The comments received are listed in Appendix D of the attached report. The comments were reviewed and evaluated by the Hilltop Institute, and their responses to the comments and resulting changes to the final report are noted in Appendix E.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Deputy Chief of Staff at (410) 767-6480 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

cc: Sarah Albert, Department of Legislative Services (MSAR # 11714)

The Hilltop Institute

Rate Methodology Study
Pursuant to Section 2 of HB 1696 (Chapter 798 of the Acts of 2018)

January 1, 2019

UMBC

Suggested Citation: Henderson, M., & Stockwell, I. (2018, November 26). *Rate Methodology Study Pursuant to Section 2 of House Bill 1696 (2018)*. Baltimore, MD: The Hilltop Institute, UMBC.

Rate Methodology Study Pursuant to Section 2 of House Bill 1696 (2018)

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Rate Methodology Study Pursuant to Section 2 of House Bill 1696 (2018)

Introduction

The Maryland Department of Health has asked The Hilltop Institute to complete a rate methodology study of all "Program 3" waivers (Medical Day Care Waiver, Model Waiver, Community Options Waiver) and programs (REM, EPSDT Nursing, CFC, ICS, and CPAS)—as well as the Brain Injury Waiver—in order to compare the rate of reimbursement for these services with the actual cost to providers.

Hilltop examined the services across these waivers and programs and arrived at 50 distinct program-service combinations. Given the significant service overlap between programs—for example, Medical Day Care is offered in multiple programs—Hilltop first condensed these services to create a master list of unduplicated service descriptions and associated provider qualifications. The master list consists of 20 separate services (see Appendix A).

The cost estimate model is based on the following formula, which is a version of the model employed by reimbursement rate methodology studies in Virginia,[1] Maine,[2] and Arizona:[3]

Total Cost = Labor + Transportation + Facility + Supply + Administrative + Program Support

However, not all costs apply to each service. For example, non-facility-based services such as "Behavioral Counseling" do not incur a facility or supply cost; in this case, we set these parameters to zero. We drew our estimates of key parameters from three sources: 1) national data sets such as the Bureau of Labor Statistics' (BLS) National Compensation Survey or the Centers for Disease Control and Prevention's (CDC's) National Study of Long-Term Care Providers; 2) other states' rate reimbursement studies (in particular, Virginia, Maine, and Arizona); and 3) COMAR regulations, waiver applications, and MD provider solicitations. Where applicable, we adapted the inputs to the model to be as granular as possible in order to best approximate specific service-level costs.

Operationally, the per-participant-per-hour cost was estimated using the following formula:

[1] "My Life, My Community – Provider Rate Study" (Virginia – November 12, 2014). Retrieved from http://www.dbhds.virginia.gov/library/developmental%20services/ods-proposed%20waiver%20rate%20models%202014%20november%2012.pdf
[2] "Section 21 Rate-Setting Initiative" (Maine – February 3, 2015). Retrieved from https://www.maine.gov/dhhs/oads/docs/MEOADSRateModelsProposedFinal.pdf
[3] "RebaseBook 2014" (Arizona – June 30, 2014). Retrieved from https://des.az.gov/sites/default/files/rate_rebase_2014.pdf

$$\frac{\left(\frac{Wage}{(1-ERE\ \%)}\right) * Productivity}{Attendance\ Rate * Participants\ per\ Staff} + Transportation + Facility + Supplies$$
$$1 - Administrative\ Cost\ \% - Program\ Support\ \%$$

Below is a more detailed explanation of the cost centers.[4]

Labor

In order to calculate the labor cost per participant hour, it is important to account for three factors: 1) the hourly wage required for an hour of service delivery to one participant; 2) non-wage compensation costs incurred by the provider; and 3) time costs incurred in the provision of services that are legitimate—but not billable—activities. Each of these steps is explained in detail below.

Wage Estimates

Based on the qualifications of providers and the description of the services, Hilltop created a crosswalk of occupations to services, mapping BLS occupation codes and median wages to each service (see Appendix B).[5] Then, based on the language of the regulations, the 2014 National Study of Long-Term Care Providers,[6] and other states' HCBS rate methodology studies, Hilltop estimated the staffing ratio for each service (see Appendix C). This allows us to estimate a weighted "base hourly wage" for each service, which we used as the measure of per-worker-hour wage labor costs to providers. This is intended to capture the hourly labor cost of the "typical" worker within each service. In order to account for wage growth since May 2017, when the BLS estimated these median wages, Hilltop trended the wage estimates forward until January 2019.[7]

[4] This model differs from The Hilltop Institute's 2016 reimbursement rate methodology study for the Community Options waiver in three ways. First, it incorporates transportation, facility, and supply costs as levels, not as percentages. Second, it incorporates a program support factor to account for non-administrative costs that are not related to direct care but which are necessary for operations (rate studies for VA, ME, and AZ all include this factor). Third, we introduce an attendance rate assumption for non-residential facility-based services to account for reduced cost-spreading due to unplanned participant absences.

[5] BLS codes and median salaries from the "May 2017 State Occupational Employment and Wage Estimates – Maryland" (https://www.bls.gov/oes/current/oes_md.htm).

[6] https://www.cdc.gov/nchs/data/nsltcp/2014_nsltcp_state_tables.pdf

[7] We use the Federal Reserve Bank of Atlanta's Wage Growth Tracker (https://www.frbatlanta.org/chcs/wage-growth-tracker.aspx?panel=1) for the South Atlantic Census Division (of which Maryland is one state) to estimate wage growth since May 2017. We average all annual growth rate estimates from May 2017 onward to estimate the annual wage growth has been 3.24%. Then, in order to trend forward to January 2019, which is 20 months after the base period of May 2017, we adjust each of the May 2017 wages by a factor of (1.0324)^(20/12) = 1.055.

We also corrected for the recent increases in state- and county-specific minimum wages in 2017 and 2018.[8]

Employee-Related Expenditures (ERE)

Wage is only one component of labor costs incurred by employers. Firms also offer supplemental benefits such as paid leave, health insurance, dental insurance, and retirement plans, and must contribute to legally defined benefits such as Medicare, Social Security, and federal unemployment insurance. In order to account for these, Hilltop drew upon BLS data on employer costs for employee compensation based on the National Compensation Survey. Hilltop proposes to use .301 as our employee-related cost factor, which is the percentage of total compensation provided as non-wage benefits to private industry health care and social assistance workers as of March 2018.[9]

It is important to note that this is the percentage of *total compensation* that are non-wage benefits. Therefore, in order to incorporate this percentage into our model, Hilltop first translated it to a multiplicative scaling factor for wage.[10]

This value is similar to the values used in other states' rate reimbursement methodology studies. For instance, Nebraska uses a value of .2781, and Minnesota uses .2416. Virginia and Maine use values specific to each service, ranging from .18 -.327 for Virginia and .266-.441 for Maine for services comparable to those in this study.[11]

Productivity

The productivity adjustment is intended to account for provider time that is used for legitimate, service-related purposes (such as training or record-keeping) but is not directly billable. Given

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[8] Prince George's County raised its minimum wage to $11.50 per hour on 10/1/2017, Montgomery County raised its minimum wage to $12.00 per hour on 7/1/2018, and the State of Maryland raised its minimum wage to $10.10 per hour as of 7/1/2018 (https://www.dllr.state.md.us/labor/wages/wagehrfacts.shtml, https://www.dllr.state.md.us/labor/wages/minimumwagelawpg.pdf). However, the extent of this issue is limited: all inflation-adjusted occupational wages in our cost models are above the new Maryland minimum wage of $10.10, and only occupational wage (recreation workers, 39-9032, $10.75 per hour) is below the county-specific minimum wages of $11.50 and $12.00 for Prince George's and Montgomery Counties, respectively. We correct for this by assuming that 1/3 of all services are for enrollees in either Prince George's or Montgomery Counties, and adding a correction factor of (1/3)*(12-10.75) = $0.42 per hour to the wage for recreation workers, for a final occupational wage of $11.16 for these workers. This is intended to reflect the fact that only a fraction of providers will incur the higher labor costs due to the increase in county-specific minimum wages.

[9] https://www.bls.gov/news.release/ecec.t14.htm

[10] This follows from the following algebra: Total Costs = Wage Costs + Benefit Costs.
Benefit costs = .301*Total costs (from the BLS estimates).
Therefore, Total Costs = Wage Costs + .301*Total Costs, or, equivalently, (1-.301)*Total Costs = Wage Costs.
Therefore, Total Costs = Wage Costs/(1-.301).

[11] "Developmental Disabilities Home- and Community-Based Services Rate Development" (Nebraska – October 4, 2011); "Disability Waiver Rate System" (Minnesota – January 15, 2017).

that the provider incurs the cost of these services, it is necessary to include them in order to calculate the true service cost per *billable* hour. For example, suppose that the wage and benefit cost of an hour of employee time is $20, and that employees work eight hours per day. However, because of training, travel, and other activities, suppose that the employee is only able to deliver four hours of direct care services per day. This implies a productivity factor of 8/4, or 2. In order to fully recoup his or her costs, the provider would need to bill $40 ($20*2) per billable hour instead of just the $20 in hourly labor costs.

The productivity factor necessarily depends on the nature of the service. Facility-based services may require activity preparation and cleanup times and staff training to meet licensure standards. Hourly home-based services for licensed professionals require travel time, intensive record-keeping, and training time, and should receive a high productivity adjustment. Home-based services in which providers are unlicensed or un-degreed require travel time but fewer requirements for record-keeping. Daily home-based services (offered for 12 or more hours per day) require minimal transportation time because the provider does not have to travel between clients and should receive a low productivity factor. To that end, Hilltop proposes using the following productivity factors derived from other states' provider cost surveys (see Table 1).

Table 1. Productivity Factors from Other States' Provider Cost Surveys

Grouping	Services Included	Productivity Factor
Facility-based (residential and non-residential)	Medical day care; senior center plus; assisted living; residential habilitation; day habilitation; respite care; supported employment services	1.24[12]
Home-based (hourly), individual provider is licensed/degreed	Case management (REM and non-REM); family training; dietitian and nutritionist; behavioral consultation; private duty nursing; CNA/HHA services; initial nursing assessment; participation by physician in team meeting; nurse monitoring	1.38[13]
Home-based (hourly), individual provider is not licensed/degreed	Personal assistance (hourly); individual support services; consumer training	1.15[14]
Home-based (daily)	Personal assistance (daily)	1.05[15]

[12] This is the average of the following services: ME's "Community Supports-Facility-Based," Tier 1 (1.22), Tier 2 (1.22), and Tier 3 (1.19) and VA's "Day Supports – Facility Services," Tier 1 (1.29), Tier 2 (1.26), Tier 3 (1.25), and Tier 4 (1.23).

[13] This is the average of the following services for VA - "Nursing-Registered Nurse" (1.36), "Nursing-Licensed Practical Nurse" (1.41), "Therapeutic Consultation-Therapists" (1.53), "Therapeutic Consultation-Psychologist/Psychiatrist" (1.53), "Therapeutic Consultation-Other Professionals" (1.53) – and the following services for Maine – "Therapies (Maintenance and Consultative)" (1.30), "Certified Occupational Therapist Assistant" (1.30), "Consultative Services – Behavioral" (1.30), "Consultative Services – Psychological"(1.30), "Skilled Nursing – RN" (1.30), "Skilled Nursing, LPN" (1.30).

[14] This is the average of ME's "Home Support – Short Term" (1.13), ME's "Respite" (1.10) and VA's "In-Home Residential Support, Intermittent" (1.22).

[15] Drawn from ME "Home Support – Long Term" (1.05).

Participants per Staff and Attendance Rate

For certain services, COMAR regulations permit a single staff member to deliver services to multiple participants (for example, in Medical Day Care). This tends to lower the per-participant labor costs, as a single participant receives the hourly services of a "fraction" of a provider. These staffing ratios are from three sources: 1) the language of the COMAR regulations, 2) the National Study of Long-Term Care Providers, and 3) assisted living facility licensure data provided to Hilltop by the Department. Where applicable, Hilltop blended differing requirements for awake and non-awake staffing ratios into one value. See Table 2 below.

Table 2. Proposed Staffing Ratios

Service	Staffing Ratio	Source
Medical Day Care	1 to 4.52[16]	See footnote 16
Senior Center Plus	1 to 8	10.09.54.07.E
Assisted Living (all levels)	1 to 7.4[17]	See footnote 17
Respite	1 to 7.4	Same as assisted living
Residential Habilitation Level 1	1 to 4.67[18]	10.09.46.07.D
Residential Habilitation Level 2	1 to 4	10.09.46.07.D
Residential Habilitation Level 3	1 to 2.67	10.09.46.07.D
Day Habilitation Level 1	1 to 6	10.09.46.08.D
Day Habilitation Level 2	1 to 4	10.09.46.08.D
Day Habilitation Level 3	1 to 1	10.09.46.08.D

In order not to over-estimate the reduction of per-participant labor costs due to staffing ratios, Hilltop also incorporated an attendance factor to account for random non-attendance of scheduled participants in non-residential facility-based services. Hilltop proposes using 90 percent for this, which is used in the 2014 Virginia rate methodology study.

Transportation

It is important to account for transportation costs for two reasons. First, certain facility-based services cover transportation for participants to and from the facility in the case of non-residential services, or in order to facilitate necessary medical care in the case of residential

[16] We estimate this using Maryland-specific data from the 2013-2014 National Study of Long-Term Care Providers. Details available upon request.
[17] We estimate this using Assisted Living Facility licensure data provided by the Department. Details available upon request.
[18] Per COMAR 10.09.46.07 - level 1 residential habilitation "requires a minimum of 1:3 staff to participant ratio during the day and evening shifts and non-awake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift." Assume that for the 8 hours of the overnight shift, participants have a 1:8 staff to patient ratio. This averages to a per-hour ratio of (16/24)*3 + (8/24)*8 = 4.67. Staff ratios for levels 2 and 3 are calculated similarly using a 1:6 staff to patient ratio for the overnight shift.

services.[19] Second, home-based services generally require the site of delivery to be the participant's residence, implying that providers seeing multiple participants per day incur travel costs between appointments. While the time component of this is accounted for in the productivity factor, costs to vehicles are not.

Based on Virginia's rate reimbursement study, Hilltop proposes using the per-participant-per-hour transportation costs presented in Table 3. As these estimates are from November 2014, we adjusted them for inflation and trended them forward to January 2019.[20]

Table 3. Proposed Transportation Costs

Grouping	Services Included	Transportation Cost per Participant per Hour
Facility-based (residential)	Assisted living; residential habilitation; respite care	$0.18[21]
Facility-based (non-residential)	Medical day care; day habilitation; supported employment services	$0.89[22]
Home-based (hourly)	Case management (non-REM); case management (REM); family training; dietitian and nutritionist; behavioral	$4.42[23]

[19] Medical Day Care provides transportation "to enable participants to attend the center and to participate in activity outings, medical appointments, or other participant required services" (COMAR 10.12.04.27.A); Senior Center Plus does not cover transportation (COMAR 10.09.54.15.E.1); Assisted Living must "facilitate access to any appropriate health care and social services" and "provide or arrange transportation" to social and recreational activities, per the resident's service plan (COMAR 10.07.14.28.F,G); transportation requirements for Respite services are assumed to mirror those for Assisted Living; transportation requirements for Residential Habilitation are assumed to mirror those of Assisted Living; Day Habilitation services provide "transportation between a participant's residence and the provider's site, or between habilitation sites if the participant receives habilitation services in more than one place" (COMAR 10.09.46.08.B.4); Supported Employment Services "include transportation or the coordination of transportation between a participant's residence that the supported employment job site" (COMAR 10.09.46.09.B.5).

[20] We use CPI-U for Transportation (from https://fred.stlouisfed.org/series/CPITRNSL) to inflate the transportation cost center. From November 2014 to October 2018, the price index rose from 210.384 to 214.422. We linearly extrapolate to January 2019, and estimate that the price index will be 214.422 + 3*(214.422 - 210.384)/47 = 214.68, implying (214.68 – 210.384)/ 210.384 = 2.0% growth over this period. We use this as our correction factor, and increase the relevant transportation costs from the VA study by 2.0%.

[21] Drawn from VA's "Congregate Residential Support – Group Home w/ Twelve Beds." This estimates weekly mileage cost per participant at $29.50; assuming 24 hour care, this implies an hourly cost of $29.50/(7 * 24) = $0.176. Corrected for inflation, this is $0.176 * (1.02) = $0.18. To the extent that the daily rate for Assisted Living facilities reflects fewer than 24 hours per day of services, we adjust this hourly transportation cost up proportionally (for example, an 18 hour day in assisted living would imply an hourly transport cost of $.18 * (24/18) = $0.24).

[22] Drawn from VA's "Day Supports – Facility Services" ($0.87). Corrected for inflation, this is $0.87 * 1.02 = $0.89. We only use mileage estimates from Virginia, and not both Virginia and Maine, because Virginia's geography and density better approximate that of Maryland than Maine's.

[23] This is the average of the following services for VA – "In-Home Residential Support, Intermittent" ($2.13), "Nursing-Registered Nurse" ($3.81), "Nursing-Licensed Practical Nurse" ($3.95), "Therapeutic Consultation-Therapists" ($5.36), "Therapeutic Consultation-Psychologist/Psychiatrist" ($5.36), "Therapeutic Consultation-Other Professionals" ($5.36). This average is $4.33; corrected for inflation, the value is $4.33 * 1.02 = $4.42.

Grouping	Services Included	Transportation Cost per Participant per Hour
	consultation; private duty nursing; CNA/HHA services; initial nursing assessment; nurse monitoring; personal care; individual support services; consumer training	
Home-based (daily)	Personal Care (daily)	0

Hilltop estimated that home-based daily personal care has a mileage cost of zero because of the nature of the service; that is, participants must receive at least 12 hours of personal care each day in order to qualify for this reimbursement, and we assume that this care is delivered by the same individual provider who does not provide care to other participants on any given day. Additionally, given that Senior Center Plus explicitly does not cover transportation costs (COMAR 10.09.54.15), we set these as zero. Hilltop also assumes that the principal physician participates in team meetings in her office or over the telephone, thus incurring 0 transportation costs. Finally, note that hourly services delivered to the same participant consecutively implies a cost-spreading of the transportation cost center by reducing the likelihood of daily inter-participant travel. Where justified by the language of the regulations or observed shift lengths, we have attempted to incorporate this factor into our models. See the "Other Adjustments" section for more details.

Facility

Facility-based services incur costs to rent or lease the facility or, if the facility is owned, incur depreciation costs. Hilltop proposes using $1.30 as a per-participant-per-hour value of facility costs for non-residential services (comprising medical day care, senior center plus, day habilitation, and supported employment services). [24] While assisted living and residential habilitation are facility-based services, they explicitly do not cover room and board per COMAR regulations; therefore, we do not include the facility cost center in the cost estimate for these services. For respite care, which entails 24-hour care in a residential facility, Hilltop proposes

[24] This is the average of per-participant-per-hour facility costs used in Virginia's rate reimbursement study for "Day Supports – Facility Services": $1.33 per participant per hour for Northern Virginia, and $1.00 per participant per hour for the rest of the state, adjusted for inflation: ((1.33 + 1)/2)*1.118 = 1.30. See footnote 26, below, for details of the 11.8% inflation adjustment.

using $0.20 per-participant-per-hour.[25] As with the transportation cost center, we adjusted our facility cost estimates for inflation and trended them forward to January 2019.[26]

Table 4. Proposed Facility Costs

Grouping	Services Included	Transportation Cost per Participant per Hour
Facility-based (residential)	Respite care	$0.20
Facility-based (non-residential)	Medical day care; senior center plus; day habilitation; supported employment services	$1.30

Supply

Facility-based services incur supply costs in the course of direct care (for example, food, materials for activities, and light medical supplies). Hilltop proposes using $0.35 per participant per hour, the value used in Virginia's "Day Supports – Facility Services" rate model adjusted for inflation. As above, this cost center is not included for assisted living and residential habilitation, which do not cover room and board for participants. Additionally, as with the transportation and facility cost centers, we adjusted this estimate for inflation and trended it forward to apply to January 2019.[27] Additionally, based on input from provider groups, we included a $.20 per-participant-per-hour supply cost for in-home health care (private duty RN, LPN, and CNA/HHA).

Administrative Cost and Program Support

Administrative costs are the expenses associated with the operation of the organization and includes insurance costs, administrative salaries, financial and accounting expenses, and office supplies and equipment. Program support costs are those costs that are neither direct care nor administrative: for example, program development, training, quality assurance, and service

[25] Virginia's non-residential facility rates are based on assumptions of 6 hours of participant attendance per day, 225 days per year. We translate this into a residential facility rate by assuming 24 hours of attendance per day, 365 days per year. Total annual cost is $1.17*6*225 = $1579.5. Adjusted for residential attendance, this is $1579.5/(24*365) = $0.18 per hour. Corrected for inflation, this is $0.18 * (1.118) = $0.20. See footnote 26, below, for details of the 11.8% inflation adjustment.

[26] We propose to use CPI-U: Housing (https://fred.stlouisfed.org/series/CPIHOSNS) to adjust facility costs for inflation. From November 2014 to October 2018, the price index rose from 234.315 to 260.268. We linearly extrapolate to January 2019, and estimate that the price index will be 260.268+ 3*(260.268- 234.315)/47 = 261.92, implying (261.92 – 234.315)/ 234.315 = 11.8% growth over this period. We use this as our correction factor, and increase the relevant facility costs from the VA study by 11.8%.

[27] Given that the supply cost center is intended to capture a variety of items, we propose to use the all-item CPI-U (https://fred.stlouisfed.org/series/CPIAUCSL) to account for price increases. From November 2014 to October 2018, the price index rose from 237.042 to 252.827. We linearly extrapolate the price index across months to January 2019, and estimate that the January 2019 price index will be 252.827 + 3*(252.827- 237.042)/47 = 253.83, implying (253.83 – 237.042)/ 237.042 = 7.1% growth over this period. We use this as our correction factor, and increase the relevant supply costs from the VA study by 7.1%.

coordination. Hilltop proposes using values of 10.33 percent of total costs for administrative cost, and 6 percent of total costs for program support.[28]

Other Adjustments

- The Model Waiver (COMAR 10.09.27.04.A.4.f.i, 10.09.27.04.A.5.b) and EPSDT-Nursing (COMAR 10.09.53.04.D.1) cover CNA/HHA services for shifts of four or more hours (Model Waiver) or two or more hours (EPSDT-Nursing). Hilltop calculated using MMIS claims that in FY2018, the median units per daily claim for non-shared CNA/HHA services was 32 units (8 hours). In order to account for the transportation cost-spreading due to long shifts, Hilltop lowered the travel costs per hour to $4.42/8 =$0.55 and used the lower productivity factor of 1.15.
- The Model Waiver (COMAR 10.09.27.04.A.1.a) only covers shift nursing (both RN and LPN) when "the complexity of the service or the condition of a participant requires the judgment, knowledge, and skills of a licensed nurse for a shift of 4 or more continuous hours." Hilltop calculated using MMIS claims that in FY2018, the median units per daily claim for LPN services was 48 units (12 hours) for non-shared services and 64 units (16 hours) for shared services. Hilltop assumed this implied no daily inter-participant travel, and thus lowered the hourly travel cost to 0. Analogously, Hilltop calculated using MMIS claims that in FY2018 the median units per daily claim for non-shared RN services was 40 units (10 hours). Again, Hilltop assumed that inter-participant daily travel is 0 and lowered the hourly travel cost to 0. This adjustment was also applied to shared RN services. For both set of services – shared and non-shared LPN and RN – Hilltop applied the lower productivity factor of 1.15 to account for the reduced hourly travel requirements.
- The initial nursing assessment (EPDST-Nursing) is covered provided that it lasts for three hours or less. Hilltop presents estimates for both two and three hours, and adjusted hourly transportation costs downward accordingly: to $4.42/2 = $2.21 or $4.42/3 = $1.47, respectively. Due to the reduced hourly travel requirements, Hilltop applied the lower productivity factor of 1.15.

[28] We estimate 10.33% as the average of the administrative cost percentages for Arizona (10%), Virginia (11%), and Maine (10%). While Maine and Virginia used a fixed estimate for program support costs per participant per hour, we believe that it is reasonable to assume that more costly services incur more support costs: therefore, we follow Arizona and use the mid-point of its two values for program support costs (8% and 4%, for an average of 6%). It is important to note that these are estimated as a fraction of total costs, and not labor costs. Therefore, as with the ERE correction to wages, we use the following algebra: Total Costs = Labor + Transportation + Facility + Supplies + Admin + Program Support;
Admin = .1033*Total and Program Support = .06*Total;
Total Costs = Labor + Transportation + Facility + Supplies + .1033*Total + .06*Total;
Total Costs = Labor + Transportation + Facility + Supplies + .1633*Total;
(1-.1633)*Total Costs = Labor + Transportation + Facility + Supplies;
Total costs = (Labor + Transportation + Facility + Supplies)/.8367

- Based on FY18 MMIS claims data, Hilltop estimated that the median shift length for behavioral consultation services is 2 hours. Accordingly, Hilltop adjusted the hourly travel costs to be $4.42/2 = $2.21 and applied the lower productivity factor 1.15 to account for reduced hourly travel time.
- Based on ISAS data provided by the Department, the average personal assistance services provider works 6.52 hours per day and sees 1.18 clients per week. This scales to an average per-client shift length of 6.52/1.18 = 5.53 hours. Accordingly, for non-shared personal assistance services, Hilltop scaled down the hourly travel costs to $4.42/5.53 = $0.80 and applied the lower productivity factor 1.05 to account for the reduced hourly travel time.
- Several services (for example, personal assistance) offer both individual and shared options. Hilltop modeled this as if for a group service with a staffing ratio of two, thereby assuming two participants for every worker, but with two changes. First, we applied the *level* of the administrative and support costs from the non-shared service to each enrollee in the shared service (instead of a percentage). This accounts for the fixed reporting and administrative costs for each enrollee in the shared service. Additionally, we spread the transportation costs over each participant, since we assume that participants using shared services live in the same residence and would not each incur a separate transportation cost.

Table 5. Draft Cost Estimates and MDH Reimbursements

Service	FY 19 Reimbursement	Estimated Cost	Difference
Medical Day Care (6 hour day)	$79.84	$86.90	$7.06
Respite Services (provided in an assisted living facility) (24 hours)	$78.43	$136.38	$57.95
Senior Center Plus (8 hours)	$49.45	$55.04	$5.59
Assisted Living II with MDC (18 hours)	$46.63	$87.83	$41.20
Assisted Living III with MDC (18 hours)	$58.80	$91.74	$32.94
Assisted Living II no MDC (24 hours)	$62.15	$115.39	$53.24
Assisted Living III no MDC (24 hours)	$78.43	$120.60	$42.17
Residential Habilitation Level 1 (24 hours)	$211.72	$274.98	$63.26
Residential Habilitation Level 2 (24 hours)	$280.34	$320.18	$39.84
Residential Habilitation Level 3 (24 hours)	$387.84	$477.10	$89.26
Day Habilitation Level 1 (5 hours)	$54.67	$71.48	$16.81
Day Habilitation Level 2 (5 hours)	$95.35	$99.64	$4.29
Day Habilitation Level 3 (5 hours)	$134.15	$353.01	$218.86
Supported Employment Level 1 (.75 hour)	$32.43	$35.46	$3.03
Supported Employment Level 2 (1 hour)	$54.67	$47.28	-$7.39
Supported Employment Level 3 (4 hours)	$134.15	$189.12	$54.97
Dietitian/Nutritionist Services	$67.97	$85.08	$17.11
Case Management (non-REM)	$63.75	$64.12	$0.37
Behavior Consultation	$67.97	$72.39	$4.42
Family Training	$67.97	$97.16	$29.19
Personal Assistance Services (non-shared) (Hourly)	$17.50	$25.54	$8.04
Personal Assistance Services (non-shared) (Daily) (12 hours)	$225.88	$295.08	$69.20
Personal Assistance Services (shared) (Hourly)	$11.67	$14.86	$3.19
Personal Assistance Services (shared) (Daily) (12 hours)	$150.59	$171.63	$21.04
Nurse Monitoring	$86.39	$93.94	$7.55
Consumer Training	$44.08	$60.95	$16.87
Individual Support Services	$26.51	$33.14	$6.63
Private Duty RN (1 participant) - per 15 minutes	$13.57	$18.53	$4.96
Private Duty RN (2+ participants) - per 15 minutes	$9.36	$10.80	$1.44
Private Duty LPN (1 participant) - per 15 minutes	$8.80	$13.33	$4.53
Private Duty LPN (2+ participants) - per 15 minutes	$6.08	$7.78	$1.70
CNA or HHA (1 participant) - non-CMT – per 15 minutes	$3.85	$7.26	$3.41
CNA or HHA (2+ participants) - non-CMT – per 15 minutes	$2.68	$4.25	$1.57
CNA or HHA (1 participant) – CMT – per 15 minutes	$4.65	$7.29	$2.64
CNA or HHA (2+ participants) – CMT – per 15 minutes	$3.20	$4.27	$1.07

Service	FY 19 Reimbursement	Estimated Cost	Difference
Initial Nursing Assessment (2 hours)	$150.00	$153.05	$3.05
Initial Nursing Assessment (3 hours)	$150.00	$226.93	$76.93
Coordinated Care Fee, Initial Rate (5 hours)	$400.21	$416.46	$16.25
Coordinated Care Fee, Risk Adjusted High Initial (4 hours)	$295.51	$333.17	$37.66
Coordinated Care Fee, Risk Adjusted Low (3 hours)	$176.13	$249.88	$73.75
Coordinated Care Fee, Risk Adjusted Maintenance Level 3 (1.5 hours)	$92.96	$124.94	$31.98
Participation by physician in plan of care meeting (15 minutes)	$40.50	$58.43	$17.93

Appendix A. Program 3 and Brain Injury Waiver Service Definitions and Provider Qualifications*

Waiver Service	Service Definition	Provider Qualifications
Medical Day Care **(ICS, TBI Waiver, CO Waiver, MDC Waiver, Model Waiver)** **79.84/day**	Medical Day Care (MDC) is a program of medically supervised, health-related services provided in an ambulatory setting to medically disabled adults, due to their degree of impairment, need for health maintenance, and restorative services supportive to their community living in accordance with COMAR 10.09.07. MDC includes the following covered services per COMAR 10.09.07.05: (1) Health care services which emphasize primary prevention, early diagnosis and treatment, rehabilitation, and continuity of care (2) Nursing services (3) Physical therapy services (4) Occupational therapy services (5) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene (6) Nutrition services (7) Social work services (8) Activity Programs (9) Transportation Services. According to COMAR 10.09.07.03 (Medical Day Services, Conditions for Participation) MDC's must be open for at least six hours a day, five days a week.	Must be licensed by the Office of Health Care Quality (OHCQ) under COMAR 10.12.04 (Day Care for the Elderly and Adults with a Medical Disability). In accordance with COMAR 10.09.07.04 (Medical Day Services, Staffing Requirements) and 10.12.04.14 (Medical Day Licensure, Staff) staff must consist of: (1) A director: (full or part-time) who must hold a bachelor's degree in the health and human services field or be an RN (2) A licensed social worker (full or part-time) (3) A medical director who is a licensed physician and who has one year of experience in the care of impaired adults (full-time, part-time, or contractual) (4) An RN with at least three years of experience (5) An LPN: who works with the RN and shall meet the nursing service needs when the RN is not on-site (6) A certified nursing assistant (CNA): who is present when an RN or LPN are not on-site (7) An activities coordinator: who possesses a high school diploma or general equivalency diploma (GED) and has at least three years of experience (8) Program assistants: who possess or are enrolled in a program leading to a high school diploma or GED. COMAR 10.12.04.16 (Medical Day Licensure, Program Components) states that the MDC may use specialists on a part-time or consultant basis in: (1) Psychiatry (2) Physiatrics (3) Orthopedics (4) Other specialties according to the needs of the participants.

Waiver Service	Service Definition	Provider Qualifications
Senior Center Plus **(ICS, CO Waiver)** **49.45/day**	Senior Center Plus is a program of structured group activities and enhanced socialization provided on a regularly scheduled basis. The program is designed to facilitate the participant's optimal functioning and to have a positive impact on the participant's orientation and cognitive ability. Senior Center Plus is provided for one or more days per week, at least four hours a day, in an outpatient setting, most often within a senior center. Services available in a Senior Center Plus program include social and recreational activities designed for elderly/disabled individuals, supervised care, assistance with activities of daily living and instrumental activities of daily living and enhanced socialization, as well as one nutritional meal. Health services are not included; therefore, Senior Center Plus is an intermediate option between senior centers and medical day care that is available as a waiver service. Some providers of Senior Center Plus elect to provide transportation even though it is not required (and is not covered in the rate, COMAR 10.09.54.15, Home and Community-Options Waiver, Covered Services, Senior Center Plus). If a Senior Center Plus program does not offer transportation, the waiver participant can request transportation through the transportation program.	Must be certified as a Senior Center Plus provider by the Maryland Department of Aging (MDoA) and also be approved as a nutrition service provider. In accordance with COMAR 10.09.54.07 (Home and Community-Based Options Waiver, Specific conditions for Provider Participation, Senior Center Plus), the provider must employ as the center's manager or in another position an individual who: (1) Is a licensed health professional or a licensed social worker; (2) Has at least 3 years of experience in direct patient care at an adult day care, nursing facility, or health-related facility; and (3) Participates in training specified and approved by the MDoA.

Waiver Service	Service Definition	Provider Qualifications
Respite **(CO Waiver)** **78.43/day**	Respite may be provided on a short-term basis to relieve those family caregivers who normally provide the participant's care. Respite care may be provided in a Medicaid-certified nursing facility or other assisted living facility approved by the state. Respite care that entails performing delegated nursing functions such as assistance with self-administration of medications or administration of medications by the aide are covered if the service is provided by an appropriately trained aide under the supervision of a licensed RN, in accordance with Maryland's Nurse Practice Act, COMAR 10.27.11 Delegation of Nursing Functions. According to COMAR 10.09.54.18-1 (Home and Community-Based Options, Covered Service, Respite Care) respite care services include room and board and overnight care.	Must be licensed by OHCQ (nursing facilities or assisted living facilities for levels two or three) and have appropriate facilities for overnight care. In accordance with COMAR 10.09.54.10-1 (Home and Community-Based Options Waiver, Specific Conditions for Participation, Respite Care) and 10.09.54.05 (Home and Community-Based Options Waiver, Specific Conditions for Provider Participation, Assisted Living) and 10.07.14.14-15,18-20 (Assisted Living Programs) staff must consist of: (1) A manager: who must be a licensed physician, licensed RN, licensed LPN, or have at least 3 years of experience in direct patient care (2) An alternative manager: who has at least two years of experience in a health-related field (3) Additional staff: who must be 18 years or older, unless licensed as a nurse (4) A delegating nurse: who must be an RN.

Waiver Service	Service Definition	Provider Qualifications
Case Management **(ICS, CO Waiver, Model Waiver, CFC, CPAS)** **63.75/hour** **15.9375 per 15-minute unit**	Case management (also called "supports planning" in CFC and CPAS), has two components: transitional comprehensive and ongoing case management. Transitional comprehensive case management is the case management that is provided to the applicants who are applying for enrollment in the waiver or program. The scope of transitional comprehensive case management activities includes: (1) Assisting applicants with obtaining the necessary eligibility determinations (2) Developing a comprehensive plan of service (POS) that identifies services and providers and includes both state and local community resources (3) Coordinating the transition from an institution to the community (4) Ensuring service providers are ready to begin services upon enrollment. Ongoing case management focuses on the ongoing monitoring of the participant's health and welfare, through oversight of the services received by the participant as approved in the participant's POS. The case manager is responsible for initiating the process for determining the participant's level of care, both the initial determination and the annual re-determination. A case manager's caseload may vary from 20 to 45 participants.	In accordance with COMAR 10.09.54.11 (Home and Community-Based Options Waiver, Specific Conditions for Provider Participation, Case Management Services), a provider of case management services under the Community Options waiver must be an area agency or other entity designated by the MDH through a process approved by CMS. Case managers for participants in the Model Waiver (COMAR 10.09.27.03: Home Care for Disabled Children Under a Model Waiver, Conditions for Participation) cannot also be a provider of medical supplies and equipment or nursing services. In accordance with COMAR regulations 10.09.84.07 (Community First Choice, Specific Conditions for Provider Participation, Supports Planning) and 10.09.20.06 (Community Personal Assistance Services, Specific Conditions for Provider Participation, Supports Planning), providers shall either be identified by the department through a solicitation process, or be the area agency on aging that is enrolled to provide case management services under COMAR 10.09.54 (Home and Community-Based Options Waiver).

Waiver Service	Service Definition	Provider Qualifications
Case Management **(REM)** **400.21 (Initial Rate)** **295.51 (Risk Adjusted High Initial)** **176.13 (Risk Adjusted Low)** **92.96 (Risk Adjusted Maintenance Level 3)**	REM participants receive an initial case management assessment, performed by a REM case manager, in which the case manager: 1) Gathers all relevant information needed to determine the participant's condition and needs 2) Consults with the participant's current service providers 3) Evaluates the relevant information and completes a needs analysis. Other case management services include: 1) Assisting the participant with selecting a PCP when necessary 2) Developing a plan of care in conjunction with the participant, the participant's family, and the PCP 3) Implementing the plan of care and assist the participant in gaining access to medically necessary services 4) Monitoring service delivery and performing record reviews 5) As necessary, initiating and implementing modifications to the plan of care 6) Monitoring a recipient's receipt of EPSDT services as specified in COMAR 10.09.67 7) Assisting the participant with the coordination of school health-related services.	In accordance with COMAR 10.09.69.06 (Maryland Medicaid Managed Care Program: Rare and Expensive Case Management, Requirements for Provider Qualifications) case managers for participants in the Rare and Expensive Case Management Program must be: 1) An RN or social worker AND 2) Licensed.

Waiver Service	Service Definition	Provider Qualifications
Behavior Consultation **(ICS, CO Waiver)** **67.97/hour**	Behavior consultation services are provided in a participant's home or the assisted living facility to assist the caregiver(s) in understanding and managing a participant's problematic behavior. The provider performs an assessment of the situation, determines the contributing factors, and recommends interventions and possible treatments. The provider prepares a written report which includes the assessment and the provider's recommendations which are discussed with the waiver case manager, the assisted living providers, or family. The appropriate course of action is determined and the provider may also recommend resources such as medical services available to the participant under the State Plan. Time spent in related activities before or after the home visit are not compensable.	If services are provided by a residential services agency, the agency must be certified in accordance with COMAR 10.07.05. In accordance with COMAR 10.09.54.06 (Home and Community-Based Options Waiver, Specific Conditions for Provider Participation, Behavior Consultation), the individual rendering the services must: (1) Be an RN, a psychologist, a psychiatrist, or a clinical social worker AND (2) Be licensed AND (3) Have direct experience working with adults with behavioral problems.
Family Training **(ICS, CO Waiver)** **67.97/hour**	Training and counseling services are available as needed for family members. For this service, "family" is defined as the person/s that lives with or provides care to a waiver participant, and may include a parent, spouse, children, relatives, foster family, in-laws, or other unpaid "informal" caregivers. Family does not include individuals who are employed to care for the participant. Training may include such topics as how to work with the participant's self-employed personal care aides and other waiver providers. Instruction may also be provided about treatment regimens, dementia, and use of equipment specified in the participant's POS. This service is provided on a one-on-one basis during a home or office visit with the family member. The unit of service is one hour and providers may only bill for the length of the visit, not for related activities performed before or after the visit.	If family training services for Community Options waiver participants are provided by an agency, the agency must be licensed by OHCQ (assisted living, home health agencies, and residential service agencies). A personal care nurse case monitoring agency, such as a local health department, may also provide the service. In accordance with COMAR 10.09.54.08 (Home and Community-Based Options Waiver, Specific Conditions of Provider Participation, Family Training) the individual rendering the services must: (1) Be an RN, OT, PT, or social worker AND (2) Be licensed AND (3) Have experience.

Waiver Service	Service Definition	Provider Qualifications
Dietitian/Nutritionist **(ICS, CO Waiver)** **67.97/hour**	Nutritionist and dietitian services are rendered one-on-one in a participant's home or the provider's office. Services include individualized nutrition care planning, nutrition assessment, and dietetic instruction. The service is provided when the participant's condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian to assess participants and assist them and their caregivers with a plan to optimize nutritional outcomes.	In accordance COMAR 10.56.54.09 (Home and Community-Based Options Wavier, Specific Conditions for Provider Participation, Dietitian and Nutritionist Services), the individual rendering the services must be licensed in accordance with the Board of Dietetic Practice (COMAR 10.56.01) and Health Occupations Article, Title 5, Annotated Code of Maryland.

Waiver Service	Service Definition	Provider Qualifications
Assisted Living (all levels) **(ICS, CO Waiver)** **46.63/day – Level II with MDC** **58.80/day – Level III with MDC** **62.15/day – Level II no MDC** **78.43/day – Level III no MDC**	These services are available to all participants regardless of level of care: (1) Three meals per day and snacks ▪ Provision of or arrangement for special diets ▪ Four- week menu cycle approved by a licensed dietitian or nutritionist at the time of licensure approval and licensure renewal (2) Daily monitoring of resident & resident's assisted living service plan ▪ 24-hour supervision (3) Personal care and chore services including: ▪ Assisting with activities of daily living, including instrumental activities of daily living ▪ Routine housekeeping, laundry, and chore services (4) Medication management including administration of medications or regular assessment of a participant's ability to self-medicate, regular oversight by the facility's delegating nurse, and on-site pharmacy review for residents with 9 or more medications (5) Facilitating access to health care, social, and spiritual services (6) Nursing supervision and delegation of nursing tasks by an RN (7) Basic personal hygiene supplies (8) Assistance with transportation to Medicaid covered services. Only level two or three assisted living services are reimbursed, as these levels of service are consistent with the needs of individuals with a nursing facility level of care (NF LOC). Additionally, room and board will not be reimbursed. The provider bills Medicaid for level two without medical day care, level two with medical day care, level three without medical day care, or level three with medical day care assisted living services according to the participant's assessed level of assisted living care and medical day care participation. There is a daily rate reduction in the AL rate when a participant attends MDC. The Medicaid assisted living service daily waiver reimbursement rates for level two with/without medical day care and level three with/without medical day care cover all of the required services listed above including the referral to medical and social services.	Must be licensed by OHCQ (for level two or three) and have appropriate facilities for overnight care. In accordance with COMAR regulations 10.09.54.05 (Home and Community-Based Options Waiver, Specific Conditions for Provider Participation, Assisted Living) and 10.07.14.14-15,18-20 (Assisted Living Programs) staff must consist of: (1) A manager: who must be a licensed physician, licensed RN, licensed LPN, or have at least 3 years of experience in direct patient care (2) An alternative manager: who has at least two years of experience in a health-related field (3) Additional staff: who must be 18 years or older, unless licensed as a nurse (4) A delegating nurse: must be an RN with a current license. Additionally, the aides should have first aid certificates and the facility must always have enough aides with CPR certificates on duty. The facility must have a CMT on duty if medications are to be administered. A CMT works under the supervision of a delegating nurse hired by the ALF.

Waiver Service	Service Definition	Provider Qualifications
Personal Assistance **(CFC, CPAS, ICS)** **11.67/hour – Shared** **17.50/hour – Non-Shared** **150.59/day - Shared** **225.88/day – Non-Shared**	Personal assistance services (also called "attendant care services" in ICS) are intended to assist participants with activities of daily living (e.g., bathing, eating, toileting, dressing, and mobility) and instrumental activities of daily living (e.g., preparing a light meal, performing light chores, or shopping for groceries) and are rendered in a participant's home or in a community setting. Personal assistance also includes delegated nursing functions, such as assistance with the participant's administration of medications or other remedies in the participant's plan of service. This service does not include the cost of food or meals prepared in, or delivered to, the home or otherwise received in the community.	In accordance with COMAR regulations 10.09.84.06 (Community First Choice, Specific Conditions for Provider Participation, Personal Assistance) and 10.09.20.05 (Community Personal Assistance Services, Specific Conditions for Provider Participation, Personal Assistance), providers of personal assistance services must be licensed as residential service agencies under COMAR 10.07.05. Staff must consist of: 1) An RN who shall delegate nursing tasks, as appropriate, to a CNA or CMT 2) Workers who will accept instruction on the personal assistance services required in the plan of care. Pursuant to 10.05.07.05.11.C(5), RSA workers must be trained in CPR. Workers who perform delegated nursing services shall, if required to administer medications, be a CMT. If performing other delegated nursing functions, workers shall also be CNAs.
Consumer Training **(CFC, ICS)** **44.08/hour**	Consumer training services (also called "participant training" in ICS) includes instruction and skill-building in areas such as money-management, budgeting, independent living, meal planning, and other skills necessary for the participant to accomplish ADLs and IADLs. The unit of service is one hour, and is provided on a one-on-one basis at the participant's home. Providers may not bill for related activities performed before or after the visit (including preparation for the training, follow-up, and travel to and from the training).	In accordance with COMAR regulations 10.09.84.08 (Community First Choice, Specific Conditions for Provider Participation, Consumer Training) and 10.09.81.05 (Increased Community Services (ICS) Program, Specific Conditions for Provider Participation, Participant Training), providers may either be self-employed or agency-based trainers. Providers shall demonstrate experience in the skill being taught.
Nurse Monitoring **(CFC, CPAS, ICS)** **86.39/hour**	Nurse monitoring services (also called "nursing supervision of attendants" in ICS) are intended to assess the quality of personal assistance services received by participants. Nurse monitors periodically contact or visit participants in order to assess the participant's condition and observe the performance of the worker. Furthermore, nurse monitors review documentation related to the provision of personal assistance services and maintain an up-to-date client profile in an electronic database designated by the department.	In accordance with COMAR regulations 10.09.84.12 (Community First Choice, Specific Conditions for Provider Participation, Nurse Monitoring) and 10.09.20.07 (Community Personal Assistance Services, Specific Conditions for Provider Participation, Nurse Monitoring), providers shall employ or contract with RNs who hold a current professional license to practice in Maryland.

Waiver Service	Service Definition	Provider Qualifications
Residential Habilitation **(TBI Waiver)** **211.72/day – Level I** **280.34/day – Level II** **387.84/day – Level III**	Residential habilitation services are provided in a community-based facility and assist participants in acquiring, regaining, retaining, or improving self-help skills related to activities of daily living and the socialization and adaptive skills which are necessary to reside successfully in home and community-based settings. This includes: 1) Supervision and support up to 24 hours a day in a residence 2) Nursing supervision for any medication administration or other delegated nursing functions 3) Behavior intervention services 4) Daily coordination of the participant's clinical treatment, rehabilitation, health, and medical services with the other providers of BI waiver services. Level 1 care requires a minimum 1:3 staff to participant ratio during day and evening shifts and non-awake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift. Level 2 care requires a minimum 1:3 staff to participant ratio during day and evening shifts and awake, on-site supervision during the overnight shift. Level 3 care requires a 1:1 staff to participant ratio during day and evening shifts and awake, on-site supervision during the overnight shift. Room and board are not reimbursed by the department.	Provider agencies must be licensed by OHCQ as Community Residential Services Programs (COMAR 10.22.08). Additionally, providers must demonstrate experience in the provision of services to individuals with BI by having: 1) A history of serving individuals with brain injury for 2 years 2) A program of specialized services appropriate for the needs of individuals with brain injuries 3) Availability of licensed healthcare professionals with experience in the provision of services to individuals with BI to supervise, train, or consult with program staff 4) Accreditation by CARF for the provision of brain injury services. Additionally, providers must provide an annual continuing education program for all staff working with waiver participants on the needs of individuals with BI that may include: 1) Types of brain injuries 2) Behavioral, emotional, cognitive, and physical changes after brain injury 3) Strategies for compensation and remediation of deficits caused by a brain injury.

Waiver Service	Service Definition	Provider Qualifications
Day Habilitation **(TBI Waiver)** **54.67/day – Level I** **95.35/day – Level II** **134.15/day – Level III**	Day habilitation services are provided in a non-residential setting, separate from the home or facility in which the individual resides, and are intended to enable the participant to regain, attain, or maintain the participant's maximum functional level. Specific services include: 1) Habilitative or rehabilitative services to assist a participant in acquiring, regaining, retaining, or improving the self-help skills related to activities of daily living and social and adaptive skills, which are necessary to reside successfully in home and community based settings 2) Meals 3) Nursing supervision for any medication administration or other delegated nursing functions 4) Behavior intervention services 5) Transportation between a participant's resident and the provider's site, or between habilitation sites if the participant receives habilitation services in more than one place. The minimum staff to participant ratios by acuity level are: 1) 1:6 staff to participant for level 1 care 2) 1:4 staff to participant for level 2 care 3) 1:1 staff to participant for level 3 care. Services shall regularly be provided for 4 or more hours per day.	Provider agencies must be licensed by OHCQ as Vocational and Day Services Programs (COMAR 10.22.07). Additionally, providers must demonstrate experience in the provision of services to individuals with BI by having: 1) A history of serving individuals with brain injury for 2 years 2) A program of specialized services appropriate for the needs of individuals with brain injuries 3) Availability of licensed healthcare professionals with experience in the provision of services to individuals with BI to supervise, train, or consult with program staff 4) Accreditation by CARF for the provision of brain injury services. Additionally, providers must provide an annual continuing education program for all staff working with waiver participants on the needs of individuals with BI that may include: 1) Types of brain injuries 2) Behavioral, emotional, cognitive, and physical changes after brain injury 3) Strategies for compensation and remediation of deficits caused by a brain injury.
Supported Employment Services **(TBI Waiver)** **32.43/day – Level I** **54.67/day – Level II** **134.15/day – Level III**	Supported employment services are provided in a nonresidential community setting, separate from the home or facility in which the participant resides, and are intended to help individuals obtain and maintain paid work in integrated community settings. The covered services include: 1) A work program that includes support necessary for the participant to achieve desired outcomes 2) Rehabilitation activities needed to sustain the participant's job including support and training 3) Training, skill development, and paid employment for participants for whom competitive employment at or above minimum wage is unlikely and who, because of disabilities, need intensive ongoing support to perform in a work setting	Provider agencies must either be licensed by OHCQ as Vocational and Day Services Programs (COMAR 10.22.07), or approved by OHCQ as Mental Health Vocational Programs (COMAR 10.21.28). In accordance with COMAR 10.21.28.12 (Community Mental Health Programs-Mental Health Vocational Programs (MHVP), Program Staff) Mental Health Vocational Program (MHVP) staff must consist of: 1) A program director 2) Employment specialists 3) Program staff. A provider of MHVP services shall maintain a maximum ratio of one employment

Waiver Service	Service Definition	Provider Qualifications
	4) Transportation or the coordination of transportation between a participant's residence and the supported employment job site. The levels of service are as follows: 1) Level 1 requires that staff members provide daily contact to the participant. 2) Level 2 requires that staff members provide a minimum of 1 hour of direct support per day 3) Level 3 requires that staff members provide continuous support for a minimum of 4 hours of service per day.	specialist serving each 15 individuals receiving MHVP services. Additionally, providers must demonstrate experience in the provision of services to individuals with BI by having: 1) A history of serving individuals with brain injury for 2 years 2) A program of specialized services appropriate for the needs of individuals with brain injuries 3) Availability of licensed healthcare professionals with experience in the provision of services to individuals with BI to supervise, train, or consult with program staff 4) Accreditation by CARF for the provision of brain injury services. Additionally, providers must provide an annual continuing education program for all staff working with waiver participants on the needs of individuals with BI that may include: 1) Types of brain injuries 2) Behavioral, emotional, cognitive, and physical changes after brain injury 3) Strategies for compensation and remediation of deficits caused by a brain injury.
Individual Support Services **(TBI Waiver)** **26.51/hour**	Individual Support Services shall, in 1-hour units and in a community setting (including the participant's home), assist participants to live as independently as possible in their own homes. Specific assistance may include, but not be limited to: 1) Budgeting 2) Medication administration 3) Helping an individual to access and complete the individual's education 4) Participating in recreational and social activities 5) Accessing community services 6) Grocery shopping 7) Behavioral and other services and supports needed by the family of the individual 8) Developing relationships.	Provider agencies must be licensed by OHCQ as Family and Individual Support Services Programs (COMAR 10.22.06). Additionally, providers must demonstrate experience in the provision of services to individuals with BI by having: 1) A history of serving individuals with brain injury for 2 years 2) A program of specialized services appropriate for the needs of individuals with brain injuries 3) Availability of licensed healthcare professionals with experience in the provision of services to individuals with BI to supervise, train, or consult with program staff 4) Accreditation by CARF for the provision of brain injury services. Additionally, providers must provide an annual continuing education program for all staff working with waiver participants on the needs of individuals with BI that may include: 1) Types of brain injuries

Waiver Service	Service Definition	Provider Qualifications
		2) Behavioral, emotional, cognitive, and physical changes after brain injury 3) Strategies for compensation and remediation of deficits caused by a brain injury.
Private Duty Nursing Services **(Model Waiver, EPSDT – Nursing)** **6.08/unit (LPN, 2+ participants)** **8.80/unit (LPN, 1 participant)** **9.36/unit (RN, 2+ participants)** **13.57/unit (RN, 1 participant)**	Private nursing services (RN or LPN) are provided if the complexity of the service or the condition of a participant requires the judgment, knowledge, and skills of a licensed nurse. These services are delivered to the participant in the participant's home or other setting when normal life activities take the participant outside of the house.	Must be licensed by OHCQ as a residential service agency (COMAR 10.07.05) or home health agency (COMAR 10.07.10). In accordance with COMAR 10.09.27.04 (Home Care for Disabled Children Under a Model Waiver, Covered Services) and COMAR 10.05.53.03-04 (EPSDT – Nursing, Conditions for Participation and Covered Services), individuals rendering private duty nursing service shall be licensed RNs or LPNs. Additionally, in accordance with COMAR 10.09.53.03 (EPSDT – Nursing, Conditions for Participation), providers of nursing services shall have on staff at least one registered nurse supervisor.
CNA/HHA Services **(Model Waiver, EPSDT – Nursing)**	Delegated nursing services will be provided by a CNA or HHA when the complexity of the service or the condition of the participant does not require an RN or an LPN. These services include assistance with activities of daily living when performed in conjunction with other delegated nursing services.	Must be licensed by OHCQ as a residential service agency (COMAR 10.07.05) or home health agency (COMAR 10.07.10). In accordance with COMAR 10.09.27.03 (Home Care for Disabled Children Under a Model Waiver, Conditions for Participation) and COMAR 10.09.53.03 (EPSDT –

Waiver Service	Service Definition	Provider Qualifications
2.68/unit – Model (2+ participants) **3.85/unit – Model (1 participant)** **3.20/unit – EPDST (2+ participants)** **4.65/unit – EPSDT (1 participant)**		Nursing, Conditions for Participation), each CNA or HHA rendering services to a participant must: 1) Have a valid, non-temporary certification to provide CNA or HHA services. 2) Be certified in CPR 3) Under EPSDT – Nursing, must also be certified as a CMT. Additionally, providers of CNA/HHA services shall have on staff at least one registered nurse supervisor.
Participation by Principal Physician in Plan of Care Meetings **(Model Waiver)** **40.50**	The principal physician of the participant shall participate in plan of care meetings, including prescribing home care services and approving and signing the plan of care.	The principal physician is a licensed specialty physician who is part of the multidisciplinary team of the participant. The physician must be declared board-certified or eligible by a member board of the American Board of Medical Specialties or has been declared board-certified or eligible, by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association.
Initial Nursing Assessment **(EPSDT – Nursing)** **150**	Participants will undergo an initial assessment consisting of: 1) A comprehensive assessment of health status 2) An assessment of the need for services 3) An assessment of the scope and duration of services to be provided 4) An assessment of the recipient's residence 5) Consultation with the primary medical provider to confirm the need for services and to develop a plan of care. The assessment must be 3 hours or less, and does not require pre-authorization.	In accordance with COMAR 10.09.53.04 (EPSDT – Nursing, Covered Services), the initial assessment must be conducted by a licensed RN.

*Waiver service definitions and provider qualifications were taken from waiver applications and COMAR regulations; both were shortened when possible.
Note: Hilltop used COMAR regulations, waiver applications, provider solicitations, national surveys, and other states' reimbursement methodology studies as source materials for all appendix tables.

Appendix B. Program 3 and Brain Injury Waiver Services with Probable Scheme of Bureau of Labor and Statistics Job Classifications*

Waiver Service	Comparable BLS Job Classifications
Medical Day Care **(ICS, TBI Waiver, CO Waiver, MDC Waiver, Model Waiver)** **79.84/day**	**Registered nurses (29-1141):** Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required. **Licensed practical and licensed vocational nurses (29-2061):** Care for ill, injured, or convalescing patients or persons with disabilities in hospitals, nursing homes, clinics, private homes, group homes, and similar institutions. May work under the supervision of a registered nurse. Licensing required. **Nursing assistants (31-1014):** Provide basic patient care under direction of nursing staff. Perform duties such as feed, bathe, dress, groom, or move patients, or change linens. May transfer or transport patients. Includes nursing care attendants, nursing aides, and nursing attendants. **Occupational therapists (29-1122):** Assess, plan, organize, and participate in rehabilitative programs that help build or restore vocational, homemaking, and daily living skills, as well as general independence, to persons with disabilities or developmental delays. **Physical therapists (29-1123):** Assess, plan, organize, and participate in rehabilitative programs that improve mobility, relieve pain, increase strength, and improve or correct disabling conditions resulting from disease or injury. **Family and General Practitioners (29-1062):** Physicians who diagnose, treat, and help prevent diseases and injuries that commonly occur in the general population. May refer patients to specialists when needed for further diagnosis or treatment. **Healthcare Social Workers (21-1022):** Provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses. Services include advising family caregivers, providing patient education and counseling, and making referrals for other services. May also provide care and case management or interventions designed to promote health, prevent disease, and address barriers to access to healthcare. **Social and human service assistants (21-1093):** Assist in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care. **Personal care aides (39-9021):** Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.

Waiver Service	Comparable BLS Job Classifications
	Dietitians and nutritionists (29-1031): Plan and conduct food service or nutritional programs to assist in the promotion of health and control of disease. May supervise activities of a department providing quantity food services, counsel individuals, or conduct nutritional research. **Recreational therapists (29-1125):** Plan, direct, or coordinate medically approved recreation programs for patients in hospitals, nursing homes, or other institutions. Activities include sports, trips, dramatics, social activities, and arts and crafts. May assess a patient condition and recommend appropriate recreational activity. **Recreation workers (39-9032):** Conduct recreation activities with groups in public, private, or volunteer agencies or recreation facilities. Organize and promote activities, such as arts and crafts, sports, games, music, dramatics, social recreation, camping, and hobbies, taking into account the needs and interests of individual members.
Senior Center Plus **(ICS, CO Waiver)** **49.45/day**	**Personal care aides (39-9021):** See above. **Dietician and nutritionists (29-1031):** See above. **All other social workers (21-1029):** All social workers not listed separately. **Social and human service assistants (21-1093):** See above. **Recreational therapists (29-1125):** See above. **Recreation workers (39-9032):** See above.
Respite **(CO Waiver)** **78.43/day**	**Family and General Practitioners (29-1062):** See above. **Registered nurses (29-1141):** See above. **Licensed practical and licensed vocational nurses (29-2061):** See above. **Nursing assistants (31-1014):** See above. **Personal care aides (39-9021):** See above. **Dietician and nutritionists (29-1031):** See above. **All other social workers (21-1029):** See above. **Social and human service assistants (21-1093):** See above.

Waiver Service	Comparable BLS Job Classifications
	Recreation workers (39-9032): See above.
Case Management **(ICS, CO Waiver, Model Waiver, CFC, CPAS)** **63.75/hour** **15.9375 per 15-minute unit**	**Healthcare social workers (21-1022):** See above. **Social and human service assistants (21-1093):** See above. **Social and community service managers (11-9151):** Plan, direct, or coordinate the activities of a social service program or community outreach organization. Oversee the program or organization's budget and policies regarding participant involvement, program requirements, and benefits. Work may involve directing social workers, counselors, or probation officers. **Registered nurses (29-1141):** See above.
Case Management **(REM)** **400.21 (Initial Rate)** **295.51 (Risk Adjusted High Initial)**	**Registered nurses (29-1141):** See above. **Healthcare social workers (21-1022):** See above.

Waiver Service	Comparable BLS Job Classifications
176.13 (Risk Adjusted Low) **92.96 (Risk Adjusted Maintenance Level 3)**	
Behavior Consultation **(ICS, CO Waiver)** **67.97/hour**	**Registered nurses (29-1141):** See above. **Mental health and substance abuse social workers (21-1023):** Assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education. **Clinical, counseling, and school psychologists (19-3031):** Diagnose and treat mental disorders; learning disabilities; and cognitive, behavioral, and emotional problems, using individual, child, family, and group therapies. May design and implement behavior modification programs. **Psychiatrists (29-1066):** Physicians who diagnose, treat, and help prevent disorders of the mind.
Family Training **(ICS, CO Waiver)** **67.97/hour**	**Registered nurses (29-1141):** See above. **Occupational therapists (29-1122):** See above. **Physical therapists (29-1123):** See above. **All other social workers (21-1029):** See above.
Dietitian/Nutritionist **(ICS, CO Waiver)** **67.97/hour**	**Dietician and nutritionists (29-1031):** See above.

Waiver Service	Comparable BLS Job Classifications
Assisted Living (all levels) **(ICS, CO Waiver)** **46.63/day – Level II with MDC** **58.80/day – Level III with MDC** **62.15/day – Level II no MDC** **78.43/day – Level III no MDC**	**Family and General Practitioners (29-1062):** See above. **Registered nurses (29-1141):** See above. **Licensed practical and licensed vocational nurses (29-2061):** See above. **Nursing assistants (31-1014):** See above. **Personal care aides (39-9021):** See above. **Dietitian and nutritionists (29-1031):** See above. **All other social workers (21-1029):** See above. **Social and human service assistants (21-1093):** See above. **Recreation workers (39-9032):** See above.
Personal Assistance **(CFC, CPAS, ICS)** **11.67/hour – Shared** **17.50/hour – Non-Shared** **150.59/day - Shared** **225.88/day – Non-Shared**	**Registered nurses (29-1141):** See above. **Personal care aides (39-9021):** See above. **Nursing assistants (31-1014):** See above.

Waiver Service	Comparable BLS Job Classifications
Consumer Training **(CFC, ICS)** **44.08/hour**	**Occupational therapists (29-1122):** See above. **Occupational therapy assistants (31-2011):** Assist occupational therapists in providing occupational therapy treatments and procedures. May, in accordance with State laws, assist in development of treatment plans, carry out routine functions, direct activity programs, and document the progress of treatments. Generally requires formal training. **Community and Social Service Specialists, All Other (21-1099):** All community and social service specialists not listed separately.
Nurse Monitoring **(CFC, CPAS, ICS)** **86.39/hour**	**Registered nurses (29-1141):** See above.
Residential Habilitation **(TBI Waiver)** **211.72/day – Level I** **280.34/day – Level II** **387.84/day – Level III**	**Rehabilitation counselors (21-1015):** Counsel individuals to maximize the independence and employability of persons coping with personal, social, and vocational difficulties that result from birth defects, illness, disease, accidents, or the stress of daily life. Coordinate activities for residents of care and treatment facilities. Assess client needs and design and implement rehabilitation programs that may include personal and vocational counseling, training, and job placement. **Occupational therapists (29-1122):** See above. **Registered nurses (29-1141):** See above. **Nursing assistants (31-1014):** See above. **Personal care aides (39-9021):** See above. **Mental health and substance abuse social workers (21-1023):** See above.

Waiver Service	Comparable BLS Job Classifications
Day Habilitation **(TBI Waiver)** **54.67/day – Level I** **95.35/day – Level II** **134.15/day – Level III**	**Rehabilitation counselors (21-1015):** See above. **Occupational therapists (29-1122):** See above. **Registered nurses (29-1141):** See above. **Nursing assistants (31-1014):** See above. **Mental health and substance abuse social workers (21-1023):** See above.
Supported Employment Services **(TBI Waiver)** **32.43/day – Level I** **54.67/day – Level II** **134.15/day – Level III**	**Educational, guidance, school, and vocational counselors (21-1012):** Counsel individuals and provide group educational and vocational guidance services. **Rehabilitation counselors (21-1015):** See above. **Social and human service assistants (21-1093):** See above.
Individual Support Services **(TBI Waiver)** **26.51/hour**	**Rehabilitation counselors (21-1015):** See above. **Social and human service assistants (21-1093):** See above. **Personal care aides (39-9021):** See above.

Waiver Service	Comparable BLS Job Classifications
Private Duty Nursing Services **(Model Waiver, EPSDT – Nursing)** **6.08/unit (LPN, 2+ participants)** **8.80/unit (LPN, 1 participant)** **9.36/unit (RN, 2+ participants)** **13.57/unit (RN, 1 participant)**	**Registered nurses (29-1141):** See above. **Licensed practical and licensed vocational nurses (29-2061):** See above.
CNA/HHA Services **(Model Waiver, EPSDT – Nursing)** **2.68/unit – Model (2+ participants)** **3.85/unit – Model (1 participant)** **3.20/unit – EPDST (2+ participants)** **4.65/unit – EPSDT (1 participant)**	**Registered nurses (29-1141):** See above. **Nursing assistants (31-1014):** See above. **Home health aides (31-1011):** Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient.
Participation by Principal Physician in Plan of Care Meetings **(Model Waiver)**	**Family and General Practitioners (29-1062):** See above.

Waiver Service	Comparable BLS Job Classifications
40.50	
Initial Nursing Assessment **(EPSDT – Nursing)** **150**	**Registered nurses (29-1141):** See above.

* Bureau of Labor and Statistics (BLS) associated job classification and definition retrieved from May 2017 State Occupational Employment and Wage Estimates – Maryland (http://www.bls.gov/oes/current/oes_md.htm)

Note: Hilltop used COMAR regulations, waiver applications, provider solicitations, national surveys, and other states' reimbursement methodology studies as source materials for all appendix tables.

Appendix C. Program 3 and Brain Injury Waiver Services Wage Assumptions*

Bureau of Labor and Statistics Title and Code	Median Wage	Medical Day	Senior Center Plus	Respite	Case Management (non-REM)	Case Management (REM)	Behavior Consultation	Family Training	Dietitian/Nutritionist	Assisted Living II no medical day care	Assisted living III no medical day care	Assisted living II with medical day care	Assisted living III with medical day care
29-1062 Family and general practitioners	99.06	1%		1%						1%	1%	1%	1%
29-1141 Registered nurse	37.57	15%		9%	5%	50%	32%	33%		6%	9%	6%	9%
29-2061 Licensed practical nurse	26.99	5%		3%						3%	3%	3%	3%
31-1014 Nursing assistants	15.03	5%		5%						5%	5%	5%	5%
29-1066 Psychiatrists	99.30						4%						
29-1031 Dietitian and nutritionists	33.82	2%	2%	3%					100%	3%	3%	3%	3%
29-1122 Occupational therapists	44.49	2%						16%					
31-2011 Occupational therapy assistants	32.46												
29-1123 Physical therapist	45.13	5%						16%					
29-1125 Recreational therapist	24.74	5%	14%										
21-1015 Rehabilitation counselors	19.26												
21-1022 Health care social worker	28.55	5%			45%	50%							
21-1023 Mental health and subs. abuse social workers	22.36						32%						
21-1029 All other social workers	34.85		10%	1%				35%		1%	1%	1%	1%
19-3031 Clinical, counseling, and school psychologists	38.50						32%						
21-1012 Educ., guidance, school, and voc. counselors	30.95												

		Medical Day	Senior Center Plus	Respite	Case Management (non-REM)	Case Management (REM)	Behavior Consultation	Family Training	Dietitian/Nutritionist	Assisted Living II no medical day care	Assisted living III no medical day care	Assisted living II with medical day care	Assisted living III with medical day care
Bureau of Labor and Statistics Title and Code	**Median Wage**												
11-9151 Social and community service managers	35.60				10%								
21-1093 Social and human service assistants	16.63	5%	5%	1%	40%					1%	1%	1%	1%
21-1099 Comm. and social service specialists, all other	23.54												
39-9021 Personal care aides	12.29	30%	45%	65%						68%	65%	68%	65%
31-1011 Home health aides	12.64												
39-9032 Recreation workers	11.16	20%	24%	12%						12%	12%	12%	12%
Base Hourly Wage		**21.96**	**16.67**	**16.79**	**24.94**	**33.06**	**35.47**	**38.94**	**33.82**	**16.03**	**16.79**	**16.03**	**16.79**

Bureau of Labor and Statistics Title and Code	Median Wage	Personal Assistance	Consumer Training	Nurse Monitoring	Residential Habilitation	Day Habilitation	Supported Employment Services	Individual Support Services	Private Duty Nursing - RN	Private Duty Nursing - LPN	CNA/HHA Services	Participation by principal physician in team conference	Initial Nursing Assessment
29-1062 Family and general practitioners	99.06											100%	
29-1141 Registered nurse	37.57	2%		100%	5%	5%			100%		2%		100%
29-2061 Licensed practical nurse	26.99									100%			
31-1014 Nursing assistants	15.03	33%			15%	15%					49%		
29-1066 Psychiatrists	99.30												
29-1031 Dietitian and nutritionists	33.82												
29-1122 Occupational therapists	44.49		10%		25%	35%							
31-2011 Occupational therapy assistants	32.46		30%										
29-1123 Physical therapist	45.13												
29-1125 Recreational therapist	24.74												
21-1015 Rehabilitation counselors	19.26				25%	35%	25%	17%					
21-1022 Health care social worker	28.55												
21-1023 Mental health and subs. abuse social workers	22.36				10%	10%							
21-1029 All other social workers	34.85												
19-3031 Clinical, counseling, and school psychologists	38.50												
21-1012 Educ., guidance, school, and voc. counselors	30.95						25%						
11-9151 Social and community service managers	35.60												
21-1093 Social and human service assistants	16.63						50%	16%					

		Personal Assistance	Consumer Training	Nurse Monitoring	Residential Habilitation	Day Habilitation	Supported Employment Services	Individual Support Services	Private Duty Nursing - RN	Private Duty Nursing - LPN	CNA/HHA Services	Participation by principal physician in team conference	Initial Nursing Assessment
Bureau of Labor and Statistics Title and Code	**Median Wage**												
21-1099 Comm. and social service specialists, all other	23.54		60%										
39-9021 Personal care aides	12.29	65%			20%			67%					
31-1011 Home health aides	12.64										49%		
39-9032 Recreation workers	11.16												
Base Hourly Wage		**13.70**	**28.31**	**37.57**	**24.76**	**28.68**	**20.87**	**14.17**	**37.57**	**26.99**	**14.31**	**99.06**	**37.57**

*Wages are based on median hourly wage from the BLS May 2017 State Occupational Employment and Wage Estimates – Maryland, retrieved from http://www.bls.gov/oes/current/oes_md.htm. Percentages represent the proportion of that job's wage that makes up the base hourly wage.
Note: Hilltop used COMAR regulations, waiver applications, provider solicitations, national surveys, and other states' reimbursement methodology studies as source materials for all appendix tables.

Appendix D. Provider Comments on HB 1696 Draft Report

Name	Organization	Comment
Leslie G. Hardesty, R.N.	Esther's Place Assisted Living	This is a good step in the right direction. The reimbursement rates for MA waiver residents has been far below fair market value. Many of these residents have multiple serious medical issues that require a great deal of medical oversight and management. ie: Diabetics requiring sliding scale insulins and multiple fingerstick, Congestive Heart failure requiring weight monitoring and diuretic management. What I would ask you to consider is the rate of reimbursement for the Medical Day care days. Very few if any of our resident leave for daycare before 8am or 8:30. Most are picked up after 9am and returned by 2:30. That means they are receiving their medications before 9am; we are giving out those meds. Additionally, we often need to feed them before they go because they needing meds or because they are diabetic. So those cost are incurred by the ALF for staff to administer medicines and the meal they need. This means that's an expense the ADC is expected to incur but usually don't. I would ask your committee to consider this information and would happily allow you to come see for yourselves the reality of who meets what care cost.
Mrs. Morgan	Jobena Assisted Living I-III	I think the daily rate for providers is too low and having to deduct day program cost from daily rate makes it difficult for providers to accept clients going to day programs, which in turn could affect client's access to care.
Alex Petukhov	Personal Assistance Provider	We are an active RSA agency in Montgomery County MD, operating since 2002. Reimbursement rates have not keep up with caregiver wages over the years and we are finding ourselves between a rock and a hard place. Minimum wage is increasing and Medicaid reimbursement for our client population is not keeping up. Funding COF/CO would extend the ability for agencies such as us to take care of our most vulnerable population and lower the overall cost to the State.
Dawn E. Seek Executive Director MNCHA	Maryland-National Capital Homecare Association	Overall, there is concern about the methodology of this report in getting to what is the true cost per billable unit of care provided, especially when compared to costs of care in other settings. The current analysis seems to overlook some important costs that an average home health offices bear. Namely, please refer to the chart on p.13 in the LPN lines and the explanation that leads up to them. (Basing this

Name	Organization	Comment
		on an average office serving 40 private duty nursing clients and 80 LPNs.) · Home health care does not have a $0 facility cost. We are legally obligated to have an office within the jurisdiction where care is provided. Having office space large enough to hold support staff that handle billing, scheduling, nurse oversight, training, etc. plus the electricity, internet and phone, equipment, office supplies, premises insurance etc. can run close to $100,000 per location annually. This is a real cash outlay that is required by law but is unreimbursed. If the office serves 40 clients for 52 weeks with 40 hours of care per client per week: $1.20 unreimbursed cost per billable hour. · Home health does not have a $0 supply cost. An average home health care office serving 40 private duty clients can pay $15,000 annually for items termed personal protective equipment- gloves, masks, soap, sanitizer, gowns… This is a real cash outlay that is not reimbursed. If the office serves 40 clients for 52 weeks with 40 hours of care per client per week: $0.20 unreimbursed cost per billable hour. · Home health care nurses are required to have annual training and competency exams. For an office with 80 nurses, $20,800, annually in the nurses' wages alone. This does not include the development of training, equipment or supplies. If the office serves 40 clients for 52 weeks with 40 hours of care per client per week: $0.25 unreimbursed cost per billable hour. · A well-equipped training room costs more than $50,000 to set up. This is a real cash outlay that is not reimbursed. · Private duty nursing covers many people who have rare conditions and need specialized care and equipment. Home health care nurses must be trained on additional skills relevant to each client before they can provide care. These additional skills training costs an average office about $8,500 annually in direct nurse wages, not including the nursing supervisor's research, time spent training, or the replacement nurse who is caring for the client while training occurs. This is a real cash outlay that is not reimbursed. If the office serves 40 clients for 52 weeks with 40 hours of care per client per week: $0.10 unreimbursed cost per billable hour. · Home health care has a high turnover percentage industrywide. Recruiting and onboarding new nurses costs an average office $85,000 annually. These are real cash outlays that are not reimbursed. If the office serves 40 clients for 52 weeks with 40 hours of care per client per week: $1.02 unreimbursed cost per billable hour. · Home health care, like other settings of care, is encouraged to embrace technology, maintain electronic medical records and coordinate with other providers. The average office spends $20,000 on technology that is in place within the client's home. If the office serves 40 clients for 52 weeks with 40

Name	Organization	Comment
		hours of care per client per week: $0.24 unreimbursed cost per billable hour. Together, these items total $3.01 in costs per billable hour that this analysis does not take into consideration. We object to the use of lower productivity adjustments for home health care (Other Adjustments, p.11) for home health care because of assumed continuity of care throughout a shift. The idea that for each billable hour only 15% of non-billable time supports the home health care nurse- that includes the staffing, preparation, reporting, scheduling, coordination, oversight, insurance verification, billing, etc. of that care- is unsubstantiated.
Afshin Abedi, Ph.D.	Maryland Association of Adult Day Services	On behalf of the Maryland Association of Adult Day Services (MAADS), Maryland's only association representing over 90% of the medical adult day centers in Maryland, we appreciate the opportunity to comment on the rate study performed by The Hilltop Institute (Draft Program 3 and Brain Injury Waiver Rate Methodology Study). This study is the result of House Bill 1696: Task Force to Study Access to Home Health Care for Children and Adults with Medical Disabilities and Report on Home– and Community–Based Services from the 2018 Session. Among other provisions, this legislation required the Maryland Department of Health (MDH) to compare the rate of reimbursement with the actual cost to entities providing home-and-community based services, to the extent information is publicly available. A key component of the legislation was for MDH to consult with persons providing the services, including entities providing adult medical day care, private duty nurses, assisted living providers, and personal care assistance providers. Unfortunately, in conducting the study, Hilltop did not consult with medical adult day centers concerning either their costs or cost factors. During the same time that Hilltop was conducting its study, MAADS developed a comprehensive calculator to accurately capture the aggregate costs to provide medical adult day services across all centers. As such, ● While The Hilltop Institute's report concludes that the estimated cost to provide medical adult day services is $81.88 (a difference of $2.04 from the current reimbursed rate of $79.84), the MAADS study more accurately illustrates that the cost to provide services in 2018 is $85.70. ● This difference can be primarily associated with Hilltop Institute's underestimation of cost in the categories of transportation and labor rates (including minimum wage rates at

Name	Organization	Comment
		the State and county level). It is likely that this study will become a key benchmark for future rate analysis/decisions for the State of Maryland. Therefore, it is imperative that additional care be taken to properly tailor the study to match the realities and conditions present in Maryland rather than the study's current assumptions that many Maryland cost factors are somehow an average of the cost factors published by the three States (Maine, Virginia, and Arizona) referenced by Hilltop Institute. This type of assumption does not provide sufficient depth, documentation, or understanding of Maryland's unique criteria and factors that need to be included in such a pivotal study, which is why it was disappointing that the industry was never consulted as required. The following factors should be recognized in the study to properly reflect Maryland-specific realities and cost factors: ● Minimum wage values : Cost sensitivity to the State and county minimum wage values, their past and future expected/targeted growth rates, and the impact of minimum wage and associated inflationary pressures on the overall medical adult day (MDC) operating cost. ● License capacity: Appropriate weight factor that reflects Maryland's present distribution of Maryland MDC license capacities across the State (based on OHCQ 2018 data) and the impact of center size (and attendance) on daily (or hourly) operating costs. ● Operating models: Consideration of the variations in how many days a center may operate per week - 5, 6 or 7 day a week models, which results in different cost factors (resulting in higher productivity values and the need to allow for overtime pay in the study). ● Transportation : Maryland's transportation related costs including fuel, vehicle purchase, vehicle repair and maintenance, as well as other Department of Transportation (DoT) requirements for vehicle inspections, driver DoT medical examinations, and other Maryland-specific and transportation related costs, including better estimates on mileage, travel time, and driver pay rate and work hours. ● State compliance requirements: A more careful analysis of the differences in compliance requirements between Maryland and the three study comparison states is needed in order to calculate and incorporate a Maryland's Cost of Compliance Factor in the study. This factor provides an indication of the Maryland-specific costs associated with Office of Health Care Quality (OHCQ) and MDH requirements for compliance, and whether they

Name	Organization	Comment
		are more stringent and costly than the other states compared in the study. These costs should include (but not be limited to) the labor type, hours, and expenses associated with generation, maintenance, and submission of participant-specific reports multiple times per year including: ■ Adult Day Care Assessment and Planning System (ADCAPS) ■ LTSS ■ Physician's orders ■ Nurses notes ■ Annual participant revalidation ■ OHCQ Reportable Events ■ MDH Reportable Events ■ Patient emergency room follow-up MAADS would welcome the opportunity to provide feedback, expertise, and information to MDH and The Hilltop Institute to illustrate these points and allow them to incorporate additional and revise data into the study.
Danna Kauffman	LifeSpan	Thank you for the opportunity to provide the comments below regarding The Hilltop Institute's House Bill 1696 Rate Study - Draft Program 3 and Brain Injury Waiver Rate Methodology Study.1 At the onset, LifeSpan supports the letter and position taken by the Maryland Association of Adult Day Services. This letter focuses substantively on the study as it relates to assisted living providers participating in the State's Medicaid program. During the 2018 Legislative Session, this legislation was amended to require the Maryland Department of Health (MDH) to compare the rate of reimbursement with the actual cost to entities providing home-and-community based services, to the extent information is publicly available. In conducting the study, MDH was required to consult with persons providing the services, including entities providing adult medical day care, private duty nurses, assisted living providers, and personal care assistance providers. Unfortunately, in conducting the study, Hilltop did not consult with any assisted living providers that participate in the Medicaid program concerning either their actual costs or cost factors that should be considered for the study. Historically, the assisted living industry has raised concerns regarding the low rate of reimbursement for assisted living services under the Medicaid program. As noted in the study, Medicaid does not pay for room and board. Room and board are paid for by the resident at a cost of only $420/month. This low

Name	Organization	Comment
		rate of reimbursement combined with low reimbursement rates for services makes participating in the Medicaid program near impossible for many providers. Funding issues are exacerbated when you consider that these providers not only have to comply 1 House Bill 1696: Task Force to Study Access to Home Health Care for Children and Adults with Medical Disabilities and Report on Home– and Community–Based Services from the 2018 Session. with the same licensure requirements as non-Medicaid providers but also must comply with additional Medicaid regulations. LifeSpan is pleased that the report did recommend a much-needed increase in the rates for assisted living providers participating in the Medicaid program. However, while implementation of this rate increase is a positive step, it should not be the conclusory step. We believe that the entire reimbursement system for Waiver providers must be re-examined to include room and board (at an appropriate rate) as well as a more detailed study of the cost factors affecting Waiver providers, especially considering recent minimum wage increases and the desire to continue to increase it over the next few years. Again, we appreciate the opportunity to comment and look forward to working further with you.
Elaine Gill Owner / Director of Client Care	Always Best Care Senior Services	Thank you for the opportunity to comment on the study. I noticed there was not a reference to the cost of regular RN assessments of participants by home care agencies where there is no compensation provided. Specifically, the rates for In-Home Services where the Nurse monitor is the local department of Health. Our RNs perform regular assessments and supervision. The local health department RN request our Nurses oversight documentation but there is no payment for these services. These services should be included in the home care rate evaluation along with the other associated costs.

Appendix E. Hilltop Responses to Provider Comments on HB 1696 Draft Report

Name & Organization	Hilltop's Response
Leslie G. Hardesty, R.N. **Esther's Place Assisted Living**	In our analysis, we assumed that ALFs for enrollees in Medical Day Care (MDC) provided 18 hours of direct care, with the client spending the remaining 6 hours in MDC. Given that room and board is not covered for ALF clients, we do not include food as a cost center. Medication administration is factored into the ALF staffing ratios (see Appendix C - 9% RNs, 3% LPNs, and 5% nursing assistants), which is reflected in the labor cost center.
Mrs. Morgan **Jobena Assisted Living I-III**	Our estimates for assisted living costs are constructed on a per-enrollee, per-hour basis. We assume that ALF clients attending MDC are away from the ALF for 6 hours per day, which, according to COMAR 10.09.07.03.C, is the minimum number of hours that MDCs are required to be open each day.
Alex Petukhov **Personal Assistance Provider**	We used the most recently available Maryland-specific wage estimates (May 2017) in order to account for rising labor costs. We will further adjust our estimates to trend labo and other costs forward to incorporate inflation.
Dawn E. Seek **Maryland-National Capital Homecare Association**	Regarding the $1.20 per hour facilities cost, in our cost model, we intend facilities to mean those premises used for direct care of clients. We allocate 16.33% of total costs for administrative costs and program support including, but not limited to, insurance costs, administrative salaries, financial and accounting expenses, office supplies and equipment, program development, training, quality assurance, and service coordination. We assume that this covers administrative office rent. Regarding the $0.20 per hour supply cost, we acknowledge that we did not include this cost center in the draft estimates. We will update our estimates to include this cost center. Regarding the $0.25 annual training and competency costs, we incorporate training costs into both the productivity adjustment and the above-mentioned program support costs. Regarding the $0.10 per hour additional skills training costs, we incorporate training costs into both the productivity adjustment and the above-mentioned program support costs.

Name & Organization	Hilltop's Response
	Regarding the $1.02 per hour recruiting and onboarding costs, we acknowledge that providers incur costs related to training new employees, and that this was not explicitly mentioned in the cost study. However, we feel that these are adequately accounted for in the cost model for two reasons. First, we use median wage estimates from the BLS (as opposed to the 10th or 25th percentile), which might actually overstate the true wages of new hires. To the extent that new hires are not fully productive, then this gap may be offset by the over-estimate in wage costs. Second, we allow for training costs in both the productivity adjustment and the program support costs. Regarding the $0.24 per hour technology cost, we are unaware of regulations mandating the use of technology placed within the client's home as a requirement of the service. The productivity adjustment is intended to account for activities performed by direct-care providers but which are not billed, such as reporting, preparation, or traveling. Other activities mentioned in the comment, such as staffing, scheduling, coordination, oversight, insurance billing, are accounted for under administrative or program support. Given the cost spreading due to multi-hour shifts, we feel that a 1.15 productivity adjustment is not inappropriate.
Afshin Abedi **Maryland Association of Adult Day Services**	Regarding the minimum wage increases in 2017 and 2018, we acknowledge that our data source, which is the most recent available occupational wage data for Maryland (May 2017), pre-dates the county and state increases to minimum wage that occurred in 2017 and 2018. We acknowledge that, for certain occupations, this may have led us to marginally underestimate the current median wage. However, the extent of this issue is limited: all occupational wages in our cost model for Medical Day Care are above the new Maryland minimum wage of $10.10, and only two occupational wages are below the county-specific minimum wages of $11.50 and $12.00 for Prince George's and Montgomery Counties, respectively. Moreover, the extent of the underestimation is further limited given that only 1/3 of Medical Day Care participants reside in these counties.

Name & Organization	Hilltop's Response
	To more accurately account for increases to the labor cost center, however, we will adjust all costs for inflation, and index them to January 2019, which is the mid-point in FY19. Additionally, if any component wages are under $12.00/hour after indexing for inflation, we will increase the component wage by (1/3)*(12 – wage), under the assumption that 1/3 of providers are in the counties with the higher minimum wages and therefore face the higher labor costs. Regarding the need to account for differential license capacity, we believe that we have properly accounted for this. We constructed the model from the enrollee upward, rather than the MDC downward, and therefore do not need to weight our estimates to account for facility size as our estimates are already at the level of enrollee-day. Moreover, our assumption of $1.17 per member per hour facility cost is based on an assumption of 75 square feet per member, which we assume to hold regardless of license capacity. Additionally, our model accounts for 10% unplanned absences. Regarding the consideration of alternative operating models which may result in higher labor costs (such as operating seven days per week), we feel that no adjustment is needed. We aimed to represent the cost of the typical firm which operates in such a way as to minimize costs. As COMAR 10.09.07.03.C states that MDCs must be open for at least 6 days a week, 5 hours per day, we based our estimates on this operating schedule. Regarding the more detailed consideration of Maryland-specific transportation factors, we believe that, consistent with the legislative mandate to use only publicly available information, it is appropriate to use estimates from Virginia's rate study (which was based on a provider survey). However, we acknowledge that their estimate of $.87 per enrollee per hour is from November 2014, and therefore should be updated for inflation and indexed to January 2019. We will change this for the final version of the report. Regarding the request for a more thorough analysis of the compliance differences between Maryland and the comparison states, we do not believe that additional analysis

Name & Organization	Hilltop's Response
	is required. We relied on multiple states for our model inputs precisely to avoid the possibility of using only high-cost, or low-cost, states as sources of information.
Danna Kauffman **LifeSpan**	Hilltop did not consult with providers to obtain cost factors because the language in HB 1696 explicitly required the use of publicly available information in determining actual costs to providers. Regarding a re-examination of the entire reimbursement system, Hilltop believes that this is outside of the scope of the legislative mandate of HB 1696, which is to compare the rate of reimbursement with the actual cost to providers (to the extent information is publicly available).
Elaine Gill **Always Best Senior Care**	We believe that we are already accounting for the cost of RN oversight of personal care services. Per COMAR 10.09.84.06, personal assistance providers must employ an RN to delegate nursing functions and, if need be, certified nursing assistants to do those functions. We incorporate this into the cost estimate for personal assistance through the staffing ratio (in Appendix C), which we assume is 2% RNs. This is based on the assumption that if participants receive 8 hours of care per day, 7 days a week, then an RN oversees the care for 1 hours per week. This implies a staffing ratio of 1/56 = 1.8% RNs, which rounds up to 2%.

The Hilltop Institute

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Memorandum re_ Delayed Implementation of Self-Dire

Uploaded by: Alex Petukhov

Position: UNF

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

MEMORANDUM

To: Community First Choice Stakeholders
Community Personal Assistance Services Stakeholders
Home and Community-Based Options Waiver Stakeholders
Increased Community Services Stakeholders

From: Marlana R. Hutchinson, Director *mrh*
Office of Long Term Services and Supports

Subject: Delayed Implementation of Self-Direction

Date: September 14, 2023

Note: Please ensure the appropriate staff members in your organization are informed of the contents of this memorandum.

The Office of Long Term Services and Supports (OLTSS) will delay the implementation of self-direction for the Community Personal Assistance Services, Community First Choice, Home and Community-Based Options Waiver and Increased Community Services programs until July 1, 2024. The delay will allow sufficient time to build the financial management and counseling services (FMCS) infrastructure to ensure a successful implementation.

Deputy Secretary Ryan Moran and I will be meeting with stakeholders at the next Community Options Advisory Council meeting (September 26, 2023 @2pm) to discuss next steps and address any questions.

written testomony not to SB 197 .pdf
Uploaded by: Alex Petukhov
Position: UNF

CIRCLE OF FRIENDS, LLC
17830 NEW HAMPSHIRE RD SUITE 302 ASHTON, MD 20861
PHONE: (301)260-0338
FAX: (301)260-9441

02/01/2024

Honorable Members of the Finance Committee,

Thank you for allowing me to express our opposition to SN197. We have been in business providing care for elderly Medicaid recipients since 2002 and have seen many trends over the years. Currently, we are seeing a push from a 1099 to a W-2 employment model. We strongly believe this is a mistake that could lead to much higher caregiver shortages for our already underserved community.

There are hundreds of RSA's (Residential Service Agencies) companies in Maryland that are reimbursed by Medicaid. Many of them use a well-established model of 1099 contractors as caregivers. If this is passed, it will negatively affect hundreds of agencies in every corner of Maryland and send caregivers running to other industries and states. Here are some reasons why hundreds of agencies will suffer and could go out of business.

1. This transition would shock the home care industry with substantial additional costs for the already substantially underfunded RSA's.

In 2018, the House and Senate passed a bill to authorize a study of costs called HB1696 or the Hilltop Study. Based on this study, we were underpaid substantially. In 2018, the difference was $8.04 per hour! In 2024, the costs of providing services have gone up substantially. Despite these increasing costs Medicaid reimbursement was only $1.86 per hour. (see page 15 of attachment or page 11 of Hilltop study) To transition without a substantial reimbursement increase would be overwhelming, burdensome, and will negatively affect senior home care for years to come.

2. Taking away the ability to use 1099 contractors in home-based Medicaid population would greatly affect so many companies by causing them to lower hourly pay and struggling to retain workers. They will lose many benefits of contractor work.

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Many caregivers prefer to work as 1099. Caregivers work for more than one registry at the same time. They call around looking for this as an option. Some caregivers are looking for a full-time position while many are looking for a part-time supplemental income to fit into their already busy schedule. They enjoy the flexibility of choosing their hours (night, morning, while kids are at school etc.). They want the ability to write off milage, gas and other expenses, as allowed by law. Many caregivers prefer to get all their money upfront rather than have deductions and hope to have a return at tax time. They are willing to take on new cases for freedom of choice and to forgo some of the traditional safety nets of W-2. When a case is over, they move on to another client or different agency altogether. On the other hand if they want to work under as a W-2 caregiver, there are agencies who operate under that model.

3. We think agencies should continue to have a choice of operating as a registry module for more flexibility and choices for such caregivers as family caregivers. Our family caregivers don't need a W-2 model and prefer the ability to have part-time work as 1099 and all the benefits that come with it, such as flexibility, competitive high pay rate, and various tax benefits.

One area of the Medicaid program where the W-2 model is also not necessary is the Family Caregiving Program. This program allows family members of Medicaid recipients to get reimbursed for caring for their loved ones. In Maryland, the family member must be approved by the State and must work through an RSA. These paid family caregivers typically have other full-time work and commitments. They work for their elderly and/or disabled loved ones either by themselves or alongside a team of our part-time caregivers. Some clients have a different caregiver daily, depending on their hours and level of care.

4. Caregivers have a higher take home wage rate with a 1099 model.

Agencies with a registry model generally provide a higher wage rate, and that rate is negotiable based on the caregiver's availability, skills and experience. May caregivers have been with us for years.

5. Choice of worker status by RSAs – whether an RSA employs a caregiver or has a contract relationship with them will determine other aspects of the business.

If businesses comply with existing worker laws, businesses should be able to choose under which model they prefer to operate. Caregivers should also have a right to choose which model is more appropriate for them. Each registry has it own unique

demographics, its pool of different caregivers, and a specific business niche they specialize in. Let's allow the clients, their families, and caregivers to choose what is right for them.

6. This bill potentially discriminates against RSA's that help the Medicaid population.

MDH is preparing a dramatic change to the way this long-term care is available to the Medicaid population. With the start of "Self-Directed Program" in Maryland in 2024 the individual clients will be able to hire RSAs' caregivers directly as 1099 contractors, side-step the agencies. Although we are in support of these programs for the good of participants and freedom of choice, we believe the RSAs should not lose the ability to offer this as an option for its work force.

Sincerely,

Alex Petukhov
Circle of Friends, LLC
President, Managing Partner
alex@cofllc.com

Opposition Letter .pdf

Uploaded by: Binita Chhetree

Position: UNF

Dear Senators,

I am writing concerning the proposed Bill 197, and am asking that you please consider some of the implications that this bill may have on both the Residential Service Agencies (RSAs), as well as on the population that they serve. Enforcing this bill would mean that agencies could no longer have the flexibility to rely on independent contractors. The cost to cover this transition could be enough to put a large number of RSAs out of business, all at once, which would negatively impact an even larger number of people who rely on these agencies, day in and day out. Such a disruption to the home care industry, an industry already facing ever-increasing demands, would be significant, so I am strongly requesting that you reconsider this bill at this time. Thank you very much for taking the time to review my viewpoint and for all that you do.

Sincerely,

Binita Chhetree

Kashyu Bill 197 (1).pdf
Uploaded by: Kashyu Dua
Position: UNF

Dear Senator,

I am writing to share my concern about Bill 197 and the impact that this will have on our communities. As someone who has firsthand experience in the home care industry, I firmly believe that this bill would place a large number of RSAs in a precarious position. As it stands now, RSAs have a difficult time operating within a tight budget. Mandating the use of employees vs. independent contractors could be enough to put many agencies out of business, which would have devastating consequences on the populations that are served under the Medicaid Waiver programs. For this reason I am strongly urging you to reconsider this bill. Thank you for your time and consideration.

Sincerely,

Kashyu Dua

Opposition Letter Bill 197.pdf
Uploaded by: Laura Sarti
Position: UNF

February 7, 2024

Dear Senators,

I am writing to you as a dedicated nurse and a long-time professional in the home care industry. The reason I am writing is to urge you to oppose Senate Bill 197. As many are already well aware, RSA operations in Maryland are expected to serve thousands of people in need, but are expected to do so on increasingly narrow margins. This proposed measure, of restricting RSA operations to no longer count upon 1099 contractors, would adversely impact the ability of RSA operations to provide critical services to the communities in which they serve. This additional financial and logistical burden will undoubtedly make it extremely difficult for a large number of RSA operations to stay in business, potentially leaving a significant number of those in need without an agency to support them. Such an action would result in wide ranging consequences for an industry already struggling to meet incredibly high demands across the state of Maryland. In order for operations to survive, and for those in need to continue receiving high quality services without any lapses or disruptions to their care, the implications of this bill must be reconsidered. Consequently, I do not believe that proceeding with this bill would be in the best interest of the communities that we serve.

Thank you very much for your time and for considering my perspective. I truly hope that you will advocate for what would be the most sensical decision, given the points stated above. And of course, thank you for your services and for your ongoing devotion to our communities.

Sincerely,

Laura Sarti

Laura Sarti
931 Beacon Square Ct., Apt. 38 Gaithersburg, MD
301-908-1959
Lsarti711@gmail.com

The Private Care Association Opposes the Home Care

Uploaded by: Lori Dahan

Position: UNF

Private Care Association

Position: OPPOSES the *Homecare Workers Rights Act of 2024*, H.B. 39

January 19, 2024

The Private Care Association ("PCA")[1] opposes the *Homecare Workers Rights Act of 2024*, H.B. 39, because it would eliminate any consumer choice for those consumers whose home-care is reimbursed by a state-funded home-care program. The bill also would deny self-employed home-care providers access to consumers under such programs. Finally, the bill would exacerbate the risk of a caregiver shortage for consumers who rely on such programs to meet their home-care needs.

I. Background

The State of Maryland offers a license to only two types of entities that are permitted to contract with self-employed providers of home care, namely, a residential service agency[2] ("RSA") and a nursing referral service agency[3] ("NRSA"). State-funded home-care programs currently contract with RSAs – but deem NRSAs *ineligible* to participate in such programs. It follows that the only licensed entity through which a self-employed home-care provider can gain access to consumers whose home care is reimbursed by a state-funded home-care program is an RSA.

An RSA that participates in a state-funded home-care program and contracts with self-employed home-care providers can function as a caregiver registry. Accordingly, in Maryland, an RSA is the only licensure option available to a caregiver registry seeking to participate in a state-funded home-care program. Such an RSA facilitates the matching of self-employed home-care providers with home-care recipients, based on their respective objective preferences. These arrangements offer consumers access to consumer directed home care (discussed below).

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[1] PCA, www.privatecare.org, is a national association representing caregiver registries. The PCA, since 1977, has been the voice of caregiver registries and consumer directed home care. PCA's membership consists of caregiver registries that refer self-employed care providers who can provide companion care, homemaker services, and nursing services in a client's home. PCA members facilitate consumer directed home care, which is based on the idea of consumer choice in home care, where consumers can make decisions and manage their home-care arrangement based on their own specific needs and preferences.

[2] "Residential service agency" means:
(i) An individual, partnership, firm, association, corporation, or other entity of any kind that is engaged in a nongovernmental business of employing or contracting with individuals to provide at least one home health care service for compensation to an unrelated sick or disabled individual in the residence of that individual; or
(ii) An agency that employs or contracts with individuals directly for hire as home health care providers. Md. Code Ann., Health-Gen. § 19-4A-01(f).

[3] "Nursing referral service agency" means one or more individuals engaged in the business of screening and referring, directly or in accordance with contractual arrangements that may include independent contractors, licensed health professionals or care providers to clients for the provision of nursing services, home health aid services, or other home health care services at the request of the client. Md. Code Ann., Health-Gen. § 19-4B-01(h).

H.B. 39 would require any RSA that participates in a state-funded home-care program to classify all home-care providers who provide services in connection with that program as employees of the RSA. The practical consequence of this requirement would be to ban caregiver registries from state-funded home-care programs and deny access to such programs to self-employed home-care providers.

PCA opposes H.B. 39 for the following reasons.

II. The Bill Contradicts Federal CMCS Policy

The bill's de facto banning of caregiver registries from state-funded home-care programs – which would include Medicaid programs – flatly contradicts a December 12, 2023, *CMCS Informational Bulletin*[4] issued by the Center for Medicaid and CHIP Services that *encourages* states to utilize caregiver registries. It states, in pertinent part:

> The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin to remind states and stakeholders that the use of worker management platforms, often called registries, is an important strategy for ensuring that individuals receiving Medicaid-covered home and community-based services (HCBS) have awareness of and access to qualified workers who deliver services. Importantly, the use of these registries does not require CMCS approval.

CMCS's endorsement of the use of registries in such programs reflects decades of history and experience of registries participating in state Medicaid programs throughout the nation – with very positive outcomes. The enactment of H.B. 39 would create a law that precludes Maryland from complying with the federal government policy set forth in the *CMCS Informational Bulletin.*

III. The Bill Would Eliminate Consumer Choice Under State-Funded Programs

H.B. 39 would deny consumers who rely on a state-funded program for access to home care any choice between agency directed home care (under which a third-party agency manages a home-care arrangement and provides the care with its staff of caregivers) and consumer directed home care (under which a consumer self-manages the consumer's own home-care arrangement and selects the independent care providers who will provide the care).

If the bill were enacted, the only choice available to consumers under such programs would be the agency directed model. Multiple studies have found that many consumers strongly prefer the consumer directed option, so they can ensure that their home-care arrangement operates in the manner that best meets their individual circumstances and they can ensure continuity of care by care providers they select. For example, professors at UCLA who studied these two different home-care delivery models published a paper reporting the following findings:

> On average, [*agency-directed* model] recipients have relatively little say about who their providers are, since the agency makes worker assignments. More [*agency-*

[4] Available at, https://www.medicaid.gov/sites/default/files/2023-12/cib12122023_0.pdf.

> *directed* model] users experience worker turnover and schedule changes, because agencies rotate workers to create scheduling efficiencies….
>
> In the [*consumer-directed* model], the match between recipient and worker is done as the recipient makes hiring decisions. On average, recipients have more choice in naming their provider… [*Consumer directed* model] workers have longer tenures in the job… [and] may be better trained to work with a given recipient and may acquire skills better tailored to the needs of that client.[5]

The home-care experience – for those consumers who prefer the consumer directed home-care option – would necessarily suffer if H.B. 39 were enacted.

IV. The Bill Would Unfairly Discriminate Against Legitimate Self-Employed Providers of Home Care

Individual home-care providers who choose to offer their services as self-employed independent contractors – so they can enjoy the flexibility of choosing their own clients, negotiating their own pay rates, and working hours that fit their schedule – would be denied access to consumers whose home-care is reimbursed by a state-funded home-care program if H.B. 39 were enacted.

While the bill is titled "Homecare Worker Rights Act of 2024," the bill actually would *deny* rights to those home-care providers who choose to offer their services as self-employed independent contractors. Today self-employed home-care providers who contract with a licensed NRSA to gain access to private pay clients, or obtain such clients through other means, e.g., by referral or through internet-based platforms, have the right to concurrently contract with a licensed RSA to gain access to clients who participate in state-funded home-care programs. H.B. 39 would *deny* these independent care providers the right to provide home care to consumers whose care is paid for by a state-funded program.

There is no discernible basis for discriminating against these home-care providers – solely because they choose to offer their services as self-employed independent contractors. PCA opposes worker misclassification, but H.B. 39 would unfairly disadvantage those independent home-care providers who choose to work as legitimate self-employed care providers.

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[5] Benjamin, Mathias, and Franke, *Comparing Consumer-directed and Agency Models for Providing Supportive Services at Home*, Vol. 35 Part II, 351, 361 *Health Services Research No. 1 Selected Papers From the Association for Health Services Research Annual Meeting* (April 2000), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089106/. See also Applebaum and Mahoney, *Expanding Self Direction and Its Impact on Quality*, Public Policy & Aging Report (Jan. 2016), available at (PDF) Expanding Self Direction and Its Impact on Quality (researchgate.net) "In the early days of self-direction, there was a concern that the absence of outside provider agencies would result in a greater potential for fraud, abuse, and poor quality care. To the contrary, the early experience indicated that consumers will choose quality when they have the opportunity to do so. Choice should be thought of as an activity that enhances quality, not a liability to assuring it."

V. The Bill Would Exacerbate the Risk of a Caregiver Shortage for Consumers Who Rely on State-Funded Home Care

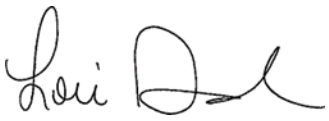
At a time when concern has been expressed about a caregiver shortage,[6] H.B. 39 would exacerbate this risk for consumers who rely on state-funded home-care programs in Maryland to meet their home-care needs.

The bill would potentially result in self-employed home-care providers severing their relationship with licensed RSAs and ceasing to provide care for consumers whose home-care is reimbursed by a state-funded home-care. These independent care providers could instead focus their business solely on private pay clients or clients with long-term care insurance, which they could find on their own or by contracting with an NRSA. Worse, they could choose to leave home care entirely and seek work in other industries that are more tolerant of an individual's right to work independently.

VI. Conclusion

For the foregoing reasons, PCA respectfully submits that H.B. 39 would be harmful to consumers and harmful to self-employed home-care providers who currently participate in state-funded home-care programs, and that the bill would potentially exacerbate the risk of a caregiver shortage for consumers who rely on such state-funded programs to meet their home-care needs. Accordingly, PCA urges a "NO" vote on H.B. 39.

Respectfully submitted,



Lori Dahan, President

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[6] See, e.g., Marchese, *The Caregiver Shortage: Which States Are Doing Best?* (Jun. 19, 2023) available at https://www.asbestos.com/support/caregivers/shortage-by-state/. The report identifies Maryland as a problematic state with fewer than 10 caregivers per 1,000 people. To provide a perspective relative to nearby jurisdictions, the report found that Pennsylvania has 21.1 caregivers per 1,000 people and the District of Columbia has 20.7 caregivers per 1,000 people. The report suggests that Maryland is already vulnerable in this area.

No to bill SB197.pdf
Uploaded by: Nabilla Adio
Position: UNF

02/07/2024

I Prefer Being a CONTRACTOR

Good afternoon. My name is Nabilla Adio, and I enjoy being a caregiver from the bottom of my heart. I look forward to taking care of my clients and making a difference in their lives. Most of my clients need non-medical day-to-day care. I focus mainly on personal care and tasks of daily living such as getting dressed, grocery shopping and providing heartfelt companionship.

I choose and prefer to work as a 1099 contractor because it gives me the flexibility to make my own choices about the clients, location, my schedule, and my pay. I work part-time for multiple agencies at the same time. In this line of work, you lose clients often due to the hospitalization, rehabilitation, transition to a skilled level of care, or death. By dealing with multiple agencies, I have a higher chance of filling my available almost instantly. I also highly depend on my full check to pay my bills and prefer to deal with taxes at tax time.

When I look for work as a caregiver, I look only for companies that use the 1099 contractor model. Before I start on a new case, the company and I discuss our arrangement. They tell us what hours the client may want, and the level of care that may be expected. Then I proceed with starting with my clients and ensuring that they are pleased with their services.

When working for companies with a 1099 model, I feel taken care of and valued. I appreciate that my availability is always considered. If I am not happy with a certain client, I am free to choose someone I am comfortable with instead. This makes me feel nothing but being respected, cared for and appreciated.

I love the idea that I get to negotiate my hourly wage. In my experience, companies that hire 1099 caregivers have a much higher wage. Most of my colleague caregivers prefer a 1099 model.

In closing, I request that you do not pass any bill that stops me from being able to work as a contractor for private or Medicaid clients in Maryland. Thank you for considering my point.

Sincerely,

Nabilla Adio

nabilla.adio@gmail.com

Opposition To Bill for1099 Contractor Work.pdf
Uploaded by: OLUKAYODE TAIWO
Position: UNF

Dear Senators,

We were made aware of this killer's bill, this bill will scrap and deprive the 1099 contractors from being hired or being use by RSA agencies in the state of Maryland. We call this a killer's bill, because it will kill the use of these individuals. For so many other negative effects and impacts from this bill will have on other individuals, clients and businesses in our community, please do not pass it. Below are four areas of negative outcomes that this bill will impact our community, that made us to strongly oppose the passing of the bill. These are the facts, that passing of this bill will;

1. **Encourage Monopoly and Reward the greed----------**
   -The big companies do not want any competitors; home health care business are in high demands and greater needs in communities. The big companies are getting in to this area of the industry, and they have enough volume to support and afford to pay overtime, fringe benefits, allowances, and big salaries etc.
2. **Discriminate against individuals and businesses in the community----------**
   -This bill targeted Many RSA businesses owned by minorities companies. Whose workers and labor forces are minorities, who are looking for this type of work. Many other businesses and companies who receives Medicare and Medicaid in the state of Maryland and other states have no restriction in hiring 1099 contractors. Maryland RSA businesses will be restricted to only hire W2 staff or employees who have no or less experience, that MD companies have to spend a lot of money to train, supervise and monitor for them to perform and provide a good quality health care to our clients and citizens in the community.
3. **This bill will take away people's rights, and business/company's rights away-----**
   -People's right to work flexible hours, People financial rights to look for agency of their choice, where they can work and make as much money as they wish, People and clients rights to look for an agency in their preferred location. And agency rights to have hiring options to bargain and hire an employment at will.
4. **This bill will short down and close so many small businesses in our community.**
   –Due to low reimbursement to RSA agencies, an RN staff is mandatory, and this is not included in the reimbursement. Many RSA small companies cannot afford to keep or pay RN staff thousands of dollars. Many RSA workers, such as aides and other staff preferred to be paid high salary or go to other state or agency to work because MD agencies cannot afford it. These staff or workers that goes to another state to seek employment for higher wages, continue to leave us while Maryland companies have very high staff shortage. Not many small business or companies can survive all these conditions without closing their business doors.

Opposition Letter.pdf
Uploaded by: Poe Thein
Position: UNF

Dear Senator,

This letter is to state that I am in opposition of Bill 197, which would require RSAs to utilize only independent contractors, in order to get reimbursed by Medicaid. This bill would have major financial consequences for RSAs, and it could cause many to potentially go out of business. As you know, there are many people who depend on these services and there are many more who have embraced the flexibility of the independent contractor model, and have done so for many, many years. A disruption of this scale, on an already overburdened industry would be less than ideal and for this reason I am kindly requesting that you oppose this bill. Thank you very much for your time and consideration.

Sincerely,

Poe T

Opposition Letter to Senate Bill 197 .pdf
Uploaded by: Reshma Karki
Position: UNF

2/7/24

Reshma Karki

23162 Robin Song Drive,

Clarksburg, MD, 20871

reshzesh@gmail.com

Dear Senator,

I am writing this to express my opposition to Senate Bill 197, which is currently under consideration. This is to highlight that many Residential Services Agencies (RSA) in Maryland are already struggling to operate with a slim margins and competitiveness out there in the community. With this new bill in consideration of restricting RSA's to prohibit from using 1099 contractors is going to put these RSAs in a critical position to continue providing services to hundreds of vulnerable people that are being served and cared for. This is simply unsustainable for RSAs and puts them at a higher risk of going out of business. With many RSAs currently using 1099 contractors and serving hundreds of Medicaid participants, it is a valid concern that these vulnerable populations will get impacted adversely as this change will make it challenging for these current RSAs to operate and remain afloat. These RSAs have been highly dedicated in serving these populations for many years and will continue to do so. This is to urge you to carefully evaluate the potential consequences of Senate Bill 197, on our community, the Medicaid participants and the RSAs.

I appreciate your dedication to public service and the hard work you put into representing the community. Please take into account the valid concerns raised here.

Thank you for your attention to this matter and trust that you will make an informed decision that reflects the best interests of our community.

Sincerely,

Reshma Karki

Reshma Karki

Opposition Bill.pdf
Uploaded by: Sangita Adhikari
Position: UNF

Dear Senators,

It has come to my attention that Bill 197 is proposing that in order for RSAs to be reimbursed by the Medicaid Waiver program, RSAs would no longer be allowed the flexibility to use independent contractors. This would have far-reaching consequences, not just for RSAs but for the communities that they serve as well. There are a large number of people who currently require the support of an RSA to provide them with high quality care and this bill jeopardizes the future of those very RSAs who work hard every single day, within these tight margins, to meet their communities' needs. Additionally, for an RSA to realistically meet this requirement, it would only be reasonable for the Medicaid reimbursement rates to be significantly higher than they are today (as past trends have shown, a rate high enough to cover this added expense may never happen). So I am urging you to please reconsider this bill, for the sake of the hardworking RSAs, for the health and wellbeing of our communities, and for the integrity of the whole Medicaid Waiver program.

Sincerely,

Sanjita