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TESTIMONY

**BEFORE THE
COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON WORKFORCE PROTECTIONS
UNITED STATES HOUSE OF REPRESENTATIVES**

ON

H.R. 3582: the Fair Home Health Care Act

PRESENTED BY

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ON BEHALF OF THE

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE, INC.

OCTOBER 25, 2007

Thank you for the opportunity to present testimony regarding H.R. 3582. My name is William A. Dombi, Vice President for Law at the National Association for Home Care & Hospice, Inc.(NAHC). In Washington, D.C. NAHC is a trade association representing the interests of home health agencies, home care organizations, and hospices throughout the country. Our membership includes entities of all sizes and types including not-for profit and proprietary organizations. These providers of care are freestanding companies, government-based, or part of a health system. All told, NAHC members serve over 5 million of the nation's elderly and disabled citizens with personal and skilled care that enables these individuals to maximize functioning and stay safely in their own homes.

H.R. 3582 is of great interest to the home care community as the providers of home care services employ tens of thousands of workers that could be impacted by the proposed revision to the "companionship services" exemption under the Fair Labor Standards Act of 1974 (FLSA). In home care, the worker who provides services that would be considered "companionship services" generally works under the title of home health aide, home care aide, or personal care attendant. These workers are the pillars of support for a growing community based long term care system that our nation needs to respond to the graying of America.

H.R. 3582 follows on the heels of a recent decision of the U.S. Supreme Court in *LI Care at Home v. Coke* where a unanimous Court upheld the validity of a 30 year old regulation of the US Department of Labor that exempted individuals who are employed by third parties to provide companionship services from the protections of the FLSA with respect to overtime compensation. Ms. Coke argued unsuccessfully that the exemption applies only when the worker is directly employed by the person receiving care. While H.R. 3582 purports to reverse the Court's decision, it actually would limit the FLSA exemption even in situations where the worker is directly employed by the person receiving care.

The proposed legislation represents a well-intentioned effort to provide support for individuals working in an undervalued job. However, it is a piecemeal action that will not only fail to solve the important concerns expressed by the home care aide workforce, but will serve to compound their problems. Instead, NAHC calls for a comprehensive, broad-based strategic plan that integrates action to address worker compensation, access to health insurance, competencies and training, career opportunities, and funding. In the absence of that comprehensive effort, HR 3582 will trigger predictable consequences that naturally develop when health care providers are encumbered with added costs without the essential financial support to meet those increased obligations.

The impact of the proposed legislation must be understood in a very practical context. Most funding for home care services comes from federal and state programs such as Medicaid, Medicare, the Administration on Aging, and TRICARE. Under these programs, the employer of home care aides has little or no control over the price of services and can only act to affect the costs of care. As a result, the unfunded cost

increases that evolve from this legislation will lead the employer/home care agency to control costs through such steps as eliminating overtime work, reducing base compensation rates to minimum wage, and dropping any employee benefit programs. This foreseeable reaction is unlike those that are only speculative in a market driven economy where the seller of services has the option of raising prices to increase revenue to offset the increased compensation costs. These are real consequences when the health care provider must operate in a system of funding that is controlled by federal and state health care programs.

Consumers of home care aide services also will suffer unintended consequences. Limiting hours of work for the home care aide will disrupt continuity of care as multiple caregivers will be assigned to an individual to avoid unfunded overtime compensation. The anticipated increase in employee turnover when workers cannot get enough work hours will bring consumer dissatisfaction as every day different caregivers arrive on the scene.

These issues are all solvable, but not through an isolated action that addresses only the matter of worker compensation. NAHC sincerely recommends that the Committee re-direct its efforts to bring about the broad-based solution that is needed to protect both the worker and the consumer of care.

WHO RECEIVES COMPANIONSHIP SERVICES

Companionship services, otherwise known in health care as home care aide and personal care attendant service, are provided to millions of Medicare, Medicaid, TRICARE, and private pay recipients of care. They are young and old, permanently disabled and chronically ill. In 2000, the U.S. Department of Health and Human Services reports that the number of individuals receiving home care services was 7,178,964.

In 2006, Medicare expenditures for home health services provided to 3.1 million elderly and disabled, homebound beneficiaries with expenditures totaling \$13.2 billion. Medicaid expenditures for home care in 2000 reached \$24.3 billion, of which \$11.6 billion was spent on personal support services. Since 2000, Medicaid spending on home care has grown exponentially with a rebalancing of spending away from institutional care and into community-based services. Medicaid home care recipients are of all ages, from infant to very advanced age, all with one common characteristic—they must rely on others to safely stay at home.

The 1974 amendment to the Fair Labor Standards Act (FLSA) that established the “companionship services” exemption at issue in this matter is a unique action through which Congress offered protection to a class of consumers rather than employees. The central feature of the exemption is to provide a cost protection for the elderly and the infirm who require personal care and other support services, known as companionship services, to remain in their communities and in their own homes.

From the time of the 1974 amendment through today, all branches of the federal government have recognized the importance of providing community based care to the elderly, infirm, and disabled. For example, in 1980, Congress enacted amendments to the Medicare program to eliminate coinsurance requirements under the home health benefit in order to remove any barriers to care in the home that might lead to more costly and less humane institutional care. Section 930(h) of the “Medicare and Medicaid Amendments of 1980,” P.L. 96-499, codified at 42 USC 13951(b)(2).

More recently, with the enactment of the Americans with Disabilities Act of 1990, Congress ensured that individuals with disabilities be afforded the opportunity to receive public services and programs in the most integrated setting appropriate to their needs. 42 USC 12101~~fff~~. The right of disabled individuals to community-based care under the ADA and its implementing regulations was affirmed by this Court in *Olmstead v L.C.*, 527 US 581 (1999).

The Executive Branch of the United States government also has weighed in heavily in favor of home care. The “New Freedom Initiative” was announced by President Bush on February 1, 2001, followed by Executive Order 13217, Community-Based Alternatives for People with Disabilities (June 18, 2001).

The United States Department of Health and Human Service (HHS), which manages many of the public home care programs, set out its implementation of the Executive Order establishing civil rights compliance activities that facilitate community integration in “Delivering on the Promise, HHS' Report to the President on Executive Order 13217.” www.hhs.gov/newfreedom/eo13217.html.) The HHS initiative is a nationwide effort to remove barriers to community living for people of all ages with disabilities and long term illness.

PROFILE OF THE HOME CARE AIDE/COMPANION

The U.S. Department of Labor, Bureau of Labor Statistics, reports that 663,280 workers provide companionship services as home health aides and personal care aides.¹ Among the employers of these workers are 8,728 Medicare certified home health agencies throughout the country.²

The bald statistics tell only a minor part of the story about home care aides. In the community of home care, aides are considered heroes. Most often, it is the aide who is the reason the patient can stay at home safely to receive needed health care services. The home care aide is generally considered to have the toughest job in home care as she must respond to a myriad of personal care needs of her patients ranging from simple bathing to managing incontinent, nonambulatory elderly patients with Alzheimer’s Disease. Aides

¹ *Occupational Employment Statistics*, U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wages, May 2005 (www.bls.gov/oes/current/oes311011.htm”nat) . Internet search 12/11/06.

² Centers for Medicare & Medicaid Services, Center for Information Systems, Health Standards and Quality Bureau, November 2006.

are task oriented, schedule regimented, caring people who become the equivalent of temporary family members providing essential caregiving with a tender touch. They care for people who are afflicted with chronic illness or who are recovering from an acute illness or injury. Aides are also significant team members in hospice care, providing special care to individuals at the end of life.

The home care aide may care for one individual or provide services on a shift basis to several. Some provide visit oriented services that occur several times per week per patient for one to two hours a visit. Versatility and dependability are hallmarks of the home care aide. Most are women, but men also participate in this work.

Home care aides are deserving of respect and admiration. They also are well deserving of society's support and recognition for their great contributions. They are truly heroes of home care.

THE PROFILE OF HOME CARE FINANCING

The provision of essential care by home care aides happens only with the significant financial support of federal and state health care and personal care service programs. It must be recognized that the proposed changes to the FLSA, designed to guarantee home care aides overtime compensation when applicable, will increase the costs of those important programs. In addition, the nature, structure, and operation of these programs demonstrates that the increased costs occurring through a new overtime compensation obligation will not lead to near term changes in reimbursement rates to reflect and reimburse employers of home care aides for that new cost. In fact, the experiences with state Medicaid programs demonstrate that payment rate changes occur only after access to care problems reach a crisis level.

Medicare pays for home health services through a prospective payment system, 42 USC §1395fff; 42 CFR §484.200 (HHPPS). The HHPPS payment rate is adjusted annually through the application of a "market basket index," a sort of inflation factor. 42 USC §1395fff(b)(3)(B); 42 CFR §484.225.

However, the market basket index formula and the database utilized to apply that formula are not designed to address sudden cost changes without unreasonable delay. For example, the database utilized for the inflation factor for the calendar year 2005 proposed rates includes wages and salary data from 2000. 69 F.R. 31248 (June 2, 2004).

Compounding the problems with the Medicare market basket index update is the use of a wage index for geographic variation in payment rates. 42 USC §1395fff(b)(4)(A)(ii)i; 42 CFR §484.210(c).

However, changes in home care aide wages will not affect payment rates because the home health wage index is based upon hospital services wage data. As a result,

providers of companionship services will experience increased cost and unaffected Medicare payment rates.

Medicaid payment systems are even less predictable than the Medicare HHPPS. States participating in Medicaid are required to establish payment rates sufficient to enlist enough care providers to secure services at a level of access comparable to the non-Medicaid patient population. 42 USC §1396a(a)(30)(A); 42 CFR §447.204. Typically, state Medicaid programs adjust payment rates only after individuals have lost access to necessary care. See, *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993); *Orthopedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997).

In *Ball, et al v. Bledess, et al*, the District Court held that the Arizona Medicaid program home care payment rates violated 42 USC §1396a(a)(30)(A). CIV 00-0067-TUC-EHC (D. AZ. 8/13/2004). The court noted that despite multiple studies and reports since 1998 indicating the loss of access to care triggered by inadequate payment rates, the state did not respond.

Many of the Medicaid home care programs are designed around a standard of cost effectiveness. These programs, otherwise known as home and community-based care waivers, exist only to the extent that the cost of care is less than the cost of placement in an institutional setting. 42 USC §1396h(c) The increase in costs triggered by new overtime compensation obligations threatens the viability of these waiver programs and will block home and community-based care options for currently served individuals.

TRICARE, the health services program for over eight million military dependents and retirees will also be adversely impacted. Its basic home health services program is built on the Medicare payment model referenced above. 32 CFR Part 199. In addition, its Extended Home Care Benefit is founded on cost-effectiveness principles comparable to the Medicaid waiver programs discussed herein. 69 F.R. 44942 (July 28, 2004).

WHY IS THE FINANCING OF HOME CARE RELEVANT?

The financing system for home care can be boiled down to two basic concepts: (1) the provider of care does not control the price of services; and (2) the provider of care has limited control over the cost of care. Addressing the pressing needs of home care aides in a piecemeal fashion, focusing solely on overtime compensation, compounds rather than solves the problems faced by home care aides.

As the preceding discussion indicates, the price of care is controlled by federal and state programs that purchase the care from the providers of home care on behalf of participants in the programs. At best, these programs are slow to act to reflect cost changes in payment rates. At worst, there is no reaction to increase service costs leading to serious access problems.

With the inability to respond to increased costs through price increases, the employer of home care aides has no alternative but to take steps to reduce costs. Some costs cannot be avoided as they are creatures of regulatory standards designed to ensure quality of care. For example, Medicare home health agencies must meet rigorous standards for participation that include training and competency standards for home health aide service, 42 CFR 484.36. In addition, most states have provider licensing standards with many requiring full criminal background checks on all caregiving staff. In addition, the home care agency must manage staff recruitment, scheduling, and travel costs to patients' homes. As with any employer, the home care agency also must cover the costs of Workers' Compensation, Unemployment Compensation, and the Social Security tax.

These employer obligations leave few options for the home care agency to control costs and respond to an increase in costs such as overtime compensation. In the absence of immediate changes in payment rates by federal and state programs, the home care agency is left with two cost control options and one cost avoidance option. In terms of cost control, the home care agency can reduce the basic hourly wage of home care aides or eliminate or reduce any available employee benefits such as health insurance. Currently, the employee benefits are, at best, minimal because of currently inadequate payment rates.

The cost avoidance option is for the home care agency to limit the hours worked by the home care aides, capping those hours at 40 per week to stay under any overtime compensation obligation.

Who gains from this dynamic—no one! The patient loses because of the loss of continuity in caregivers. The home care agency loses because of higher recruitment costs and staff scheduling costs to reference just a few. The worker loses because she is subject to capped compensation with no alternative but to find additional supplemental employment.

ARE THERE OTHER RISKS WITH THE PIECEMEAL APPROACH?

The proposed legislation purports to address compensation protections for home care aides regardless as to whether they are employed by the person receiving the care or by a third party. As Justice Breyer pointed out during the oral argument in *Coke v. LI Care at Home*, the argument advanced by Ms. Coke would have the unacceptable consequence of discriminating against individuals who did not have the faculties or means to directly employ the home care aide by creating an overtime compensation obligation for individuals that needed to acquire care through a third party. As such, NAHC is very supportive of the proposal in terms of its inclusion of all home care aides within the minimum wage and overtime compensation protection except those that truly work on a casual basis. However, it can reasonably be expected that consumers and workers in the direct employment situation may be tempted by the opportunity to “go

underground” in their arrangement to avoid the obligations, scrutiny, and reporting responsibilities that come with a formal, compliant employment relationship.

In such circumstances, both the consumer and the home care aide are losers once again. The consumer loses the quality of care protections designed into many federal and state laws. Oversight, worker screening and training, and the ready availability of substitute workers is sacrificed. For the home care aides, protections such as Workers’ Compensation, Unemployment Compensation, and Social Security contributions are lost.

These risks can only be addressed through a comprehensive strategy to enhance the status of home care aides. Focusing on the isolated overtime compensation concern is not a step toward that strategy. Instead, it is a step backward unless it is part of a plan to include consideration of care financing, health insurance protection, and career building opportunities.

A BROAD-BASED HOME CARE AIDE PROTECTION PLAN

To insure unintended consequences triggered by this proposed legislation, NAHC recommends that Congress develop a broad-based strategic plan that provides a comprehensive approach to the protection of home care aides. That comprehensive protection is needed for both the home care aide and the individuals under their care. That plan should include, at a minimum, the following:

1. Mandates for all federal and state programs that finance home care aide services to reform payment rates to accommodate increased costs of improved compensation.
2. Requiring all federal and state home care programs to provide the necessary financial support for a basic health insurance plan for home care aides.
3. Providing support for programs that establish career ladder opportunities for home care aides including scholarships and grants for higher education and training.
4. Establishing economical and efficient background check systems to allow for expedited screening of applicants for home care aide employment.
5. Requiring consistent employee protections across all forms of home care aide employment such as Workers’ Compensation, Unemployment Compensation, OSHA job safety standards, and worker qualifications.

COMMENTS ON THE LANGUAGE OF H.R. 3582

NAHC recommends that H.R. 3582 move forward only as part of a comprehensive plan to address home care aide protections and employment. However, as it is currently structured, the language is confusing and ambiguous.

Specifically, it is unclear whether proposed subparagraphs (A) and (B) are intended to establish the definition of “casual basis” or add restrictions on the

applicability of the “casual basis” exemption. For example, must the companionship service be both “casual basis” work and “irregular or intermittent”? Alternatively, is casual basis defined as work that is irregular or intermittent?

Similarly, the phrase “or an individual employed by an employer or agency other than the family...,” may be intended as a wholesale exclusion from the companionship services exemption or one applicable when involving services on a casual basis that are irregular or intermittent.

With respect to subparagraph (B), it appears that the 20 hour per week standard may be either an additional qualification on the “casual basis” standard, an additional qualification on the “irregular or intermittent” standard, or a definition of one or both of those standards.

Finally, it is ambiguous as to which employer under the “20 hour in the aggregate” standard has the responsibility for overtime compensation. Is it the employer who is employing the worker for the hours that exceed the aggregate of 40 hours that is responsible for overtime compensation or are the multiple employers responsible only when their employment itself exceeds 40 hours?

NAHC is readily available to work with the Committee to clear up this confusion and these ambiguities.

CONCLUSION

Home care aides are essential caregivers of the elderly and the disabled. They deserve comprehensive worker protections. However, by addressing the single concern of the application of the FLSA companionship services exemption to the exclusion of the interrelated issues of care financing, health insurance coverage, career support, and other matters, H.R. 3582 is a well intentioned effort that will have unintended adverse consequences for both consumers of home care aide services and the home care aides. NAHC recommends a broad-based strategic legislative plan to address these interrelated concerns to achieve the goals of H.R. 3582.