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Comments submitted by Trey Kovacs, Competitive Enterprise Institute

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Via www.regulations.gov

Introduction

On behalf of the Competitive Enterprise Institute (CEI), I respectfully submit the following comments in response to the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking (NPRM) on *Reassignment of Medicaid Provider Claims*, 83 Fed. Reg. 32252, RIN 0938-AT61, CMS-2413-P (July 12, 2018).

Founded in 1984, the Competitive Enterprise Institute is a non-profit research and advocacy organization that focuses on regulatory policy from a pro-market perspective.

CMS 2018 Proposed Rule "Reassignment of Medicaid Provider Claims"

The Competitive Enterprise Institute commends the CMS proposed rule to remove the invented regulatory exception to the statutory prohibition on reassigning Medicaid funds to third parties. The CMS 2014 Final Rule "Provider Payment Reassignment" permits States to withhold Medicaid payments to care providers and reroute them to third parties who provide "benefits customary to employees." Specifically, the CMS NPRM "Reassignment of Medicaid Provider Claims" would remove the regulatory text found at 42 CFR 447.10(g)(4).

This is a necessary reversal of agency policy. The Social Security Act (SSA) does not delegate authority to CMS to either create any new exemptions to the direct payment requirement or divert Medicaid payments to third parties who provide employee benefits.

CEI's comments seek to establish:

1. The CMS exceeded its statutory authority in its 2014 Final Rule, "Provider Payment Reassignment," and must reverse this policy;
2. 1902(a)(32) of the SSA prohibits the voluntary or involuntary reassignment of Medicaid payments to unions and any other third party not expressly permitted under the Act;
3. Unions often obtain portions of Medicaid Payments from home care providers through coercive means;
4. A significant amount of Medicaid Funds have been diverted from caregivers to labor unions.

Background

The Social Security Act (SSA) was amended in 1965 to establish the Medicaid program.[1] Congress established the joint federal-state program to provide health care to individuals with low income, people with disabilities, the elderly, and children meeting certain criteria.

States create plans on how to administer Medicaid programs, and federal regulatory agencies review these plans for approval. One Medicaid program, the Home and Community-Based Services "waiver" program, allows the elderly or disabled individuals to use Medicaid funds to pay for in-home care, rather than

[1] "Medicaid (Title XIX of the Social Security Act)" Brain Injury Association of America, Accessed on July 19, 2018, https://www.biausa.org/public-affairs/public-policy/medicaid-title-xix-of-the-social-security-act.

enroll in an institution. Often, family members or friends provide this in-home care. Otherwise, independent providers serve these Medicaid clients.

Unfortunately, even though Medicaid payments are statutorily required to be sent directly to caregivers or individuals receiving care, some States have been diverting a portion of these funds to labor unions. Labor unions, prominently the Service Employee International Union (SEIU), have influenced states to automatically deduct union dues from home care providers' Medicaid payments and send them directly to labor organizations. It is estimated that over $100 million in Medicaid funds are diverted from caregivers and individuals annually.

"Provider Payment Reassignment" Rule

Reassigning Medicaid funds to third parties is a misappropriation of tax dollars and harms those who care for the most needy in our society—the elderly and disabled. In this rulemaking, it is incumbent on CMS to make clear that it is illegal to divert Medicaid funds directly to labor unions, or other third parties, by removing the regulatory exception created by the CMS 2014 "Reassignment of Medicaid Provider Claims" rule.

The trouble began when the CMS initiated a rulemaking in 2012 that culminated in 2014 with the promulgation of the "Provider Payment Reassignment" regulation. This rule is in direct conflict with Section 1902(a)(32) of the SSA, which mandates that Medicaid payments for "any care or service provided to an individual" are to be sent directly to the beneficiary of services or to the person or institution providing such services. Congress created a defined set of four exceptions to this direct payment requirement,[2] and did not delegate any authority or grant discretion to any administrative agencies to create new exceptions. Reassigning Medicaid funds to labor unions is not included in the four statutory exceptions.

Despite the unambiguous text in the SSA related to the direct payment requirement, in 2012, the CMS set forth on a rulemaking that completely ignores the statute. CMS first proposed to create a new exception to the direct payment requirement as part of a NPRM entitled "Home and Community Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice."[3]

CMS acknowledged in the 2012 NPRM that Section 1902(a)(32) of the SSA forecloses the option to reassign the payment of Medicaid to anyone but the health care practitioner or individual receiving care, except for the enumerated exceptions created by Congress. As the text of the NPRM states:

> While the statute does not expressly provide for additional exceptions to the direct payment principle, we believe the circumstances at issue were not contemplated under the statute. …

[2] The four exceptions to the direct payment requirement, found at 42 U.S.C. § 1396a(32)(A)(B)(C)(D), include:
(A) payments to the employer or the facility where a physician provides health care services;
(B) payments to a governmental agency or by the order of a court;
(C) payment can be made to the physician submitting the claim for services; and
(D) a State Plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State.

[3] Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, *Proposed Rule*, CMS–2249–P2, 77 Fed. Reg. 26361 (May 3, 2012) [hereinafter Proposed Rule], https://www.gpo.gov/fdsys/pkg/FR-2012-05-03/pdf/2012-10385.pdf.

> Therefore, we proposed an additional exception to describe payments that we do not see as within the intended scope of the statutory direct payment requirement, that would allow the state to claim as a provider payment amounts that are not directly paid to the provider, but are withheld and remitted to a third party on behalf of the provider for health and welfare benefit contributions, training costs, and other benefits customary for employees.[4]

The CMS fails to provide in the NPRM any legal basis or statutory authority for creating this new exception. Instead, CMS merely asserts that "the circumstances at issue were not contemplated under the statute."[5] In another section of the proposed rule, CMS acknowledges that the statute does not "expressly provide for additional exceptions to the direct payment principle," but then goes on to argue that in "light of the statutory silence in addressing this circumstance, we are proposing that the direct payment principle should not apply because we think its application would contravene the purpose of the provision."[6]

In summary, the CMS views its newly created exception, which sidesteps the direct payment requirement, as valid because "we are proposing an additional exception to describe payments that we do not see as within the intended scope of the statutory direct payment requirement."[7]

Other than the CMS' own belief, it cites several States that have requested for the federal government to create additional exceptions to the direct payment principle that permits the States to withhold payments from personal care providers to send to third parties for "health and welfare benefits, training costs, and other benefits customary for employees."[8] In some States' view, providing them with the authority to withhold payment on behalf of personal home care providers for benefits customary of employees could stabilize the workforce and improve the quality of service provided.[9]

In 2014, CMS completed the rulemaking process and issued the Final Rule for "Provider Payment Reassignment."[10] The Final Rule created the regulatory exception to permit States to reassign payments from care providers to third parties for the purposes of "workforce stability, health and welfare, and trainings, and provide added flexibility to the state."[11]

As with the NPRM, the Final Rule acknowledges, "the statute does not expressly provide for additional exceptions to the direct payment principle." It is clear this prohibition did not discourage the agency from taking extra-statutory regulatory action. CMS justification for the Final Rule mirrors that of the proposed rule. The agency believes "the circumstance at issue were not contemplated under the statue."

CMS also appears to defend its Final Rule by reiterating that some States requested that CMS adopt "additional exceptions to the direct payment principle to permit withholding from the payment due to the

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[4] Proposed Rule at 26364.
[5] Proposed Rule at 26364.
[6] Proposed Rule at 26382.
[7] Proposed Rule at 26382.
[8] Proposed Rule at 26381.
[9] Proposed Rule at 26381.
[10] Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, *Final Rule*, CMS–2249–F; CMS–2296–F, 79 Fed. Reg. 2947 (January 16, 2014) [hereinafter Final Rule], https://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf.
[11] Final Rule at 2948.

individual practitioner for amounts paid by the state directly to third parties for health and welfare benefits, training costs and other benefits customary for employees."[12]

Ultimately, the Final Rule created the regulatory exception, found at 42 CFR 447.10(g)(4), to the "Prohibition against reassignment of provider claims,"[13] which states "In the case of a class of practitioners for which the Medicaid program is the primary source of service revenue, payment may be made to a third party on behalf of the individual practitioner for benefits such as health insurance, skills training and other benefits customary for employees."[14]

2014 Final Rule "Provider Payment Reassignment" Exceeds Statutory Authority

As described, the CMS created an additional regulatory exception to the direct payment principle by suggesting that the statute did not contemplate the circumstances at issue. In both the NPRM and Final Rule, the CMS put forth that "in light of the statutory silence in addressing this circumstance, we are proposing that the direct payment principle should not apply because we think its application would contravene the purpose of the provision."[15]

The CMS erred in creating a new exception, and provided no legal statutory authority for creating a new exception. The plainly stated purpose of this section of the statute is that "no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise."[16] Congress also created four statutory exceptions to the prohibition against reassigning payments to care providers or Medicaid beneficiaries. In general, the exceptions permit a reassignment of Medicaid payment when "made to a governmental agency or entity or ... established by or pursuant to the order of a court."[17]

The text of the SSA does not permit States to authorize the reassignment of Medicaid payments to a third party on behalf of an individual care provider for the purposes of "benefits customary to employees."[18] Importantly, this prohibition makes it irrelevant as to whether the home care provider voluntarily or involuntarily requests that the State reassign Medicaid payments to a third party for benefits customary to employees. States may only reassign Medicaid payments because of an order of the court or to a government agency.

CMS' reasoning for creating the extra-statutory regulatory exception partially relies on the incorrect theory that the statute did not consider the circumstances at issue. Congress has spent an inordinate amount of time contemplating the SSA. Since 1965, when Congress amended the SSA to create Medicaid, the law has been amended over 20 times.[19] As such, Congress has had ample opportunity to amend the statute to create additional exceptions to the direct payment requirement. Alternatively, Congress could have decided to amend the statute to delegate authority to CMS or to another federal

[12] Final Rule at 2949.
[13] 42 CFR 447.10
[14] 42 CFR 447.10(g)(4)
[15] Proposed Rule at 26382.
[16] SSA Section 1902(a)(32) https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.
[17] SSA Section 1902(a)(32)(b)
[18] 42 CFR 447.10(g)(4)
[19] Geoffrey Kollmann, "Social Security: Summary of Major Changes in the Cash Benefits Program," Congressional Research Service, May 18, 2000, https://www.ssa.gov/history/reports/crsleghist2.html.

agency to create additional exceptions to the prohibition against reassigning Medicaid payments. Congress has repeatedly declined to do so.

CMS' claim that the statute is "silent" on whether CMS may create a new exception for the purposes of reassigning payments from home care providers is a grave misinterpretation of the statute. CMS appears to imply that because Congress did not speak to a specific issue that the legislative body is silent and provides an opportunity for the agency to fill some purported gap. That is not the case. Federal regulatory agencies have no more authority than given to them by Congress. Congress enumerated four clear exceptions that permit Medicaid funds to be reassigned to entities other than home care providers. No more, no less.

As the Supreme Court has stated, "Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes."[20] In other words, for CMS to create a new exception, it should be able to point to some statutory text that permits such action, not its mere belief that Congress had not contemplated the circumstances at issue. In fact, during the rulemaking process, CMS continually points out the opposite, that there is a statutory prohibition on reassigning Medicaid funds to third parties.

When interpreting a statute, the court's first consideration is whether the text is clear or whether there is ambiguity.[21] 1902(a)(32) of the SSA is abundantly clear in its prohibition on reassigning Medicaid funds. When the language of a statute is clear, "there is no need to look outside the statute to its legislative history in order to ascertain the statute's meaning.[22] This is a canon of statutory interpretation known as the "plain meaning rule," which bars "courts from relying on legislative history when statutory language is plain."[23] In both the CMS proposed rule and Final Rule, the agency incorrectly, in part, relies on the legislative history of the SSA to justify creating the extra-statutory regulatory exception.[24] All the agency should use to interpret the SSA is the text because it is plain and clear in its prohibition on assigning Medicaid payments to anyone other than the individual receiving care or the caregiver, except under four circumstances that are clearly defined by statute.

Another canon of statutory interpretation is that a law should be read as a harmonious whole. Justice Scalia describes this approach as such:

> Statutory construction ... is a holistic endeavor. A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme—because the same terminology is used elsewhere in a context that makes its meaning clear, or because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law.[25]

Under this canon, it is clear that CMS inappropriately created a new exception to the direct payment principle. As set forth in the SSA, the Act's primary is "to provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public

[20] *Whitman v. American Trucking Assns., Inc.*, 531 U. S. 457 (2001).
[21] Yule Kim, "Statutory Interpretation: General Principles and Recent Trends," Congressional Research Service, August 31, 2008, [hereinafter Statutory Interpretation] https://www.everycrsreport.com/files/20080831_97-589_920cdcc19594f29fe67412f8b90ac38d6ad8a8ed.pdf.
[22] Statutory Interpretation at 2.
[23] Statutory Interpretation at 39.
[24] See Proposed Rule at 26381 and Final Rule at 2949.
[25] United Savings Ass'n v. Timbers of Inwood Forest Associates, 484 U.S. 365, 371 (1988).

health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes."[26]

If the primary objective of the SSA is to create a system to provide benefits for the elderly and disabled, then the CMS 2014 Final Rule is contrary to "the whole law, and to its object and policy."[27] This is so because the CMS's 2014 Final Rule permits the diversion of Medicaid funds from caregivers and Medicaid beneficiaries. The purpose of the SSA to provide benefits for the care of the elderly and disabled, not divert funds away from them.

In many cases, Congress does draft vague statutory language and it is the role of administrative agencies to fill the gaps. The courts have even adopted doctrine that calls the judiciary to defer to administrative agencies and how they interpret imprecise statutes. This is not one of those cases. Congress imposed a blanket prohibition against reassigning Medicaid funds, and then created limited exceptions without delegating any authority to administrative agencies to invent new exceptions.

It is crucial for CMS to understand, in this rulemaking and in future endeavors, that 1902(a)(32) of the SSA prohibits all reassignments of Medicaid payments unless it is required by a court order or assigned to a governmental agency. The statute even prohibits home care providers from voluntarily requesting the State to reassign a portion of their Medicaid payment to a third party.

Final Rule must clarify Reassigning Medicaid Payments to Labor Unions is Prohibited

As previously discussed, the SSA prohibits the reassignment of Medicaid payments. CMS should be aware that a number of States have been automatically deducting union dues from home care aides' Medicaid payments, which is not one of the four exceptions to the statutory prohibition on reassigning Medicaid payments to third parties.

In CMS' Final Rule, "Reassignment of Medicaid Provider Claims," it should be made clear that reassigning Medicaid payments to labor unions, their affiliates, or for union-sponsored training is a flagrant violation of the SSA. This is true whether the home care provider voluntarily requested the State to deduct union dues from their Medicaid payments or not.

It is incumbent on CMS to provide clarity on this issue because Medicaid payments have been obtained by unions through coercive means and home care providers may not easily revoke such dues payments.

For example, in Washington State, SEIU Local 775 has used state mandated orientation sessions to deceive individual provider home care aides, who serve Medicaid-eligible clients, into believing that union membership is required. The Freedom Foundation, a free-market think tank located in Washington, obtained video footage of SEIU representatives falsely telling home care aides that union membership was mandatory.[28]

Documents obtained via public record requests describe SEIU 775 officials who conducted these orientation sessions as "aggressive," "forceful," "rude," "unprofessional," "coercive," "demanding," and

[26] The Social Security Act of 1935, https://www.ssa.gov/history/35act.html.
[27] United States v. Boisdoré's Heirs, 49 U.S. (8 How.) 113, 122 (1850).
[28] Maxford Nelsen, "Video Footage Shows SEIU Lying to Individual Providers in State Mandated Training," Freedom Foundation, July 7, 2015, https://www.freedomfoundation.com/labor/video-footage-shows-seiu-lying-to-individual-providers-in-state-mandated-training/.

"bullying."[29] In addition, caregivers at the orientation sessions felt "pressured," "misled," "tricked," "coerced," "intimidated," and "forced" into signing SEIU membership forms.[30]

Labor unions have also made it exceedingly difficult for home care providers to revoke union membership and automatic deduction of dues from Medicaid payments. In California, once a caregiver authorizes union dues deductions, he or she is prohibited from revoking this authorization for one year. Further, the authorization is automatically renewed annually unless the caregiver provides the union with "written notice of revocation … not less than ten (10) days and not more than twenty (20) days before the end of any yearly period."[31] Providing only a 10-day window to revoke automatic dues deductions is common among States that permit the reassignment of Medicaid payments to unions.[32]

In addition to the coercive nature of the unionization of home care providers who serve Medicaid clients, an enormous amount of Medicaid payments have been illegally reassigned to labor unions. A recent report finds "[F]rom 2000-2017, states diverted an estimated $1.4 billion in caregivers' Medicaid funds to unions." In 2017 alone, $146,600,094 in caregivers' Medicaid payments have been diverted to unions."[33]

Conclusion

CMS has a duty to ensure Medicaid funds are assigned to the proper recipients and provide for the care of the elderly and disabled. The CMS Final Rule, "Reassignment of Medicaid Provider Claims," must safeguard and guarantee all Medicaid funds reach their statutorily required destination. The SSA requires all Medicaid payments to be sent directly to caregivers or Medicaid beneficiaries. Any regulatory action on this issue must reinforce the direct payment principle enshrined in law. There is no way to interpret the SSA other than that there is a strict prohibition on reassigning Medicaid funds to any third party including labor unions. The CMS Final Rule should remove the regulatory exception found at 42 CFR 447.10(g)(4).

Respectfully Submitted,

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[29] Maxford Nelsen, "DSHS allowing SEIU to continue exploiting caregivers," Freedom Foundation, January 29, 2018, https://www.freedomfoundation.com/labor/dshs-allowing-seiu-continue-exploiting-caregivers/.
[30] Ibid.
[31] View the terms of UDW/AFSCME Local 3930 membership authorization form at: http://udwa.org/signup/.
[32] Maxford Nelsen, "Getting Organized at Home: Why Allowing States to Siphon Medicaid Funds to Unions Harms Caregivers and Compromises Program Integrity," [hereinafter "Getting Organized at Home] Freedom Foundation, July, 2018, https://www.freedomfoundation.com/wp-content/uploads/2018/07/Getting-Organized-at-Home.pdf.
[33] Ibid.