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Upholding Labor Standards in Home Care:

How to Build Employer Accountability Into America's
Fastest-Growing Jobs

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About NELP

For more than 45 years, the National Employment Law Project has worked to restore the promise of economic opportunity for working families across America. In partnership with grassroots and national allies, NELP promotes policies to create good jobs, enforce hard-won workplace rights, and help unemployed workers regain their economic footing. For more information, visit us at www.nelp.org.

Executive Summary

The home care industry has reached a crucial turning point. Years of organizing have secured critical reforms that can potentially elevate the low wages and poor conditions that have long plagued the industry. In recent decades, hundreds of thousands of home care workers have organized unions and negotiated significant wage increases and other benefits. In 2015, most of the nation's two million home care workers won federal wage and hour rights, after a long-fought effort to narrow the scope of the Fair Labor Standard Act's companionship exemption. A recent wave of state and local minimum wage increases, living wage laws, and Domestic Worker Bill of Rights campaigns have further boosted workers' legal protections.

Home care is increasingly in the national spotlight, as the movement for a \$15 wage has brought home care workers into its high-profile organizing campaigns; as people with disabilities and elder advocacy groups mobilize to maintain public funding for and access to vital in-home services; and as the public increasingly recognizes that poverty-level wages and high turnover in the nation's fastest-growing workforce will hinder the industry's ability to meet the exploding home care needs of America's rapidly aging population.

But home care workers' hard-won victories could be undermined by a fundamental weakness in the structure of the home care industry: the industry's pervasive outsourcing of employer responsibility for home care workers, combined with a lack of tools to hold employers accountable.

Few home care workers have a traditional employment relationship with one employer whom they can hold accountable for job standards. Instead, the key industry players that call the shots on worker pay have sought to distance themselves from their workforce. While the federal and state governments fund the vast majority of home care services through the Medicaid and Medicare programs, they largely rely on a host of poorly regulated private companies to hire and pay workers. And many private companies have attempted to evade

responsibility by calling workers "independent contractors," subcontracting out home care work, and using franchising schemes. As a result, home care workers may relate to multiple parties as they carry out their jobs, but can find no one to ultimately be responsible for raising wage standards or complying with workplace laws.

To turn these fastest-growing low-wage jobs into a stable profession, we must change course now and hold home care industry players responsible for both compliance with workplace laws and the quality of home care jobs. Given its power in the marketplace, the public sector must lead by attaching strong labor standards to public funding to ensure that additional money actually goes to the workers, and that publicly funded private employers comply with the law. And no matter what structure workers are employed in, they should be covered by basic labor standards and protected by enforcement that looks beyond employers' superficial labels to hold the companies calling the shots accountable for the conditions they create.

This report offers a number of policy and action recommendations to begin to address the chronic problems facing this workforce and industry. These recommendations are aimed at achieving five main objectives:

- Ensuring basic labor protections for which home care employers can be held accountable;
- Stopping lawbreaking within publicly funded home care programs;
- Prioritizing smart and strategic enforcement of basic labor standards;
- Leveraging and increasing public investment in home care to create quality jobs; and
- Strengthening workers' ability to organize and bargain for greater accountability.

Strengthening accountability now will not only help historic labor reforms deliver real benefits to a growing workforce; they will also improve quality of care and services, and set the industry on a path to a more

sustainable future. While a significant influx of funding is desperately needed to fully meet our nation's growing needs and provide living wages for all workers, the proposals we offer to improve accountability point the

way toward transforming low-wage home care jobs into the quality family-sustaining profession our nation so sorely needs.

Introduction

This report focuses on the two million workers in this country who work in home care. The term “home care workers” describe those who provide the in-home supports and services that allow older adults and people with disabilities or illness to remain in their homes. These workers can have a variety of job titles, including home health aides, personal care aides, caregivers, companions, and certified nursing assistants (who are employed in private homes rather than institutions). Their work includes dressing, grooming, feeding, bathing, toileting, and transferring, meal preparation, driving, housework, managing finances, assistance with taking medications, and arranging medical care.

Home care workers are employed in a wide variety of arrangements, ranging from informal arrangements with households who pay workers directly with private funds, often in cash, to the complex Medicaid system, where services are delivered, and employment responsibilities fragmented, throughout a web of public and private agencies. All too often, no matter what the work structure, no party takes responsibility for home care workers’ pay and labor conditions. The federal and state governments, which pay for the majority of home care services, channel funds through a variety of private and public intermediaries, distancing themselves from and not directly employing the workers. And home care businesses have often declined to assume responsibility for working conditions.

The outsourcing of employer functions—through subcontracting, privatization, franchising, and misclassification of workers as independent contractors—combined with complex funding streams, is endemic to the home care industry and not well understood. While

much has been written about the low pay and poor working conditions that have weakened the industry, and workers’ organizing to improve standards, what has not been well documented is how the fragmented industry structures and payment streams have obscured the roles these key parties play in setting pay, working conditions, and hours, complicating efforts to strengthen accountability.

In this report, we explore the patterns and effects of, and policy responses to, outsourcing in the home care industry, arguing that a crucial first step to improving conditions for home care workers is establishing clear accountability within contracting arrangements for the rampant workplace violations that form a core feature of this industry.¹

Section I provides data on the wages and rates of wage theft that characterize the industry. Section II describes the current lack of robust controls within the Medicaid and Medicare systems, and the failures within federal and state policy that have contributed to that absence. Section III describes the most common outsourced work structures in this highly varied and fragmented industry, including models in Medicaid and other publicly funded programs as well as in the private-pay sector, and the workplace violations that can stem from these often-convoluted structures. Section IV presents our detailed policy and action recommendations.

These policy reforms will help hold the fast-growing home care industry accountable to the workforce it depends on, and allow the industry to better meet the long-term needs of America’s aging population.

What do we mean by outsourcing?

We use the term outsourcing broadly to refer to work structures that diverge from direct, bilateral employment relationships in which one employer assumes employment responsibilities for its employees. Home care industry players often outsource employer responsibilities in the following ways:

Privatization: The government (usually the state) contracts with private home care agencies or managed care organizations to provide publicly funded home care services. The agency hires, pays, and dispatches the workers to consumers' homes.

Fissuring² of employer roles in state consumer-directed programs: In state-run Medicaid consumer-directed programs, the state disperses various employer roles among multiple parties, including the home care consumer, public

or quasi-public entities, and fiscal intermediaries, while maintaining some employer functions itself.

Subcontracting: A home care agency or managed care organization contracts with a private home care agency to hire, pay, and dispatch home care workers to consumers' homes.

Independent contractor misclassification: A home care employer mislabels its employees "independent contractors" and denies them the rights associated with employment.

Franchising: A franchisor sells its brand and sometimes a business model via a contract to smaller franchisees, who hire, pay, and dispatch workers and pay a fee to the franchisor.

1 Home Care Workers Earn Low Wages and Experience High Rates of Wage Theft

The nation's two million home care workers toil for low pay with poor conditions; median hourly wages for home care workers range from \$9.83 to \$10.28.³ These low wages, combined with a scarcity of full-time jobs—only 40 percent of workers work full time, year-round⁴—place much of the home care workforce in poverty. In 2013, average annual earnings for the workforce were only \$18,598.⁵ And while industry revenues are growing at a rapid rate,⁶ workers' real wages have declined by nearly 6 percent since 2004.⁷ Nearly 50 percent of home care workers live in households that receive public assistance benefits such as Medicaid, food stamps, and housing and heating assistance.⁸

Workers suffer not only from low wage rates but also from widespread violations of workplace laws. A 2009 study on wage theft in America's three largest cities found that 17.5 percent of home health care workers experienced a minimum wage violation in the week before the survey was conducted.⁹ The same study found that 82.7 percent of home health care workers were not paid the required overtime pay; 90.4 percent experienced an "off the clock" violation (they worked before and/or after their shift without getting paid for that time); and 79 percent did not receive the required meal breaks.¹⁰

Eighty-nine percent of home care workers are women, and more than half are people of color.¹¹ One in four home care aides is an immigrant to the United States.¹² The disproportionate representation of women of color in this workforce not only reflects who is harmed by low wages and wage theft; it has also fueled policymakers' decisions to underfund their work and exclude it from labor protections. Several historians have documented how sexist and racist beliefs about the workers and the worth of their labor have degraded the value of home care jobs over the decades, shaping home care policy and justifying workers' continued exclusion from workplace protections.¹³

In addition, as this report will describe, the ways in which the federal government and the home care industry have structured home care funding and employment have seriously compounded the problems facing this workforce.¹⁴ Outsourced and fragmented industry structures have allowed various responsible parties—from federal and state governments to private agencies—to evade accountability for the chronically poor conditions suffered by home care workers, and contributed to a culture of non-compliance as many home care employers skirt baseline labor and employment standards.

2 Private Home Care Providers, Funded By Public Dollars, Deliver the Bulk of Services

A. Federal and state governments have largely outsourced home care services to private actors, with little oversight of compliance with basic labor standards.

Home care services can be funded either publicly (through programs such as Medicaid, Medicare, Department of Veterans Affairs programs, workers compensation, or individual state home care programs); or privately, through out-of-pocket consumer expenditures or private insurance.

Public programs together fund 83 percent of home care services.¹⁵ The largest payer for home care services is Medicaid. Most state Medicaid programs provide for long-term personal care needs for the elderly and people with disabilities. Medicare provides minimal home care services, limited to short-term care after a specific injury or illness. The federal agency that oversees both Medicaid and Medicare is the Centers for Medicare and Medicaid Services (CMS), which is part of the Department of Health and Human Services. CMS administers over half of Medicaid home care funds and all of Medicare home care funds.

Since the inception of publicly funded home care, federal and state governments have relied on a host of private actors for service provision, often via multi-layered outsourcing arrangements.¹⁶ Private agencies thus employ the vast majority of home care workers in the industry, even those providing services through publicly funded programs.¹⁷ Federal oversight of labor compliance by these actors has been extremely limited, however. The U.S. Department of Labor (USDOL) has not enforced federal wage laws in most Medicaid and Medicare programs because, until this year, most home care workers had been exempted from federal minimum wage and overtime laws under the federal companionship exemption.¹⁸

1. Medicaid

Medicaid programs rely on joint funding from both the federal and state governments; CMS provides funding to the states, which provide additional funding and

administer the programs. Within broad federal guidelines, states have considerable leeway in setting rules for individuals' eligibility for Medicaid-funded home care services and determining the type and amount of services to be offered. Each state and the District of Columbia fully administers its own program, creating more than 50 unique Medicaid programs.¹⁹ State programs also differ in the amount of money they reimburse home care providers for particular services.

Oversight is severely lacking at both the federal and state levels. The federal government pays for at least half of Medicaid costs in each state, and yet CMS provides no oversight with regard to what a private home care agency pays workers or whether it complies with labor and employment laws. The federal Social Security Act and Medicaid regulations require that state Medicaid programs adhere to certain federal contracting principles—such as competitive bidding, avoiding conflicts of interest, and preventing fraud and patient abuse—but do not adequately address subcontractors' practices regarding wages, working conditions, or compliance with workplace standards.²⁰ The Social Security Act also mandates that state Medicaid programs may only contract with home care agency providers that meet existing state licensing requirements, but does not impose its own baseline requirements for licensing, nor does it require that states create a licensing regime if none exists.²¹ And while some states require home care agencies to get a license, most of these licensing schemes impose few requirements with regard to compliance with workplace laws.²² Finally, neither CMS nor state Medicaid programs require publicly funded private home care agencies to report data on workers' wages and work hours,²³ making it difficult to ascertain what percentage of public dollars employers allocate to worker pay and benefits, and whether or not employers are compliant with workplace laws.

2. Medicare

In contrast to Medicaid, Medicare is fully funded by the federal government.²⁴ Medicare generally has more robust standards for the use of public dollars than does Medicaid, and only pays for home care services

Table 1: Comparison of Areas of CMS Supervision in Medicaid and Medicare Programs

	CMS monitors and evaluates quality of services	CMS sets payment rates to providers and managed care organizations	CMS approves methodology by which the state programs determine reimbursement rates for home care providers	CMS requires certification of home care agencies	CMS monitors compliance with labor standards	CMS requires reporting from contractors about wages and hours
Medicaid	X		X			
Medicare	X	X		X		

Source: 42 CFR 438.214 and Sec. 1128. [42 U.S.C. 1320a-7] (a), 42 CFR 438.214 and Sec. 1128. [42 U.S.C. 1320a-7] (a), 42 CFR 431.424 and 42 CFR §431.428.

provided by Medicare-certified agencies. CMS mandates standards for both worker training and agency certification and then contracts with states to conduct the actual certification of agencies (see Appendix A, Figure A.1).²⁵ Medicare-certified agencies provide a range of services, focused on medical services such as skilled nursing and therapy, but they may also employ home care workers to provide post-acute home care services.

Like Medicaid, Medicare does not provide robust oversight of wages and working conditions (see Table 1). Medicare reimburses home health agencies based on each home health aide visit, and does not require reporting from employers about the wages or hours of home care workers.²⁶ Although oversight in the Medicare program is stronger than in the Medicaid program, it still falls far short of what is necessary to ensure strong accountability for compliance with basic labor standards. More empirical research is needed on the incidence of wage theft for Medicare-funded home care workers, as compared to their counterparts in Medicaid-funded programs.

B. Without robust controls and wage standards, home care employers may use a disproportionate share of public funds for overhead and profits rather than workers’ wages and benefits.

Theoretically, Medicaid and Medicare reimbursement rates (the amount providers are paid from Medicaid or Medicare for the services they provide) should cover

worker wages, other compensation or benefits (such as training), and the private agency’s overhead expenses. However, the lack of oversight means that there is little transparency about what the money actually pays for. With a few exceptions, home care employers in the Medicare program and most state Medicaid programs are not subject to oversight or controls on what percentage of their revenues must go to wages and other worker benefits. In addition, neither the Medicare program, nor most state Medicaid programs, mandate minimum wage levels for home care workers.

While little public information is available about what publicly funded home care employers pay home care workers, what is known about wages and reimbursement rates in home care is that median hourly wages for home care workers (including those working in both publicly funded and private-pay jobs) range from \$9.83 to \$10.28,²⁷ while the agencies are paid significantly more than that via the Medicare and Medicaid reimbursement rates (see Table 2). There is wide variation across states and programs with regard to Medicaid reimbursement rates, but in general, home care agencies generally receive higher reimbursement rates than do workers who are employed in consumer-directed models (see Appendix Table A). Ideally, the higher payments to home care agencies would account for overhead and for work supports like health benefits and training provided by the agency, but without transparency requirements, there is no guarantee that agencies use the higher rate to provide those supports to their employees.

Table 2. Range of Reimbursement Rates for Publicly Funded Home Care Services

Medicaid to home care agency	\$12.91 to \$26.88 per hour
Medicaid to independent provider	\$8.29 to \$16.76 per hour

Source: See Appendix Tables B.X and B.Y.

In the private-pay market, home care agency employers pay workers about half of what they take in from consumers. The 2015 Private Duty Benchmarking Study shows that surveyed home care employers paid workers just over 50 percent of their annual revenues, and had gross profit margins of nearly 40 percent.²⁸ Data from the 2014 survey shows average 2013 hourly billing rates that private home care agencies charged consumers were \$21 for personal care attendant services and \$22 for home health aide services.²⁹ Yet, median wages for home care workers are not much more than the minimum wage (see Section I, above).

C. The federal government has failed to leverage public expenditures on home care to improve the quality of home care jobs.

The federal government could leverage its power as the primary payer for home care services by attaching conditions to those funds, but it has largely ignored opportunities to enact federal contracting requirements for the home care industry as it has done for other types of federally funded work. During the 20th century, Congress passed three federal laws that aim to raise job standards for the millions of federally funded construction, manufacturing, and service-sector workers: the Davis Bacon Act (DBA), the Walsh-Healey Public Contracts Act (PCA), and the McNamara-O’Hara Service Contract Act (SCA). The most relevant of these, the Service Contract Act, requires contractors and subcontractors performing services on covered federal contracts in excess of \$2,500 to pay service employees prevailing wages and benefits, but it does not cover Medicaid and Medicare contractors.³⁰

3 Structures Adopted by Government and Private Industry Allow Parties to Evade Accountability of Labor Standards

A. Privatized and outsourced industry structures in state Medicaid programs hinder workers' ability to hold parties accountable for wage theft and other violations.

This section of the report examines the paradigmatic state Medicaid program structures: Medicaid fee-for-service agency models, Medicaid fee-for-service consumer-directed models, and Medicaid managed care models. These “fissured” structures have frustrated home care workers’ efforts to hold violators accountable for wage theft and other labor abuses. Identifying the roles various parties play, however, points to their potential to raise standards. (Note: states may have multiple program structures operating side by side, and many use hybrid forms, with state-specific terminology.)

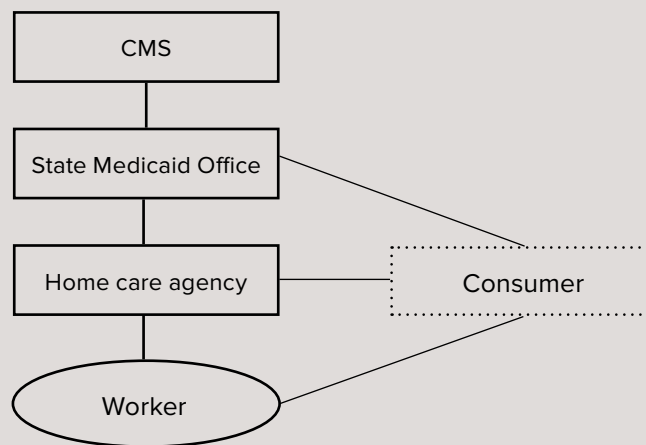
1. Medicaid Fee-for-Service Agency Models

Under a classic fee-for-service Medicaid agency model for home care service delivery, a state Medicaid program contracts with home care agencies, which hire home care workers and assign them to consumers to provide in-home services.

CMS and the states have not historically required the home care agencies they fund to provide quality jobs or explicitly conditioned Medicaid payments on compliance with all workplace laws. The lack of robust standards for Medicaid-funded home care agencies at both the federal and state levels, combined with lax monitoring by state Medicaid programs, means that public dollars flow to private companies that sometimes illegally withhold workers’ pay. For example, the Raleigh News & Observer recently reported that Medicaid-funded mental health agencies, home health companies, and group homes accounted for more unresolved wage payment cases than any other single industry in fiscal year 2014 in North Carolina.³¹ “[W]hen the companies didn’t pay their workers, the state let it happen with impunity. Medicaid reimbursements kept coming. The businesses didn’t lose their licenses. And when some employers shut down one company and opened another, they had no trouble securing more government work.”³²

Even states that have enacted living or prevailing wage legislation to improve standards for Medicaid-funded home care workers have not closely monitored home care agencies for compliance with those laws. In 2014

Figure 1. Medicaid Fee-for-Service Agency Model



and 2015, home care workers in Washington, D.C. filed a series of lawsuits against several Medicaid-funded home care agencies, seeking to recover upwards of \$150 million for violations of the city’s living wage and other workplace laws.³³ New York State enacted a wage parity law in 2011 that requires certain Medicaid-funded agencies to pay a significantly higher hourly wage to home care workers and provide a benefits package, but workers have alleged that home care agencies dodge the requirements or pay the required base wage only for scheduled service hours, rather than for all hours worked. One of the several Medicaid-funded home care agencies currently defending a class action lawsuit for unpaid wages is Americare Home Health Services, which has not only maintained its “Certified Home Health Agency” license (a New York designation) after years of documented patient abuse, fraud, and wage theft allegations, but, in 2014, Americare secured a recommendation from the state’s Department of Health to expand its license. The Department of Health dropped its recommendation only after The New York Times questioned the state’s move in light of the agency’s troubled record.³⁴

Gaps in New York’s requirements for Medicaid-funded agencies, and weaknesses in the state Department of Health’s monitoring of agencies, have permitted companies like Americare to hold onto their funding even as their illegal practices come to light. The New York

public health law requires certified agencies and managed care plans to certify they are in compliance with the state wage parity law³⁵ and requires managed care plans to “verify [the] compliance” of their subcontractors on a quarterly basis,³⁶ but it does not make compliance with wage parity and other state labor laws explicit grounds for revoking or annulling a state license.³⁷ Nor does state law require managed care plans to audit their subcontractors; and the Department of Health does not audit agencies for compliance with workplace laws, and moreover lacks a publicized system for accepting and responding to individual worker complaints.³⁸ New York State has an ombudsman for Medicaid consumers,³⁹ but it has no such office to address workers’ rights and coordinate on a regular basis with the unions, legal services providers, and the state labor enforcement agencies to combat illegal industry practices and identify violators.

2. Medicaid Fee-for-Service Consumer-Directed Models

In recent decades, many states have created consumer-directed programs that give consumers greater control in service delivery.⁴⁰ The growth of consumer-directed programs is the result of years of organizing by disability rights activists to gain better community integration and choice over services,⁴¹ and the 1990 passage of the Americans with Disabilities Act and the subsequent 1999 Supreme Court ruling in *Olmstead v L.C.*, which guarantee individuals the right to live in

Percentage of workers employed by a home care agency versus working as an “independent provider”

Home care workers may work for a home care agency, or they may work as an “independent provider,” in which they have a more direct relationship with the consumer, who assumes many employer functions. About three quarters (75.5 percent) of home care workers work for a private agency, and about one quarter (24.5 percent) work in an independent provider model.⁴² Independent providers include workers hired directly by households through private arrangements, often referred to as

the “gray market,” because they operate without private agency involvement. It is likely that this portion of workers is significantly undercounted in available government survey data. Medicaid-funded independent provider programs are referred to as “consumer-directed” programs in several states. “Independent provider” is not a legal designation, and does not mean that the worker is employed only by the individual consumer.

the least restrictive environment, and with autonomy and independence.⁴³

In consumer-directed programs, states do not contract with an agency intermediary, instead giving consumers some key employment functions, such as hiring, firing, and daily supervision. One version of the consumer-directed model grants consumers “budget authority”: the consumer receives a fixed monthly allowance which he or she can spend on personal care expenses, including workers’ wages.⁴⁴ States have generally designated consumers in consumer-directed programs as “employers of record” and considered home care workers to be the consumer’s employee or contractor.

However, it is important to note that the states’ labels and designations are not what determines whether the consumer, state, and other entities are employers. Rather, it is the facts of their relationships to the workers, and whether these relationships meet the definitions of employment under workplace laws. The extension of federal wage rights to home care workers, the USDOL’s issuance of guidance on joint employment

in home care, and the recent independent contractor Administrator’s Interpretation have provided greater clarity on what factors point towards the existence of an employment relationship under federal wage and hour law.⁴⁵

Other entities in consumer-directed programs assume employment functions that consumers may not want to or cannot perform. States contract with private fiscal intermediaries to perform payroll processing and other administrative tasks for consumers and workers. And many states have created quasi-governmental structures called public authorities to act as the workers’ employer for the purposes of collective bargaining and sometimes other employment functions, allowing for some level of protection and opportunity for organizing.⁴⁶

While these models have provided an important degree of choice and empowerment to consumers, states have not always structured their consumer-directed programs with worker protections in mind.

Figure 2. Medicaid Fee-for-Service Consumer-Directed Models

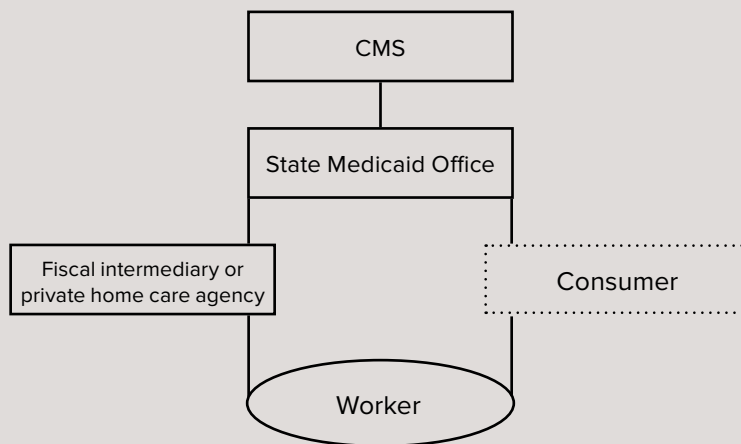
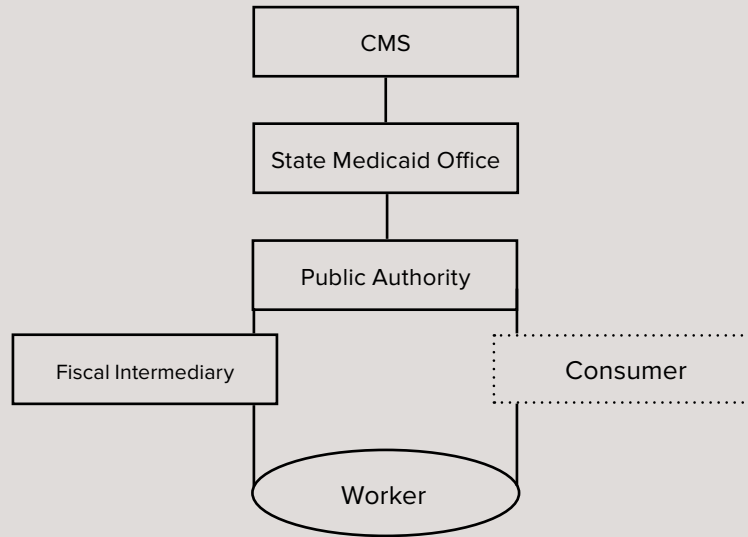


Figure 3. Medicaid Fee-for-Service, Consumer Directed, Public Authority Models



Fissuring of employment functions in consumer-directed programs can lead to violations. The diffusion of employer functions in consumer-directed programs among multiple parties—the consumer, the state, a fiscal intermediary, and sometimes other state or county agencies—can make it difficult for workers and even departments of labor to identify the employer(s) responsible for problems on the job. As described above, a state consumer-directed program may say that consumers are the worker’s sole employer, even as the state program sets basic job and training requirements, wage rates, and the scope of services provided, making it extremely difficult for a consumer to improve pay or other labor standards. In many consumer-directed programs, the state may be a joint employer along with an intermediary under federal and many states’ worker protection laws, even if it has declared itself otherwise, as the USDOL has made clear in a 2014 Administrator’s Interpretation and other guidance.⁴⁷ Too often, no party takes responsibility for compliance with labor standards.

The operation of California’s In-Home Supportive Services program (IHSS) program, the nation’s largest consumer-directed program, which serves around

450,000 consumers,⁴⁸ illustrates the challenges these diffuse structures can present for establishing accountability for labor standards. California law requires every county to act as or establish an “employer” for the purposes of collective bargaining, but gives counties choice in how to set up their programs; the structures vary throughout the state.⁴⁹ The county can choose to hire IHSS workers directly, pay consumers to hire their own workers, or can contract with a governmental, quasi-governmental, or private party to provide services.⁵⁰ A county’s board of supervisors also has the option to contract with a nonprofit consortium or establish a public authority to deliver services under California’s program. Employment roles are spread among multiple parties: consumers, pursuant to state law, have the authority to hire, fire, and supervise the worker.⁵¹ The county determines the number of hours of services provided to the consumer, and accounts for the workers’ hours in a state database, authorizing the state to disburse paychecks.⁵² In counties where there is a public authority, it bargains with workers over wages and other issues.⁵³

But while the county and its public authority set the workers’ hours and pay, they have often sought to evade accountability for unpaid wages. For example, when

Fee-for-Service Versus Managed Care

Before the 1970s, Medicaid and Medicare programs largely operated via fee-for-service delivery systems where the government paid a fee to home care agency providers for each service they delivered. Since then, both Medicare and many state Medicaid programs have shifted (in whole or in part) to managed care models to deliver home care services, paying a fixed monthly rate per consumer

to insurance plans (called managed care organizations), which contract with networks of home care agencies to provide a range of services, including home care. Managed care organizations range from large commercial insurers such as Aetna, to local non-profit and for-profit providers that evolved specifically to respond to a particular state's needs.⁵⁴

Adeline Guerrero sued the consumer she worked for, Sonoma County, and Sonoma County IHSS (the public authority) for 588 hours of unpaid wages for three months of work, the county and its public authority claimed they were not her employers and not liable.⁵⁵

In another California case, several IHSS workers sought pay for uncompensated hours when San Diego County retroactively reduced authorized hours when the consumers died; the San Diego public authority claimed it was not the workers' employer, saying that only the deceased consumers were.⁵⁶

These cases were not isolated incidences. When 40,000 IHSS workers in Los Angeles did not get their paychecks in May 2015, the president of SEIU ULTCW and provisional president of SEIU Local 2015, Laphonza Butler, remarked that “paycheck delays for this financially vulnerable population are not an uncommon occurrence.”⁵⁷ The San Francisco Gate reported that advocates say thousands of IHSS workers have been cheated of their wages.⁵⁸

Even given the resistance of California's public authorities to assume liability for wage violations, the model does provide a huge boost to workers, allowing independent providers paid through the state Medicaid program to engage in collective bargaining around wages, benefits, and working conditions. Several other states (Oregon, Minnesota, and Massachusetts) have established similar public authority systems, enabling

worker organizing and bargaining. In addition to acting as an employer for some purposes, these public authorities sometimes provide other critical services, such as matching workers and consumers, providing training, and administering service delivery. When paired with worker unionization, this model has proved to be a remarkably successful way to raise wages and improve working conditions, stabilizing the workforce and enhancing quality of care and services.⁵⁹

3. Medicaid Managed Care Models

In recent years, more than 20 state Medicaid programs have shifted from fee-for-service to managed care models for delivering home care services. In these programs, states pay a fixed monthly rate per consumer to insurance plans, referred to as managed care organizations, which coordinate networks of providers to deliver a range of home and community-based services, including home care.⁶⁰ States have adopted managed care models to administer part or all of their Medicaid home care programs in both agency-based and consumer-directed models of service delivery.⁶¹

This transition to managed care creates additional considerations with regard to accountability for workplace protections. Workers in states that have recently shifted to a managed care model have also reported problems getting paid on time, or at all. When Ohio switched its “dual eligible” population—the nearly 100,000 elderly and younger people with disabilities who are eligible for care under both Medicaid and Medicare—into a

Figure 4. Medicaid Managed Care Consumer-Directed Models

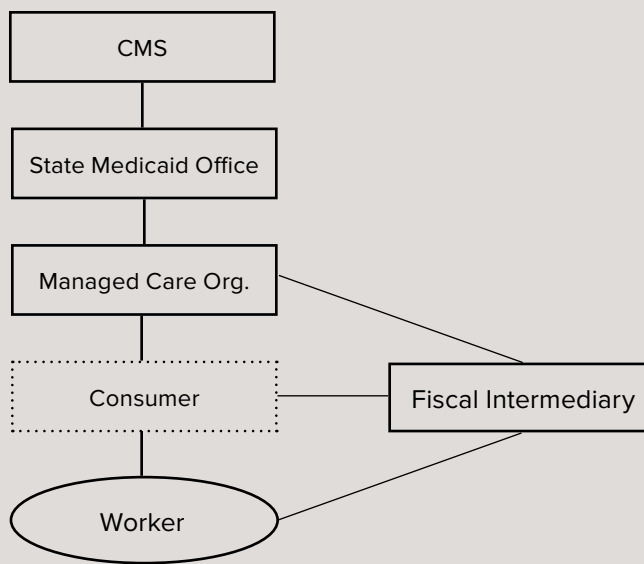
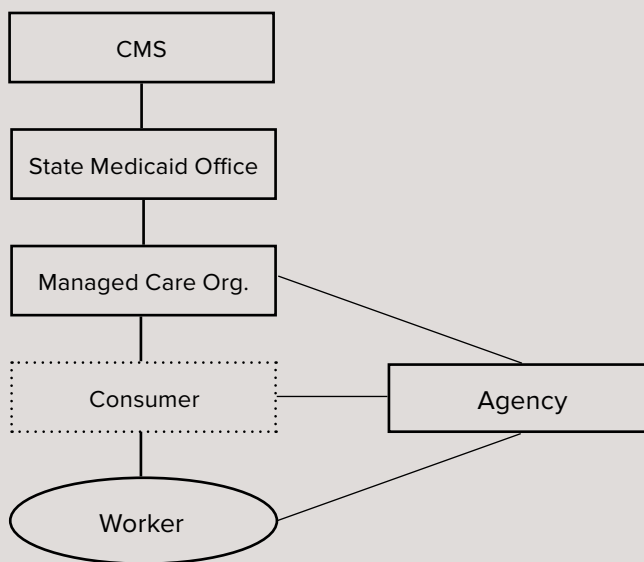


Figure 5. Medicaid Managed Care Agency Models



managed care plan called MyCare Ohio in May 2014, many home care workers began having trouble getting their paychecks.⁶² Before the transition, Ohio Medicaid paid providers, including “independent provider” home care workers, directly. But when the state began contracting with private managed care companies, including health care giants Aetna and United, the

turnaround time for payment requests became much slower, and many workers, who said they never received proper instructions on how to submit payment requests, did not get paid for months.⁶³ Home health aide Tammy Taulbee, who cared for a woman with severe disabilities, told WKCR-Cleveland in 2014 that she had not been paid for two-and-a-half months and was owed \$5,000.⁶⁴

The mother of one consumer commented, “I think it seems like Medicaid just handed this program off to three different insurance companies to administer, and they don’t seem to know what they’re doing.”⁶⁵

The shift to managed long-term care also creates new financial incentives for an intermediary—often with a profit motive—to reduce costs.⁶⁶ One managed care organization in Tennessee, for example, attempted to lower its spending on home care by eliminating more costly agency-provided services and shifting employer responsibilities onto the consumers. When Tennessee shifted to managed care for long-term care under Medicaid in 2010, the family of Billy Scarlett II, who is severely brain-damaged, was told by the managed care company, Amerigroup, that instead of paying an agency \$37 an hour to provide 24-hour care, Amerigroup would pay the family directly about \$15 an hour to hire caregivers. After the shift, the caregivers earned less per hour and lost benefits, like health insurance, while the family was left to assume employer responsibilities.⁶⁷

In both cases above, the shift to managed care also resulted in a shifting of employer responsibilities—in Ohio, from the state to private companies, and in Tennessee, from home care agencies to consumers—with attendant difficulties for the workers.

B. In the private-pay portion of the industry, some home care companies outsource accountability through franchising and by misclassifying workers as independent contractors.

Private-pay home care represents billions of dollars of home care expenditures each year, funded through out-of-pocket consumer expenditures or long-term care insurance.⁶⁸ The industry is diverse, with various types of intermediaries between consumers and home care workers. Some consumers directly hire home care workers (often referred to as the “gray market” because it is privately funded and outside of federal CMS oversight). Others rely on home care agencies or employment

agencies (the latter are often referred to as “home care registries”). These entities may directly employ workers or may provide referrals to consumers without treating workers as employees.

Private-pay home care agencies are generally not Medicare-certified and rely primarily on consumers’ private funds or private insurance to support their business.

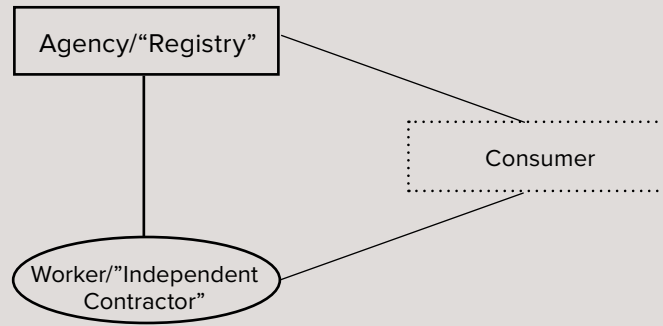
This report focuses on two forms of outsourcing in the private-pay market that potentially raise issues of employer accountability: misclassification of workers as independent contractors and franchising.

1. Private-pay registry/independent contractor model

Some private-pay home care companies call themselves “registries” and label their workers “independent contractors.” While some registries may, in fact, operate only to provide consumers with lists of potential home care workers with whom the registry has no ongoing relationship, this business model raises red flags because, in many cases, the home care workers are independent in name only and are not truly running their own separate business. Some companies misuse such labels to dodge laws and evade responsibility for the workers. (Figure 6).

Independent contractor misclassification can have devastating effects on home care workers. Because our nation’s system of workplace laws is largely built around the employment relationship, workers classified as independent contractors and other nonemployee labels can miss out on core workplace protections and social safety net benefits that apply only to employees, including the right to minimum wage, overtime pay, workers’ compensation, unemployment insurance, and anti-discrimination protections. Misclassification can also depress workers’ net income, because misclassified workers are saddled with a higher 15.3 percent self-employment tax rate for FICA and FUTA taxes instead of the 7.65 percent rate for employees, as well as with unreimbursed business expenses.⁶⁹ Misclassified

Figure 6. Private-Pay Registry/Independent Contractor Model



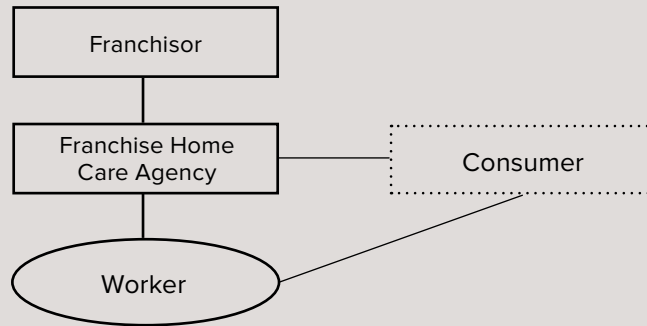
workers can challenge their designation to get workplace protections in court or with an administrative agency, but this can be a drawn-out and time-consuming battle, and many workers never do so, for fear of retaliation or lack of resources. Independent contractor misclassification also harms law-abiding home care businesses that treat their workers as employees, putting them at a competitive disadvantage against companies that illegally depress labor costs and can offer a lower price to consumers.⁷⁰

Many home care employers require workers to agree to be labeled independent contractors as a condition of getting a job, or convert workers to independent contractor status when workers seek to assert rights or when new worker protection laws go into effect. In a 2010 case in Pennsylvania against Lee’s Industries, Inc. and Lee’s Home Health Services, Inc., a home care agency forced home care workers previously treated as employees to sign an agreement calling themselves independent contractors in order to keep their jobs, despite the fact that there were no changes to the job or to the worker’s business status.⁷¹ And in a similar

case, *Cooney v. O’Connor*, a Maryland home care agency required its employees to sign an “Independent Contractor Agreement” as a condition of getting a job placement and unsuccessfully attempted to prevent former employees from collecting unemployment insurance benefits.⁷² Relatively new online “on-demand” companies have also adopted the independent contractor model: HomeHero⁷³ and Honor⁷⁴ treat home care workers as independent contractors, even though both companies provide screening, list training requirements, and set wages—key employer functions. Other companies peddle the independent contractor model: Contractor Management Services, a company that advertises itself as a “full-service firm for companies utilizing Independent Contractors,”⁷⁵ promotes to home care agencies the use of an “independent contractor model.”⁷⁶

In fact, home care workers rarely run their own independent business, and these designations should be scrutinized carefully to ensure that no misclassification is occurring.

Figure 7. Private-Pay Franchising Model



2. Private-pay franchising model

Another significant outsourcing trend that has taken hold in the private-pay portion of the home care industry is home care franchising. Some of the private-pay home care companies that have expanded using a franchising model include Brightstar, Griswold, Interim, Home Instead, Comfort Keepers, Visiting Angels, and Home Helpers. Franchisors often promise low startup costs and high profits to their franchisees. For example, Comfort Keepers, a home care franchisor with over 600 franchisees operating in all 50 states, tells potential franchisees that they will need just \$77,550 to \$109,960 in startup costs (\$45,000 of which to cover franchise fees), and reports that its high-performing franchisees reap on average 37 percent annual gross profits.⁷⁷

Franchisors that sell a low-cost home care business model to potentially undercapitalized and poorly prepared small business owners can shift economic risks of doing business to both franchisees and workers,

leading, at least in some cases, to low wages and wage theft. If the franchisee cannot make payroll or otherwise violates workplace laws, its employees may have a hard time seeking recourse against the franchisor that may have engendered the franchisees' illegal acts, but which seldom takes responsibility for workplace violations or conditions. In 2014, for example, a group of California-based franchisees of Griswold International sued the national franchisor for fraudulently selling them a "proven" independent contractor business model that Griswold had alleged would allow the franchisees to avoid employer-side taxes and liability for workplace laws and give them a competitive advantage over other home care companies.⁷⁸

The problems and abuses described above call out for policy reforms to create greater accountability for home care workers' conditions and labor rights, no matter who pays for the worker's services or in what structure she is employed.

4 Policy Recommendations to Strengthen Accountability for Labor Standards in the Home Care Industry

Policies that attach quality workplace requirements to public funds, provide for a robust enforcement system with adequate resources, and secure workers' coverage under labor standards can help to ensure accountability for labor standards, even when industry structures are complex and multi-layered. The policies listed below can help protect workers from the negative effects of fissured industry structures, promote more efficient arrangements, and ensure that the parties in the best position to prevent labor violations and improve working conditions are held accountable. (These models are illustrative rather than exhaustive, because every state's unique home care system, political landscape, and resources call for different sets of interventions.)

A. Ensure Basic Labor Protections for Which Home Care Employers Can Be Held Accountable

To create broad compliance in the home care industry, home care workers first need baseline protections for which industry players can be held accountable. Historically, many key workplace laws have exempted some or all home care workers or subjected them to a lower level of coverage. Until recently, the Fair Labor Standards Act (FLSA) exempted virtually all home care workers from its minimum wage and overtime protections; regulatory reforms closed this exemption in 2015, but others endure. Many states' wage, unemployment insurance, and workers' compensation laws exempt domestic or private household workers—categories that have been understood to include home care workers; or they place significant limitations on home care worker coverage, such as exempting live-in home care workers from overtime or excluding part-time household workers from workers' compensation coverage.⁷⁹ The National Labor Relations Act does not cover home care workers employed solely by private households;⁸⁰ state health and safety laws and the Occupational Safety and Health Act also provide limited coverage.⁸¹ Closing these gaps is a fundamental step towards building greater accountability.

Implement the USDOL home care rule

Guaranteeing that new federal wage and hour rights take hold is necessary to cement bedrock rights, no matter what structure workers are employed in. A USDOL rules change taking effect in 2015 has now significantly narrowed the FLSA's companionship exemption, a 1974 exclusion Congress had intended to be a minor carve-out but that had been interpreted so expansively as to exclude virtually the entire workforce from federal wage and hour protections.⁸² The FLSA exclusion contributed to low wages and to wage theft even in those states where workers had state-level coverage because, without federal oversight, employers faced minimal chance of enforcement and developed abusive pay schemes that became standard industry practice. Strong and coordinated efforts to publicize the changes and enforce new rights are key to solidifying these basic protections.⁸³

Close state-level exclusions for home care workers

To ensure full workplace rights, states must follow suit and close exemptions in their minimum wage and overtime acts, and in unemployment insurance, workers' compensation, and other laws. Even with federal wage and hour coverage in place, state-level protections are critical: many states offer a minimum wage, overtime rules, and remedies superior to the federal law; state-run workers' compensation and unemployment insurance programs provide key protections to a workforce at great risk of workplace injury and job loss; and state labor enforcement is a necessary supplement to federal oversight.⁸⁴

States that track federal FLSA coverage⁸⁵ should make clear through opinion letters or other guidance that state law coverage has expanded consistent with the federal rules change, and other states should enact laws extending their state laws to home care workers. Arizona, Missouri, Michigan, and Ohio are examples of states that closed exemptions for home care workers in their minimum wage and overtime laws in the years before the USDOL rules change.⁸⁶ About half the states still do not cover home care workers in their wage and hour laws, however.

Establish a \$15 wage floor for home care, as more cities and states are doing

The Fight for \$15 organizing campaign is spurring growing numbers of cities and states to raise the wage floor to \$15 per hour—and in the process is helping deliver very significant raises for home care workers and other low-wage workers. Over the past two years, a half-dozen cities, including Los Angeles, Seattle, and San Francisco, have all raised their minimum wage to \$15.⁸⁷ Massachusetts approved a \$15 minimum wage for the state’s 35,000 Medicaid home care workers.⁸⁸ New York and California are now considering \$15 statewide minimum wages, which, if approved in 2016, would raise pay for home care workers to \$15 in the two states with the nation’s largest home care workforces.⁸⁹

More cities and states should follow their lead by raising the minimum wage to \$15—either for all workers, or for their Medicaid home care programs. And CMS should explore adopting a \$15 minimum wage for Medicaid and Medicare home care workers nationwide.

Raising home care workers’ wages to \$15—either through citywide or statewide \$15 minimum wage increases or through a Medicaid program \$15 wage floor as Massachusetts adopted—will have a profound impact, not only on workers, but also on their communities.⁹⁰ Applied to all home care workers, a \$15 wage floor would result in an approximate average increase of \$8,000 in yearly earnings. Estimated consumer spending from this would generate as much as \$6.6 billion in new economic activity; that activity could lead to the creation of as many as 50,000 jobs outside of the home care industry.⁹¹ Creating this wage floor for publicly funded home care programs will likely drive up wages in the private-pay market as well. A study of home care workers in San Francisco revealed a 57 percent drop in turnover after the living wage was enacted.⁹² Turnover is estimated to cost the industry \$6 billion per year—money much better spent on investments in the workers.⁹³ New York City⁹⁴ and the District of Columbia⁹⁵ include home care workers in their living wage laws, promoting better wages and workforce stability.

B. Stop Lawbreaking Within Publicly Funded Home Care Programs

Public funds for home care often flow through a host of private actors, such as home care agencies, fiscal intermediaries, and payroll processors, before reaching the workers. By attaching responsible contractor conditions and workplace compliance controls to public funds, state and federal agencies can better ensure that a greater portion of public dollars goes toward quality services and worker pay rather than business profits and overhead. As an increasing number of private managed care organizations and other contracted entities provide Medicaid home care services, these controls can be particularly critical.

End government contracts with bad industry players

States have the right to end and prohibit future publicly funded contracts with home care agencies that have a record of violations. Ensuring that both public dollars and home care workers are protected requires effective and well-resourced enforcement efforts. State and local responsible contracting strategies include screening out repeat violators of workplace, tax, and other laws; favoring contractors that pay living wages and provide quality health benefits and paid leave; and certifying that all workers are properly classified as employees and covered by workers’ compensation and unemployment insurance.⁹⁶ Public contracts should be publicly available, and states should adopt a transparent contracting process.

Furthermore, CMS and state Medicaid agencies should consider wage theft and other labor violations a form of fraud, and use their resources to root out fraudulent practices imposed on workers. Protecting workers and federal dollars, the U.S. Department of Health and Human Services’ Office of the Inspector General should exclude home care employers from participation in federal health care programs (e.g., Medicare and Medicaid) upon a conviction or administrative determination of wage theft.⁹⁷

The federal government should maintain a database of all home care companies, including information on recorded instances of workplace violations, to aid state Medicaid programs in selecting “high road” home care vendors. An example of a law that establishes a government database that tracks government contractors and subcontractors and their compliance with workplace laws is the National Defense Authorization Act.⁹⁸

Require detailed reporting of hours and wages from contractors

Contractors and subcontractors should be required to report worker hours and wages and attest to compliance with labor laws. Many states have already imposed reporting and auditing requirements aimed at ensuring financial viability and rooting out fraud, which could serve as models. In Virginia, home care agencies must document their financial resources, which are subject to a triennial audit from an independent certified public accountant.⁹⁹ In a 2011 ballot initiative, Washington State went even further, requiring audits twice a year by the state auditor’s office.¹⁰⁰ CMS and the states should require contractors and subcontractors to report on wage and hour compliance, either in addition to or within existing reporting requirements. Better data collection, sorely lacking within the industry, on the number of workers, hours worked, retention and recruitment practices, turnover and vacancy rates, training and advancement opportunities, rates of pay, benefits, and source of pay, can also help to address stratification.

Adopt strong legal compliance review procedures

CMS and the states should guarantee that public dollars are going to contractors and subcontractors with good workplace standards. When reviewing contract proposals, CMS and state Medicaid agencies should adopt strong legal compliance review procedures that require bidders to first demonstrate their compliance with labor laws. This screening, along with a transparent contracting process that discloses firms seeking to contract or prequalify to contract and allows for public comments, will help promote responsible contractors and better working conditions.

A recent executive order requires prospective federal contractors to disclose labor law violations and abide by wage and hour, safety and health, collective bargaining, family and medical leave, and civil rights laws.¹⁰¹ The contractor is required to semi-annually report on both its compliance as well as that of any subcontractors. While the executive order is specifically for contracts that exceed \$500,000, removing this monetary threshold and applying it to home care contracts could be pivotal to ensuring taxpayer dollars are not paid to companies with labor violations. Similarly, federal and public contracting authorities have adopted provisions, outlined in “Jobs to Move America’s U.S. Employment Plan,” that require contractors to regularly submit reports and certify that neither they nor their subcontractors have been debarred, suspended, or declared ineligible to participate in contracting activities.¹⁰²

Attaching these conditions to the use of government home care funds, rather than to a specific contractor or subcontractor, further promotes accountability, regardless of the structure and the potential layers between the government and workers.

Strengthen CMS requirements for Medicaid-funded home care agencies

With nearly 83 percent of annual home care expenditures coming from public sources, labor standards requirements tied to public dollars can help set standards for the entire industry. CMS Medicare regulations discourage fissuring, encourage employer accountability, and require reporting. For example, conditions of participation for Medicare-funded home care agencies stipulate that the home care agency is responsible for subcontractors as if they were “furnishing the services directly.”¹⁰³ While CMS management of Medicare could be strengthened by requiring that the agencies report on wages and hours, compliance with state and federal wage and hour laws, or other measures, the existing Medicare requirements, if applied to Medicaid, could serve to improve Medicaid oversight.

C. Prioritize Smart and Strategic Enforcement of Basic Labor Standards

State and federal labor enforcement agencies should prioritize labor standards enforcement in the home care industry, with an emphasis on securing broad employer accountability.

Look beyond superficial labels in enforcing the law

First, labor enforcement agencies should account for multiple employers when investigating and enforcing wage theft to recover against all responsible parties, including upper-level companies that may be in a better position to ensure long-term compliance and pay workers' claims. Investigators should be trained to elicit information from home care workers, state programs, and the companies to determine whether workers have more than one employer, and enforcement actions should target all employers rather than only the employer that hired or directly pays the worker. Enforcement officials should also scrutinize independent contractor agreements and businesses that call themselves "registries," with no employees. They should seek to determine whether the workers are truly in business for themselves rather than focusing their inquiry solely on the degree of control exercised by the putative employer, consistent with a recent USDOL Administrator's Interpretation.¹⁰⁴

Issue joint employment guidance

State labor enforcement agencies should issue guidance outlining how broad definitions of employment can be applied to the home care industry. USDOL has issued guidance on home care rules implementation,¹⁰⁵ joint employment in consumer-directed Medicaid home care programs,¹⁰⁶ and on independent contractor abuses in the home care industry.¹⁰⁷ States should similarly provide guidance and other information explaining how their state laws, including joint employment doctrines, apply to the home care industry.

Engage in inter-agency collaboration to make best use of collective knowledge and resources

State labor enforcement officials should work in concert with other relevant state agencies, including the

agencies that administer the state's Medicaid home care programs and state licensing agencies, both of which have effective enforcement tools currently unavailable to labor enforcement agencies. State Medicaid programs can effectively remedy workplace violations through their ability to withhold or recoup Medicaid payments and their authority suspend or withdraw licenses, and are a valuable source of information about the industry. State labor enforcement agencies can and should collaborate with licensing agencies to revoke business licenses for home care agencies in cases of workplace or labor standards violations.¹⁰⁸ Some state labor officials already work in cooperation with licensing agencies to enforce workplace laws: when the Massachusetts and Connecticut Departments of Labor determine an employer has not made unemployment insurance contributions, they contact state liquor licensing authorities, who can revoke the license until UI payments are made.¹⁰⁹

Create a home care worker ombudsman program

Relatedly, a state home care worker ombudsman that works across several state agencies could provide oversight, serve as a resource, and protect workers.¹¹⁰ This office could mirror the existing federal and state ombudsman program for consumers and serve as a central entity for linking state health and labor agencies.

Assign clear employment responsibility; create automatic coverage for home care workers

Laws that create automatic coverage for home care workers or home care employers under key workplace laws are a good way to secure rights for workers who rarely, if ever, should be classified as independent business owners; place liability with the parties in a position to best ensure compliance with workplace laws; and create more certainty for both workers and employers.

A good example of such a policy is Connecticut House Bill 6432: An Act Concerning Homemaker Services and Homemaker Companion Agencies, last introduced in the Connecticut legislature's 2013 session.¹¹¹ HB 6432 would have designated certain home care agencies and registries as the employer of their home care workers for

the purposes of unemployment compensation, wages, and workers' compensation, and would have removed liability from the consumer for such workers' personal injuries arising out of and in the course of employment.

A California law passed in 2014 makes labor contractors jointly liable along with client employers for all workers supplied by that labor contractor for the payment of wages and the failure to obtain valid workers' compensation coverage.¹¹² A.B. 1897 also prohibits a client employer from shifting to the labor contractor legal duties or liabilities under workplace safety provisions with respect to workers provided by the labor contractor. The law applies to all workers and could be a powerful tool for subcontracted home care workers. A similar bill pending in Massachusetts, H.1748/S.966, would establish joint liability for lead companies and their subcontractors in a wide range of industries, including home care.¹¹³

Establish and strengthen state licensing requirements

States that do not currently require home care agencies to get a license to operate within the state or only require certain types of agencies to license, should enact such requirements on all home care agencies, and all states should explicitly condition license issuance and renewal on compliance with workplace laws. States can additionally require that home care agencies renew their licenses annually and disclose information regarding outstanding wage judgments or pending claims against them.¹¹⁴ CMS could also make state licensing a condition of funding.

Require wage bonds for home care companies at the local level

Requiring employers to post a wage bond—that is, to put money into a state agency fund or with a bonding company to cover potential claims—ensures that the employer has sufficient capital up front to responsibly engage in business and, if it fails to pay workers, that a pool of money exists against which workers may claim their wages.¹¹⁵ In the home care industry, a bonding requirement could discourage the proliferation of

poorly capitalized home care employers to which larger industry players subcontract hiring and wage payment, as can happen with franchising chains. Moreover, it protects workers from losing wages that may disappear during investigations or appeals. Tied to a license or registration, the bond should be large enough to cover possible owed wages and penalties. These policies exist in 38 states for at least some jobs (most typically public works jobs or the construction industry).¹¹⁶

Maximize the potential of private enforcement efforts

Private enforcement can also play a critical enforcement role in securing home care workers' rights in outsourced work structures. Workers in at least one class action case currently pending in New York courts have named as joint employers both the licensed agencies that directly hired the workers and the certified home health agencies that contract with the licensed agencies to fulfill obligations under state contracts.¹¹⁷ Workers in Maryland and Pennsylvania have successfully overcome home care agency employers' claims that their workers are independent contractors.¹¹⁸ And workers in several California cases have defeated claims by counties and public authorities that workers are solely employed by the consumer.¹¹⁹ One scholar has proposed that workers may bring a qui tam or whistleblower claim under the False Claims Act to address wage theft by publicly funded home care agencies, a proposal that is an ambitious but untested strategy for ensuring private employers do not misuse government funds.¹²⁰

D. Leverage and Increase Public Investment in Home Care to Create Quality Jobs

Increase federal and state funding for home care services

Current levels of federal, state, and local funding for in-home services and supports are wholly inadequate. Compared to institutional care, home care is often less expensive¹²¹ and almost always the consumer's preference.¹²² However, current policies and budgeting that misalign priorities can hurt home care workers,

particularly when other measures (such as living wage and public funding requirements) are not in place. A wage floor of \$15 an hour and an increase in services to appropriately serve all older Americans and people with disabilities, will require a shift in policy priorities. One such proposal calls for a wage floor of \$15 an hour with health and retirement benefits for home care workers, estimated at a cost of \$110 billion annually, in mostly public funds—an annual investment of \$350 for every American.¹²³

Attach job quality standards to Medicaid and Medicare home care funding

The Service Contract Act (SCA) requires that contractors and subcontractors performing on Federal contracts must observe minimum wage and safety and health standards and must maintain certain records, unless a specific exemption applies.¹²⁴ However, the SCA does not cover contracts under the Medicaid program which are financed by federally-assisted grants to the states, and contracts which provide for insurance benefits to a third party under the Medicare program. Through an amendment to the SCA or another reform, Congress should attach labor standards to Medicare and Medicaid home care dollars that apply no matter what entity hires the workers, and even if a government contractor subcontracts to another entity.

Cap overhead for Medicaid and Medicare-funded home care agencies to ensure that more public dollars go to wages and benefits

CMS and states should require home care agencies to use most of their government reimbursement rates for worker costs rather than administrative overhead and profit. Some states require that a large percentage of public Medicaid dollars go to direct care costs, sometimes referred to as a wage pass through. For example, through a New York executive order,¹²⁵ Maine legislation,¹²⁶ Illinois administrative code,¹²⁷ and a Washington ballot initiative,¹²⁸ a percentage—ranging between seventy-seven and ninety percent - of state-authorized payments must be spent on direct care costs. These costs can encompass wages, benefits, insurance, training costs, and other worker costs prescribed by

regulation. Measures such as these can ensure that workers are compensated fairly and are not victims to “trickle down” structures. And, higher wages and better benefits have shown to attract and retain direct care workers.¹²⁹

E. Strengthen Workers’ Ability to Organize and Bargain for Greater Accountability

Like successful unions in other industries,¹³⁰ home care unions have leveraged workers’ collective power to win higher standards, but they have also played a unique role in pressing states to make structural changes in their home care programs that facilitate collective action and give workers a central entity to hold accountable. Shut out of state labor organizing rights, unions have pressed for state laws that create public authorities and allow independent providers to unionize and bargain with those public authorities over wages and other job standards. Independent provider unionization has not only resulted in significant wage increases; it has also ameliorated the intense fragmentation of employer functions in state consumer-directed programs and allowed for greater aggregation of an intensely isolated workforce. Home care workers in the private sector have been less successful at winning union recognition and contracts from home care agencies, which are covered by the National Labor Relations Act, but in several states they have also won agreements that significantly boost standards, as well as state funding increases and protective legislation.¹³¹ Policies that facilitate unionization and strengthen unions’ bargaining power enable workers to demand greater accountability in the industry.

Establish public authorities and collective bargaining rights in consumer-directed programs

The creation of state- or county-level public authorities (and other similar intermediaries), combined with legislation that grants organizing and collective bargaining rights to independent provider workers, has improved job quality and industry standards in several state consumer-directed programs. These authorities

can serve as a hub for workers and consumers, provide resources and services, and create a central decision-making body with whom workers can collectively bargain over wages and job standards. CMS could require states with consumer-directed programs to establish a public authority to assume employer functions and provide other supports. States should additionally grant, through executive action or legislation, organizing and collective bargaining rights to independent provider workers. Recent attacks on consumer-directed home care worker unions and on public sector unions¹³² threaten their ability to collect dues from the workers they are charged with serving, but even facing reduced resources, unions continue to be the most effective vehicle for consumer-directed workers to negotiate and partner with states to improve industry conditions.¹³³

Bar home care agencies from using public dollars to fight unions

“Labor peace” legislation prohibits private businesses with government contracts from using public funds to fight worker organizing. A good model for this policy is in the Head Start Act, which states, “Funds appropriated to carry out this subchapter shall not be used to assist, promote or deter union organizing.”¹³⁴ While these policies have not eliminated anti-union campaigning by publicly funded companies, they do hold the potential to reduce obstacles to worker organizing.

Apply NLRB joint employment standards to protect outsourced home care workers’ organizing rights

The National Labor Relations Board has recently issued key joint employment decisions holding “lead companies” and franchisors accountable for outsourced workers’ bargaining and organizing rights. In *Browning Ferris*, the Board applied a revised and more expansive joint employment standard to allow recycling workers to negotiate with both the staffing agency that hired

them and the recycling company that managed their worksite and shared control with the agency over their jobs.¹³⁵ A finding by the NLRB’s general counsel that McDonald’s can be named a joint employer, together with its franchises, in complaints filed by workers alleging labor law violations in its franchised restaurants, means that workers can hold corporations accountable for franchisees’ illegal acts when the corporation exercises sufficient control over franchised operations.¹³⁶ Home care workers in subcontracted or franchising structures could invoke the NLRB’s joint employment standards to establish liability for multiple entities in a position to ensure their organizing and bargaining rights are not violated, not just their direct employer, potentially paving the way for more effective organizing campaigns.

Support Nontraditional Worker Organizing

Several regional and national organizing campaigns have mobilized home care workers to press for policy reforms and to generally raise awareness of home care workers’ vital role in society. Caring Across Generations and the National Domestic Workers Alliance have been instrumental partners in the campaign to secure the USDOL home care rule change, and have also won state home care funding increases and other state reforms.¹³⁷ NDWA affiliates have campaigned for state-level Domestic Worker Bills of Rights; in several states, they have won legislation that closes minimum wage and other exemptions for domestic and home care workers and adds new industry-specific protections for the workforce.¹³⁸ The Fight for 15 has brought home care workers into its national campaign for a \$15-per-hour minimum wage, joining fast-food and other low-wage workers. Given the enormous political and practical challenges to union organizing in the home care industry, these campaigns are critically important to advancing the interests of home care workers and those they serve.

Conclusion

Home care workers are responsible for getting our loved ones out of bed in the morning, helping our neighbors get dressed, and getting our coworkers to their jobs but, far too often, no one takes responsibility for making sure they get the pay and respect they deserve. We all bear the consequences of this lack of accountability for home care workers' rights. When workers are not paid well or not paid at all, they struggle to support themselves and their families and struggle to contribute to their communities. The older adults and people with disabilities who rely on home care workers also suffer when burned-out workers are forced to look for better employment, or when well-qualified workers don't even

bother applying for low-paying home care jobs in the first place. No one who may one day need a home care worker to care for an aging parent, spouse, or himself or herself, can expect to get the services needed unless the workforce is treated better.

For that reason, we must act now to hold the home care industry accountable for the rights and standards of this critical workforce, so all home care workers, no matter what their employment situation, can support their families and communities and continue to provide the crucial services that growing numbers of Americans will be counting on in the years and decades to come.

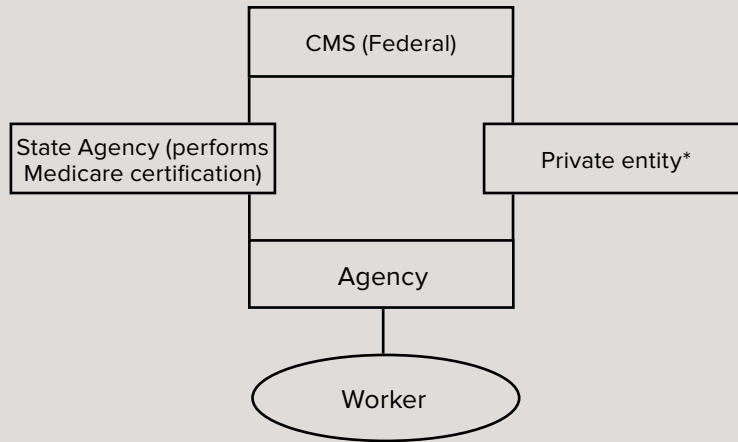
Glossary

Capitation	A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members. ¹³⁹
Consumer	A person who receives home care services. Sometimes referred to as a client or recipient.
Consumer-directed program	Refers to a publicly funded home care program in which there is no home care agency intermediary acting as an employer. Instead, the state gives consumers some key employment functions, like hiring, firing, and daily supervision. Note that the state and/or other intermediaries in a consumer-directed program may also be joint employers of the worker. Also referred to as participant-directed or self-direction.
Dually eligible	Individuals who are eligible for both Medicaid and Medicare.
Fee for service	A method of reimbursement based on payment for services rendered. Payment may be made by an insurance company, the individual or a government program such as Medicaid. With respect to service providers, this refers to payment in specific amounts for specific services rendered. In relation to individuals, it refers to payment in specific amounts for specific services received, in contrast to a set per-member per-month or other advance payment of an insurance premium or membership fee for coverage. ¹⁴⁰
Fiscal Intermediary	The Centers for Medicare and Medicaid Services (CMS) defines Financial Management Services as: A service/function that assists the family or participant to: (a) manage and direct the distribution of funds contained in the consumer-directed budget; (b) facilitate the employment of staff by the family or participant by performing as the participant’s agent such employer responsibilities as processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and (c) performing fiscal accounting and making expenditure reports to the participant and/or family and state authorities. ¹⁴¹
Home care agency	A home care agency may include Medicare-certified home health care agencies, Medicaid-funded home care agencies, personal care agencies, and other organizations or companies that employ home care workers and offer home care services to consumers.
Home care worker	We use the term “home care worker” to describe the group of workers that provide the in-home supports and services that allow older adults and people with disabilities or illness to remain in their home. This group includes home health aides, personal care aides, caregivers, companions, and certified nursing assistants (who are employed in private homes rather than institutions). Their work includes dressing, grooming, feeding, bathing, toileting, and transferring, meal preparation, driving, housework, managing finances, assistance with taking medications, and arranging medical care.
Home health aide	Home health aides are a subgroup of home care workers who assist people in their homes or in community settings under the supervision of a nurse or therapist. They may also perform light housekeeping tasks such as preparing food or changing linens. ¹⁴² CMS sets forth basic training requirements for home health aides. States may impose additional requirements.
Home health care agency	Typically refers to a large Medicare-certified company that provides limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services. ¹⁴³ See Home care agency.
Independent contractor	A self-employed worker. Only workers who run their own separate business should be classified as independent contractors. Most workers are legally “employees” even if the business they work for labels them independent contractors. Because almost all home care workers are paid an hourly wage to provide services through an entity, such as a home care agency, whose business is to arrange and oversee the services delivered by the worker, they should generally be classified as employees and protected by all workplace laws that apply to employees.

Independent provider	A home care worker who is not employed by a home care agency, but rather has a more direct relationship with the consumer. Home care independent providers may work in state Medicaid consumer-directed programs, or directly for private-pay consumers. Note that in state consumer-directed programs, the state may be a joint employer of independent provider workers.
In-home services and supports (IHSS)	A California state program, administered by each county in California for the provision of in-home care supports and services by home care workers hired by consumers. ¹⁴⁴
Managed care organization	Health insurance entity that provides members with services through a network of affiliated providers for a set monthly fee.
Payer	In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO. ¹⁴⁵
Personal care	Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include daily tasks, like using eye drops. ¹⁴⁶
Personal care attendant/assistant (PCA)	PCAs are a subgroup of home care workers who provide assistance with the activities of daily living. These workers often help with housekeeping chores, meal preparation, and medication management. Training requirements and scope of practice for PCAs are set by state law; some states have no training requirements for PCAs.

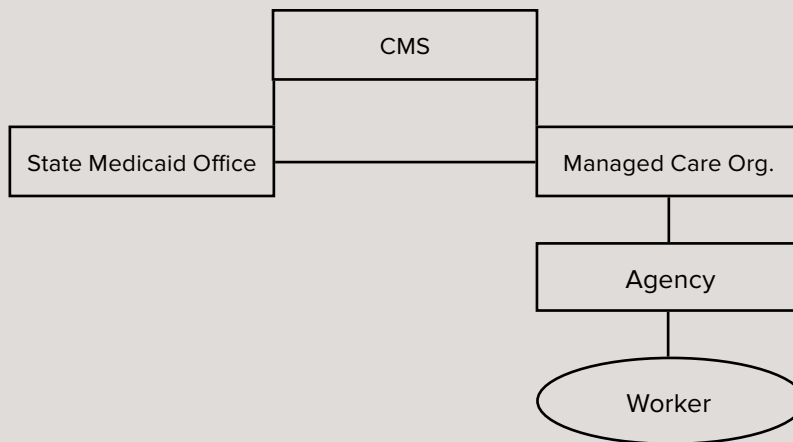
Appendices

Appendix Figure A.1. Medicare Fee-for-Service and Managed Care Models



*Medicare Administrative Contractor, private insurer, Managed Care Organization, PCMH or Accountable Care Organization

Appendix Figure A.2. Joint Medicaid/Medicare-Funded Model



Appendix Table A. Examples of Medicaid Reimbursement Rates from Various State Programs¹⁴⁷

State	Program	Consumer-Directed	Agency
AR	Alternatives for Adults with Physical Disabilities Waiver	\$9.72	\$16.76
CA	In-Home Supportive Services	\$10.15	\$20.85
CT	Home Care Program for Elders Waiver	\$14.24	\$19.36
ID	State Plan Personal Care	\$13.36	\$15.56
IL	Home Services Program Waiver	\$11.55	\$16.23
KS	Frail Elderly Waiver	\$12.04	\$14.16
ME	State Plan Personal Care	\$8.52	\$14.57
MI	State Plan Personal Care	\$8.29	\$14.15
ND	State Plan Personal Care	\$13.16	\$18.75
OH	PASSPORT Waiver	\$12.32	\$17.12
OR	State Plan Personal Care	\$10.20	\$19.94
PA	Independence Waiver	\$16.76	\$19.20
VA	State Plan Personal Care	\$8.86	\$12.91
VT	Choices for Care	\$11.48	\$26.88
WA	State Plan Personal Care	\$10.45	\$19.02

Source: HMA 2012, Appendix 2

Technical Notes

Estimating the proportion of agency-based home care workers

Estimates of the proportion of agency-based home care workers are based on the uniform extract of the 2013 American Community Survey (ACS) provided to the public by the Center for Economic and Policy Research.

The ACS, like all of the large U.S. government household and establishment surveys, presents challenges for data analysis on home care workers. First, none of the occupation and industry categories in standard classification systems are either fully inclusive of, or exclusive of, home care workers. Second, this workforce is likely to be undercounted in survey data because respondents may be less likely to report jobs that are paid “under the table,” which many home care jobs are believed to be. Third, much of the workforce is foreign born, and research has shown immigrants to be underrepresented in national surveys.

This analysis follows previous research by Shierholz (2013) and Dresser (2015) with a few modifications.¹⁴⁸

First, the total universe of home care workers is defined by identifying the top industries (representing at least 100,000 workers) for the occupations personal care attendants (4610) and nursing, psychiatric or home health aides (3600). The following five industries that were likely not home-based were then excluded: “Nursing care facilities”, “hospitals”, “residential care facilities”, and “other health care services and outpatient care centers”. The following industries were included: “home health care services”, “individual and family services”, “private households”, and “administration of human resource programs”. Although this sample likely still includes non-home care workers (facility-based workers and workers performing non-home care tasks), we believe it represents a close approximation of the universe of home care workers.

Agency-based home care workers include those:

1. Whose occupation is classified as personal care attendants (4610) or nursing, psychiatric or home health aides (3600);

2. Whose industry is classified as home health care services or individual and family services; and,
3. Who are not classified as self-employed (either incorporated or non-incorporated).

Non-agency workers include those:

1. Whose occupation is classified as personal care attendants (4610) or nursing, psychiatric or home health aides (3600); and,
2. Whose industry is classified as home health care services (8170), individual and family services (8370); and,
3. Who are classified as self-employed.

Or those:

1. Whose occupation is classified as personal care attendants (4610) or nursing, psychiatric or home health aides (3600); and,
2. Whose industry is classified as private households (9290) or, as administration of human resource programs (9480).

Note about “administration of human resource programs” industry

According to the Census Bureau, this industry comprises government establishments primarily engaged in the planning, administration, and coordination of programs for public assistance, social work, and welfare activities; and the administration of Social Security, disability insurance, Medicare, unemployment insurance, and workers’ compensation programs. The highest concentrations of workers classified in this industry and classified as home health aides and personal care attendants are in states in which there are known to be large Medicaid consumer-directed home care programs. California had the largest share of workers classified this way (43.1 percent), followed by Illinois (6.8 percent), New York (6 percent), Minnesota (5 percent), Washington State (5.7 percent), and Oregon (3.3 percent). Our analysis includes these workers in the category of non-agency workers.

Data limitations

As noted, above, while there are major limitations to using the ACS to make these estimates, we believe that this is the best source of data on this workforce. The other available government datasets based on a household survey that includes this workforce is the Current Population Survey; however, sample sizes for

these occupations and industries are much smaller than they are in the ACS. The Bureau of Labor Statistics' Occupational Employment Statistics and Current Employment Statistics are based on establishment surveys that may exclude non-agency and other home-based workers.

Endnotes

1. When we refer to home care, we are referring to non-medical services provided to people in their homes. The home care workforce encompasses workers in two main occupations: home health aides and personal care aides. Both kinds of workers assist older adults or people with disabilities at their homes with personal care (assistance with eating, dressing, bathing, and toileting) and household services (meal preparation, shopping, light cleaning, and transportation). In some states, home health aides may administer medication or check a client's vital signs under the direction of a nurse or other healthcare practitioner. Home care work is overlapping but distinct from the industry category "Home Health Services".
2. David Weil, current Administrator of the US Department of Labor's Wage and Hour, has used the term "fissuring" to describe the splitting off of functions that companies once managed internally. See *The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It* (Harvard University Press, 2014). We use the term more broadly here to describe the splitting up of employer functions that an employer might traditionally perform itself but which, in the home care context, may have been delegated to outside entities at the inception of a state Medicaid home care program.
3. BLS Occupational Employment Statistics, 2015. The figures noted refer to median hourly wages for the occupations personal care aides and home health aides, respectively.
4. *Paying the Price: How Poverty Wages Undermine Home Care in America*, (PHI - Quality Care through Quality Jobs report, February 2015), <http://phinational.org/sites/phinational.org/files/research-report/paying-the-price.pdf>.
5. *Giving Caregivers a Raise: The Impact of a \$15 Wage Floor in the Home Care Industry*, (National Employment Law Project, February 2015), <http://www.nelp.org/content/uploads/2015/03/Giving-Caregivers-A-Raise.pdf>.
6. Revenues in the home health industry have grown 48 percent over the past 10 years. BLS Quarterly Service Survey (QSS) and Service Annual Survey (SAS). Growth is calculated after adjusting for inflation using the CPI.
7. Id., using Bureau of Labor Statistics' Consumer Price Index (CPI-W) to convert nominal wages to real wages.
8. Id., at 2.
9. Annette Bernhardt, et al., *Broken Laws, Unprotected Workers: Violations of Employment and Labor Laws in America's Cities* (2009), <http://www.nelp.org/content/uploads/2015/03/BrokenLawsReport2009.pdf>.
10. Id.
11. *Paying the Price*, note 4 supra.
12. Id.
13. Peggie Smith writes, for example, that "disadvantageous working conditions" in both home care and home-based child care "hinge, in part, on the work's close association with women's unpaid work in the home, and the traditional views regarding such work. Home-based care workers suffer from society's perception that family caregiving is unskilled labor with limited economic value, and the belief that women should perform such activities not for money, but out of love. Consistent with this traditional view, research reveals that individuals who work in caregiving jobs experience a 'wage penalty' that captures the social and economic devaluation of care work." Peggie R. Smith, *The Publicization of Home-Based Care Work in State Labor Law*, (Minn. L. Rev. 2008) page 1397, <http://www.minnesotalawreview.org/articles/publicization-home-based-care-work-state-labor-law/>.
14. Decisions to outsource, privatize, and misclassify workers as independent contractors have also been motivated by racism, sexism, and relatedly, in a backlash to welfare rights movements. In their 2012 book, *Caring for America*, Eileen Boris and Jennifer Klein provide an excellent account of California's move to an independent provider system and the growth of the vendor agency model in New York in the 1970s, explaining, "In California and New York, local and state governments turned to contracting home care to private agencies or designating home care workers as 'independent contractors' without benefits or job security. By distancing such workers from public employment, states denied responsibility for the working conditions of an occupation whose contours government policies had done so much to set during the previous quarter century." New York City Mayor Edward Koch capitalized on "the racially charged atmosphere of late 1970s New York City" and backlash from the War on Poverty to justify such moves, remarking publicly about home care workers, "They are jackals feeding on the health, safety, and the very lives of people who need our help the most." Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State*, (Oxford University Press, pages 94-97, 2012).
15. Heather Rogers, *A Decent Living for Home Caregivers—And Their Clients*, (The American Prospect, summer 2015), <http://prospect.org/article/decent-living-home-caregivers%E2%80%94and-their-clients>.
16. See Boris and Klein, *Caring for America*, note 14 supra.
17. While we don't have specific numbers delineating the exact proportion of publicly-funded services provided by agency-employed providers as opposed to via consumer-directed programs, we do know that across the industry (both publicly-funded and private pay), most workers are employed by agencies. (See text box on page 10). Even in states (such as CA, OH, MN and WA) that allow for Medicaid-eligible consumers to access services from a provider without an agency go-between (i.e. independent provider or consumer-directed programs), state governments have declined to recognize workers as state employees.
18. After decades of exclusion from federal wage protections, home care workers have finally gained FLSA coverage as new rules adopted by the Obama administration DOL took effect this year. Almost all personal care attendants, home health aides, and other workers who provide in-home services to older adults and people with disabilities are now entitled to the federal minimum wage, overtime pay, pay for travel time between consumers, and other federal protections.
19. Each U.S. territory also has authority to create its own program.
20. Sec. 1128A. [42 U.S.C. 1320a-7a] (a) and Sec. 1902. [42 U.S.C. 1396a] (a). See also, 42 CFR 431.424 and 42 CFR §431.428.
21. 42 CFR 438.214 and Sec. 1128. [42 U.S.C. 1320a-7] (a).
22. Internal NELP research memo, on file with authors.
23. In the absence of home health specific wage data, CMS has used inpatient hospital wage data in developing a wage index to be applied to home health payments. While CMS does not require reporting on wages or hours for home care workers, it will begin, in 2016, to require nursing homes receiving Medicare funding to report on staffing turnover and other staffing data (Centers for Medicare & Medicaid Services, *Staffing Data Submission PBJ*, (accessed Nov. 6, 2015), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html>). Extending similar requirements to home care employers in the Medicaid and Medicare systems would provide valuable insight into working conditions in these jobs as well as provide more tools to ensure compliance with basic labor standards.

24. There are two primary types of Medicare coverage from which beneficiaries can elect, fee-for service (i.e. “Original Medicare”) and Medicare managed care (i.e. “Medicare Advantage”). Seventy percent of beneficiaries currently elect to enroll in Original Medicare. Some 9 million consumers are eligible for both Medicaid and Medicare, and their services are funded through both sources. In one demonstration project, aimed at coordinating Medicare and Medicaid benefits, spending, and services, more than 350,000 enrollees have enrolled to date. This demonstration involves a three-way contract between CMS’ Medicare-Medicaid Coordination Office, participating states and private managed-care plans. (See Appendix Figure A2.)
25. CMS contracts out to private companies, known as Medicare Administrative Contractors (MACs) to process medical claims for Medicare beneficiaries and serve as the primary operational contact between CMS and home health agencies. CMS contracts with State agencies to conduct initial certification of home health agencies, but provides explicit guidance through the Home Health Agency Conditions of Participation (CoPs). As such, at the very least, the Medicare system defines an accountable entity which is serves as the employer for home health aides, and must abide by certain contracting, data collection, record-keeping and reporting requirements. The managed care organizations which contract with Medicare to furnish home care services may provide such services either directly or through Medicare-approved home health agencies. If a managed care organization provides home health services directly, it is still required to meet the same requirements that a Medicare-certified home health agency would (See 42 CFR Part 417.416(a) and 42 CFR Part 422.20(b)(3).)
26. In the absence of home health specific wage data, CMS has used inpatient hospital wage data in developing a wage index to be applied to home health payments.
27. BLS Occupational Employment Statistics 2015. The figures noted refer to median hourly wages for the occupations personal care aides and home health aides, respectively.
28. The 6th Annual Edition of the Private Duty Benchmarking Study (Home Care Pulse, pages 65-68, 2015).
29. Id. at 76.
30. “[C]ontracts let under the Medicaid program which are financed by federally-assisted grants to the States, and contracts which provide for insurance benefits to a third party under the Medicare program are not subject to the Act.” 29 CFR 4.107.
31. Mandy Locke, “Taxpayer-supported companies fail to pay workers, with impunity,” (The Raleigh News & Observer, October 2015), <http://media2.newsobserver.com/static/content/multimedia/projects/labor/labor02.html>. “Since 2006,” the paper noted, “the state has paid at least \$72 million to 17 companies that ended up failing to pay workers wages they earned in 2014.”
32. Id., at 2.
33. The workers filed their lawsuits soon after federal law enforcement officials announced charges against some of the same companies for fraudulent billing practices. “DC Homecare Workers File a Lawsuit against Three of the City’s Largest Medicaid Providers,” (Service Employees International Union, December 15, 2014), http://www.1199seiu.org/dc_homecare_workers_file_a_lawsuit_against_three_of_the_city_s_largest_medicaid_providers#sthash.ceizOEmA.dpuf. Ben Rooney, “Home Health care Worker Sue Employers for Back Pay,” (CNN Money, April 8, 2015), <http://money.cnn.com/2015/04/08/news/home-health-workers-lawsuit-wages/>.
34. Nina Bernstein, “State Health Dept. Defers Action on Troubled Agency,” (New York Times, Jan. 30, 2014), <http://www.nytimes.com/2014/01/31/nyregion/state-health-dept-defers-action-on-troubled-agency.html>.
35. “No payments by government agencies shall be made to certified home health agencies, long term home health care programs, or managed care plans for any episode of care without the certified home health agency, long term home health care program, or managed care plan having delivered prior written certification to the commissioner, on forms prepared by the department in consultation with the department of labor, that all services provided under each episode of care are in full compliance with the terms of this section and any regulations promulgated pursuant to this section.” New York Public Health Law § 3614-C (6), *Home Care Worker Wage Parity*, https://www.lawsolver.com/law/state/new-york/ny-laws/ny_public_health_law_3614-c.
36. “[T]he certified home health agency, long term home health care program, or managed care plan must obtain a written certification from the licensed home care services agency or other third party, on forms prepared by the department in consultation with the department of labor, which attests to the licensed home care services agency’s or other third party’s compliance with the terms of this section...” New York Public Health Law § 3614-C (7).
37. See New York Public Health Law § 3605, “Licensure of home care services agencies,” and § 3608 “Certification of home care services agencies.”
38. The New York State Department of Health website’s materials on the Wage Parity law, for example, are geared towards employers and their requirements under the law rather than workers’ rights. The FAQs focus on Wage Parity requirements and do not address other wage and hour requirements or other workplace laws that are of concern to workers, such as: compensation for travel time, overnight shifts, trainings and off-the-clock work; reimbursements for uniforms and supplies. An FAQ for workers provides only an email address to which further questions about the law may be directed, rather than guidance to workers about their options in the instance of a suspected violation. See https://www.health.ny.gov/health_care/medicaid/redesign/mrt61_hc_worker_parity_faqs_5_30_14.htm.
39. New York State’s Independent Consumer Advocacy Network (ICAN) serves as an ombudsman program for people with Medicaid long term care services, <http://www.cssny.org/programs/entry/independent-consumer-advocacy-network-ican>.
40. National Resource Center for Participant-Directed Services (NRCPS) website, *Overview of Participant Direction*, retrieved November 25, 2015, <http://www.bc.edu/schools/gssw/nrcpds/tools/toolkit/program-toolkit/overviewpd.html>.
41. Id.
42. NELP calculations based on American Community Survey, 2013.
43. *Caring for America*, note 14, supra, pages 187-188. In 2014, all states but Arizona, District of Columbia, Delaware, Georgia, Maine, and Rhode Island offered consumer-directed models. Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2012 Data Update*, Table 12, November 3, 2015, <http://files.kff.org/attachment/tables-medicaid-home-and-community-based-services-programs-2012-data-update>.
44. Some states offer consumers the option of “employer authority” (in which the consumer is the so-called “employer of record”), or “budget authority” (in which the consumer receives a fixed monthly allowance which s/he can spend on personal care expenses, including workers’ wages.) Another variation of the consumer-directed model is “agency with choice”, in which a

- state-contracted agency and the consumer are designated as co-employers of home care providers. The consumer selects and manages the home care worker, but the agency is named as the primary employer, determining wage rates and monitoring the quality of care. See *A Guide to the Employer Authority Model of Participant Directed Home and Community-Based Services*, (Health Management Associates, 2012).
45. U.S. Department of Labor, Wage and Hour Division, *Joint employment of home care workers in consumer-directed, Medicaid-funded programs by public entities under the Fair Labor Standards Act*, (Administrator's Interpretation 2014-12, June 19, 2014), http://www.dol.gov/whd/opinion/adminIntrprtn/FLSA/2014/FLSAAI2014_2.pdf. See also, *Fact Sheet #79E: Joint Employment in Domestic Service Employment Under the Fair Labor Standards Act (FLSA)* (U.S. Department of Labor, revised June 2014), <http://www.dol.gov/whd/regs/compliance/whdfs79e.htm>.
 46. California, Massachusetts, Minnesota, and Oregon are examples of states with a public authority.
 47. U.S. Department of Labor, Wage and Hour Division, *Joint employment of home care workers in consumer-directed, Medicaid-funded programs by public entities under the Fair Labor Standards Act*, (Administrator's Interpretation 2014-12, June 19, 2014), http://www.dol.gov/whd/opinion/adminIntrprtn/FLSA/2014/FLSAAI2014_2.pdf. See also, *Fact Sheet #79E: Joint Employment in Domestic Service Employment Under the Fair Labor Standards Act (FLSA)* (U.S. Department of Labor, revised June 2014), <http://www.dol.gov/whd/regs/compliance/whdfs79e.htm>; *Bonnette v. Cal. Health and Welfare Agency*, 704 F.2d 1465 (9th Cir. 1983).
 48. "The program, funded by the state and federal governments, pays 356,000 workers to care for 448,000 low-income elderly, blind or disabled Californians..." Bob Egelko, "Home care worker can sue county for pay" (San Francisco Gate, June 13, 2013), <http://www.sfgate.com/health/article/Home-care-worker-can-sue-county-for-pay-4599543.php>.
 49. *Woodruff v. County of San Diego In-Home Supportive Services Public Authority* (CA Sup. Ct. No. 37-2008-00096957-CU-OE-CTL), page 13.
 50. These include: a city, county, or city or county agency, a local health district, a voluntary nonprofit agency, a proprietary agency, or an individual. Id.
 51. *Meyers-Millas-Brown Act* (MMBA), the California law governing labor relations for local government employees, (CAL. GOV'T. CODE § 3500), <http://www.perb.ca.gov/laws/statutes.aspx#ST3500>. Also see, "County May be IHSS Provider's Employer for Purposes of Wage Claim," (California Public Employee Relations Journal Online, Issue 209, 2013), <http://cper.berkeley.edu/journal/online/?p=3048>.
 52. Id.
 53. Id.
 54. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016" (Kaiser Family Foundation Report, October 15, 2015), <http://kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-managed-care-reforms>.
 55. Teague Paterson, "In-Home Support services worker may be jointly-employed by county, sue for unpaid wages," (Beeson, Tayer & Bpdine, APC website, February 13, 2013), <http://www.beesontayer.com/2013/02/in-home-support-services-worker-may-be-jointly-employed-by-county-sue-for-unpaid-wages/> and *Guerrero v. Superior Court*, (Case No. A133202, Feb. 11, 2013).
 56. *Woodruff v. County of San Diego In-Home Supportive Services Public Authority* (CA Sup. Ct. No. 37-2008-00096957-CU-OE-CTL) unpublished opinion, at 7-8.
 57. Chris Megerian, "40,000 home-care workers unpaid after postal mishap involving timecards," (L.A. Times, June 4, 2015), <http://www.latimes.com/local/political/la-me-pc-home-care-workers-paychecks-20150602-story.html>.
 58. Bob Egelko, "Home care worker can sue county for pay" (San Francisco Gate, June 13, 2013), <http://www.sfgate.com/health/article/Home-care-worker-can-sue-county-for-pay-4599543.php>.
 59. Unionized workers' earnings exceed those of comparable nonunion workers by about 13.6%, a phenomenon known as the "union wage premium." (*Unions, inequality, and faltering middle-class wages*, (Economic Policy Institute, August 2012), <http://www.epi.org/publication/ib342-unions-inequality-faltering-middle-class/>). For women and women of color, the advantage is even greater with unionized women seeing a 31% increase in their earnings compared to non-unionized women. Hispanic and black women represented by labor unions have median weekly earnings that are 42% and 34% higher (respectively) than those without union representation. (*The Status of Women in the States 2015: The Union Advantage for Women*, (Institute for Women's Policy Research, 2015), <http://statusofwomendata.org/app/uploads/2015/08/R409-Union-Advantage.pdf>).
 60. Here we are referring to "capitated" managed care models. In addition to capitated models using managed care organizations (MCOs), states can use prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) in Medicaid managed care. MaryBeth Musumeci, *Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers*, (Kaiser Family Foundation, November 14, 2014), <http://kff.org/report-section/key-themes-in-capitated-medicare-mltss-background>.
 61. Paul Saucier, et. al., "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update" (Centers for Medicare and Medicaid Services, July 2012), http://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf.
 62. Rita Price, "Home-health workers go unpaid under Ohio's new managed care plan," (The Columbus Dispatch, August 25, 2014), <http://www.dispatch.com/content/stories/local/2014/08/25/workers-go-unpaid-under-new-state-program.html>.
 63. Id.
 64. "Home health aides quitting because lack of payment from the state," (News 12, MKCR – Cincinnati, July 2014).
 65. Joe Pagonakis, "Elyria family, critical caregivers report MyCare Ohio payment delays: Some care agencies not paid since April 30," (ABC News 5 Cleveland, July 3, 2014), <http://www.newsnet5.com/money/consumer/troubleshooter/elyria-family-critical-caregiveres-report-mycare-ohio-payment-delays>.
 66. While managed care organizations include non-profits and public or quasi-public organizations, for-profit organizations make up the largest share of managed care organizations providing home care – 44 percent. Private non-profit organizations are 32 percent, and public or quasi-public organizations have 24 percent. Nationally, four for-profit companies lead the market in Medicaid managed care for home care services: UnitedHealthcare, Amerigroup (recently acquired by Wellpoint), Centene, and Molina Healthcare. UnitedHealthcare has managed care contracts in eight States, Amerigroup in five States, Centene in three States, and Molina Healthcare in two. See Saucier, et. al., *Supra* Note 61.

67. Nina Bernstein, "Pitfalls Seen in a Turn to Privately Run Long-term Care," (New York Times, March 6, 2014), <http://www.nytimes.com/2014/03/07/nyregion/pitfalls-seen-in-tennessees-turn-to-privately-run-long-term-care.html? r=0>.
68. It is also important to note that many home care service providers use hybrid business models funded from both public and private sources.
69. *Independent contractor classification in home care*, (National Employment Law Project, December 2015), <http://www.nelp.org/campaign/implementing-home-care-reforms>.
70. Id.
71. *Lee's Industries, Inc. and Lee's Home Health Services, Inc. and Bernice Brown*, Case No. 4-CA-36904 (Decision by National Labor Relations Board Division of Judges, February 25, 2010); see also Catherine Ruckelshaus, *Leveling the Playing Field: Protecting Workers and Businesses affected by Misclassification*, (Testimony on behalf of National Employment Law Project before the United States Congress Senate Committee on Health, Education, Labor and Pensions, June 17, 2010), <http://www.nelp.org/content/uploads/2015/03/MisclassTestimonyJune2010.pdf>.
72. Brief of Maryland Legal Aid Bureau as Amici Curiae supporting Appellant, *Peters v. Early Healthcare Giver, Inc.* (Md. 2013), http://www.mwela.org/sites/default/files/brief-bank/AnnaBrooks/MWELA_Amicus_Brief_Peters-v-EarlyHealthcareGiver.pdf.
73. Home Heroes website, retrieved July 15, 2015. <https://www.homehero.org/help-center/legal/terms-of-use>.
74. Honor website, retrieved July 15, 2015. <https://www.joinhonor.com/terms>.
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