Budgeting for Opportunity Case Study: A Racial Equity Analysis of Medicaid-Funded Home- and Community-Based Services

State policymakers make hundreds of choices each year that have the potential to affect our daily lives, but the clearest reflection of what leaders in Annapolis are prioritizing is in the state budget. Decisions about the budget can have a profound impact on who has access to opportunity in Maryland. Even choices that appear neutral on the surface can interact with historical and ongoing forms of discrimination to either obstruct or assist Marylanders of color as they seek to contribute to a thriving state.

Racial equity analysis is a powerful tool for understanding these impacts and giving policymakers the information they need to build opportunity for all. It is also essential for informing the public about the consequences of policymakers' choices. Good intentions cannot advance equity on their own. For these reasons, policymakers should build in racial equity analysis as a standard part of the budget process.[i]

This case study is intended to provide a model of what built-in budget racial equity analysis might look like. Toward this end, the case study assesses disparate impacts of budgetary choices concerning Medicaid-funded home- and community-based services (including expenditures within the Maryland Department of Health Administration and the Medical Care Programs Administration).

This analysis is based on the Race Forward Racial Impact Assessment Tool.[ii] This tool centers on the concept of a policy proposal – the purpose of racial equity analysis is to assess the impacts of a proposed course of action. For the purpose of this analysis, "the proposal" means:

- The service itself. How do Medicaid-funded home- and community-based services advance or hinder racial equity, compared to a world in which the service does not exist?
- Policy choices embedded in the annual budget. What are the racially disparate impacts of decisions to increase or decrease funding, or maintain the status quo? Could a higher or lower budget amount do more to advance equity?[iii]
- Implementation policies. Is the service delivered in an equitable manner? Do rules regarding how the money is spent – or the lack of such rules – advance or hinder equity?

Best Practices for Budget Equity Analysis

A MDCEP report published in January 2023 recommends several best practices for racial equity analysis:

Start from a strong foundation:

- Equity analysis must always be informed by historical context on the policies, practices, and ideologies that produced present inequities.
- The goal of equity analysis is to proactively counteract the root causes of equity, not equal-dollar investments or procedural "colorblindness."
- All policy staff should receive the training needed to engage with equity analysis.

Seek out good information:

- People who are harmed by racial injustice are experts in their own experiences. Quantitative data cannot substitute for the knowledge gained through engagement with affected communities.
- Disaggregated data lie at the core of equity analysis. Wherever possible, public agencies should collect and publish disaggregated data based on uniform, thoughtful standards.
- Data should generally be disaggregated at the finest level of detail possible. Because racist systems affect different communities in different ways, more-detailed disaggregation will generally yield a more accurate picture than using a broad brush.

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Ensure strong implementation:

- Equity analysis should occur throughout the process of policy development and consideration. Starting equity analysis early on helps ensure findings receive meaningful consideration.
- The office responsible for equity analysis should be independent of the governor or legislative leadership, to ensure that the analysis is done honestly and informs policymakers.
- Equity analysis requires significant staff time and training. The body responsible for budget equity analysis must have adequate staffing and funding to do the job thoughtfully and effectively.
- For equity analysis to inform policy and promote transparency, it must be readily available to both policymakers and the public. Equity analysis should be integrated into general-purpose policy documents and prominently linked on agency websites.

Feasibility of Routine Budget Racial Equity Analysis

There is no doubt that thoughtful, effective racial equity analysis requires significant staff time, for both the body conducting the analysis and the agencies collecting relevant data. In this respect it is like much of what state government does: it requires resources, and is nevertheless worth doing. Policymakers should keep several considerations in mind while assessing the feasibility of routine racial equity analysis of the state budget:

- Effective routine budget racial equity analysis will require staff time, likely including new positions, and training. Simply adding to the responsibilities of existing staff is a recipe for failure.
- Legislative analysts are no strangers to in-depth analysis and tight schedules. For example, the DLS analysis of the Maryland Department of Health – Medical Care Programs Administration FY 2024 budget runs 58 pages.[iv] Excluding appendices and tables, the document totals approximately 13,000 words. With appropriate resources, effective racial equity analysis is an achievable goal.
- Policymakers may consider phasing in budget racial equity analysis, adding a few agencies each year until the entire budget is included. The information gained during each agency's initial analysis will reduce the time required for subsequent analyses.

Glossary

Racial equity analysis: "A systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision," which can be "used to minimize unanticipated adverse consequences" and "identify[] new options to remedy long-standing inequities."[v]

Racial inequity: A state of the world in which your race and ethnicity affect your chances in life and can be used to statistically predict outcomes like income or life expectancy.

Racial equity: A state of the world in which people of all racial and ethnic backgrounds have an equal shot and race and ethnicity are statistically unrelated to outcomes.

Data disaggregation: The practice of calculating, examining, and presenting data on population characteristics for subgroups in addition to the aggregate whole. For instance, disaggregated data on median hourly wages would include medians for workers of different racial and ethnic backgrounds, genders, disability statuses, or other characteristics. Data disaggregation is one essential component of racial equity analysis.

Budget Racial Equity Analysis:

Medicaid-Funded Home- and Community-Based Services

Agency: Maryland Department of Health

Divisions:
M00A01 Administration
M00Q01 Medical Care Programs Administration

Note: This analysis excludes services provided under M00L Behavioral Health Administration and M00M Developmental Disabilities Administration.

Program Overview:[vi]

> The Medicaid program covers HCBS [home- and community-based services] through the Community First Choice program and Community Personal Assistance Services program, among other programs. In partnership with the Centers for Medicare and Medicaid Services (CMS), MDH also implements HCBS waivers that allow older adults, people with disabilities, and children with chronic illnesses who would not otherwise qualify for Medicaid to access HCBS. Waiver participants must meet financial eligibility based on income and asset levels and medical eligibility requiring a need for institutional or facility levels of care. HCBS programs fund a variety of service types, such as case management, residential services, nursing, and personal care, that help individuals live at home, in a community setting, or in an assisted living facility, rather than in a nursing facility or State health facility.

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Executive Summary

1. **IDENTIFYING STAKEHOLDERS**

Data on HCBS stakeholders are highly incomplete. The following estimates for four major stakeholder groups are based on extremely limited available data:

- **Consumers** who receive services:
  - In FY 2021, the Maryland Department of Health paid for HCBS personal assistance services provided to 14,562 Medicaid participants, including through programs outside the scope of this analysis.
  - In FY 2022, 4,661 consumers used services under the Community Options Waiver, the largest HCBS program included in this analysis.
  - In a nonrandom sample of consumers ages 65 and over, 66% of consumers were white, 17% were Black, 14% were Asian, and 3% were Latinx or belonged to other racial or ethnic groups. Based on two data sources, between 63% and 73% of consumers are women.
- **Wait list registrants** who have requested services but are not currently receiving them:
  - As of June 30, 2022, 23,730 individuals were on a wait list for one HCBS program. A 2020 analysis by the Hilltop Institute estimated that only 16% of wait list registrants met medical and financial eligibility requirements, implying that about 3,700 individuals were

eligible for HCBS services but not receiving them. In other words, Maryland is currently serving only 56% of eligible individuals.
    - According to the Hilltop analysis, 39% of all registrants were white, 36% were Black, 5% were Asian, and 20% belonged to other racial groups or did not have race/ethnicity information. The analysis does not report data on Hispanic origin.
    - 63% of registrants were women and 32% were men.
- **Home care workers**, the primary HCBS workforce providing in-home care to consumers:
    - Based on American Community Survey data, about 16,100 home care workers provide care in Maryland. For reasons discussed in the full report, these data should be treated with caution.
    - 26% of home care workers identified in American Community Survey data are white, 60% are Black, 6% are Asian or Pacific Islander, and 5% are Latinx. 84% of home care workers are women, and 14% are men.
- **Informal caregivers** who provide unpaid care of the same or similar kind to that provided by home care workers: Essentially no information exists on this population.

2. ENGAGING STAKEHOLDERS

The state's primary venue for HCBS stakeholder engagement is the Community Options Advisory Council, which meets quarterly to "discuss policy, planning and issues with stakeholders, advocates, providers and participants."

- Consumers form the majority of the council's membership, as required under federal regulations.
- Although certain categories of worker representatives are eligible to serve on the council, there is no requirement for worker representation.
- Public information on the council's activities is severely limited**.**

3. IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES

The inadequate state of data on HCBS consumers and home care workers significantly hinders assessment of racial inequities.

Consumers

Very little publicly available information exists on consumers' access to care, quality of care, or general wellbeing.

Wait List Registrants

The most notable inequities affecting wait list registrants concern the *overall* composition of the wait list population rather than inequities *among* wait list registrants. A person's presence on the wait list is in itself an indicator of harm, as it indicates an unmet need for care.

Data in the 2020 Hilltop Institute analysis indicates significant inequity:

- 36% of wait list registrants at the time of the analysis were Black, compared to 30% of Maryland residents overall in 2020.
- 63% of wait list registrants were women. Nearly half of registrants were Medicaid-eligible, indicating significant economic hardship.
- 19% of registrants had already spent at least five years on the wait list.

Home Care Workers

Home care workers in Maryland – a workforce in which Black workers, especially Black women, as well as other workers of color are heavily overrepresented – face considerable hardship:

- In 2022, Maryland home health and personal care aides typically took home only $15.26 per hour – 38% below the 2022 statewide median hourly wage and only 22% above the minimum wage.
- To afford a basic living standard in Maryland, a single adult working full time and not caring for children would need to take home between $16.75 and $28.88.
- An analysis by the Economic Policy Institute (EPI) found that Maryland home care wages were third-most inadequate among the 50 states.[vii]
- Home care workers in Maryland are three times as likely as other Maryland workers to have family income below the federal poverty line ($30,000 for a family of four in 2023).

Informal Caregivers

A 2023 study analyzing a nonrandom sample of consumers ages 65 and over and their caregivers includes three measures of caregivers' wellbeing, not disaggregated by race and ethnicity:

- 13% of caregivers reported feeling overwhelmed.
- 5% of caregivers reported feeling distressed, angry, or depressed.
- 5% of caregivers reported that they were unable to continue caregiving.

4. EXAMINING THE CAUSES

The current state of Medicaid-funded HCBS exposes different stakeholder groups to different kinds of racialized harm:

- Consumers, wait list registrants, and informal caregivers are harmed by inadequate access to care, continuity of care, and potentially quality of care.
- Home care workers are harmed by poor wages, benefits and working conditions; inadequate training; and a lack of voice in the workplace.

These harms are closely linked: Inadequate access to care is the result of a severe **home care workforce shortage**. This shortage is overwhelmingly the result of low job quality**,** most importantly **poor compensation**. Three major factors directly contribute to poor compensation for home care workers:

- **Lack of compensation standards:** Policymakers have not adopted any specific standards for pay or benefits in Medicaid-funded HCBS.
- **Potentially inadequate reimbursement rates:** Medicaid payment rates must cover home care worker wages and administrative costs, and the agency model builds in an expectation of profit. However, due to a **lack of reliable cost data**, it is not clear whether current payment rates are sufficient to support better wages.
- **Independent contractor misclassification:** A significant number of residential service agencies inappropriately classify home care workers as independent contractors rather than employees, allowing the agencies to avoid certain legal responsibilities.

On a more fundamental level, the racial inequities in Medicaid-funded HCBS are rooted in historical and cultural forces that led to current policy choices. These factors are discussed in detail in the full report.

5. CLARIFYING THE PURPOSE

Purpose and Impacts of Medicaid-Funded Home- and Community-Based Services

Medicaid-funded HCBS advance equity along multiple dimensions (provided that the services are delivered with at least a minimum level of effectiveness):

- **Disability:** Medicaid-funded HCBS assist Marylanders with disabilities in meeting their basic needs while remaining in their own homes.
- **Income and wealth:** Medicaid-funded HCBS make assistance available to Marylanders who cannot afford to pay for long-term care out of their income or assets.
- **Race and ethnicity:** Black and Indigenous Marylanders and other Marylanders of color experience higher disability prevalence than their white counterparts, and on average have lower incomes and fewer assets. Therefore, they may have greater need for Medicaid-funded HCBS.
- **Gender:** Medicaid-funded HCBS eases significant care responsibilities for informal caregivers, the majority of whom are women. Furthermore, data on consumers and wait list registrants suggests that women may have greater need for HCBS than men.

Purpose and Impacts of the FY 2024 Adopted Budget and Implementation Policies

The most notable policy change in the FY 2024 budget is the inclusion of $207 million in additional funding (including $109 million in state funds) for health care providers to offset increased wage costs under Gov. Moore's Fair Wage Act.

Together, the FY 2024 budget and the Fair Wage Act have potential to advance racial and ethnic equity:

- The Fair Wage Act will temporarily increase wages for thousands of home care workers – predominantly women of color. Workers who are misclassified as independent contractors may see a small or no wage increase.
- The rate increase in the budget proposal has potential to advance racial and ethnic equity, to the extent that it translates into higher wages.
- Impacts on access to care are ambiguous, as home care wages will increase temporarily but will not become more competitive with other low-wage occupations.

6. CONSIDERING ADVERSE IMPACTS

The proposal adversely affects racial and ethnic equity by leaving achievable gains unrealized:

- The lack of specific wage standards for home care workers limits the proposal's ability to increase wages, especially for misclassified workers and in the long term. This perpetuates racialized harms done to home care workers and limits the proposal's ability to improve access to care.
- The decision not to improve data and reporting standards continues a severe data shortage, denying policymakers and the public of the information needed to advance equity.

7. ADVANCING EQUITABLE IMPACTS

Potential positive impacts of the proposal on racial and ethnic equity include:

- Temporarily increased wages for home care workers who are properly classified as employees.
- Possible temporary wage increases for workers misclassified as independent contractors.

- Possible but highly uncertain improvements in access to care, to the extent that temporarily increased wages due to a general minimum wage increase strengthen the home care workforce.

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS

Policymakers should consider four improvements to improve home care wages and benefits, which would likely also improve access to care and reduce racialized harms to all stakeholder groups:

- Adopt wage and benefit standards specific to Medicaid-funded HCBS, above and beyond the temporary wage increase under the Fair Wage Act.
- Restrict Medicaid reimbursement of residential service agencies for HCBS to only services provided by workers properly classified as employees.
- Strengthen home care workers' collective bargaining rights.
- Increase resources, staffing, and infrastructure for enforcement of worker protections, including active collaboration between the state's health and labor departments.

Policymakers should also consider six improvements to data practices in Medicaid-funded HCBS:

- Require residential service agencies to report individual-level data on home care workers to the state, including wage, classification, and benefits.
- Collect race and ethnicity data as well as other demographic information on home care workers, either through agency reporting or direct data collection by the state.
- Require residential service agencies to report detailed cost data including home care worker wages, administrative costs, executive compensation and profits.
- Administer recurring surveys of consumers, wait list registrants, and informal caregivers, including race and ethnicity as well as indicators of wellbeing and unmet need.
- Strengthen data infrastructure, including active collaboration between the Maryland Department of Health and Maryland Department of Labor.
- Presumptively make disaggregated data public, with appropriate guardrails.

9. ENSURING VIABILITY AND SUSTAINABILITY

The state currently does not collect sufficient cost data to assess whether the rate increase in the FY 2024 budget is necessary or sufficient to support higher wages as required under the Fair Wage Act. Moreover, the FY 2024 budget makes no improvements to enforcement, data collection, public reporting, stakeholder participation, or public accountability.

10. IDENTIFYING SUCCESS INDICATORS

The first step to track progress in improving equity around Medicaid-funded HCBS is to strengthen data collection and reporting requirements, as discussed in Section 8.

With a sufficiently robust data system in place, the state should add measures of job quality, labor supply, and access to care to the Managing For Results performance measures published with the budget each year. Performance measures should generally be disaggregated by race and ethnicity.

Budget Racial Equity Analysis: Medicaid-Funded Home- and Community-Based Services

1. **IDENTIFYING STAKEHOLDERS Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?**

There are four major stakeholder groups for home- and community-based services:

- **Consumers** who receive services
- **Wait list registrants** who have requested services but are not currently receiving them
- **Home care workers**, the primary HCBS workforce providing in-home care to consumers
- **Informal caregivers** who provide unpaid care of the same or similar kind to that provided by home care workers

Data are severely limited on all four stakeholder groups. Although the state possesses varying levels of administrative data on the first three groups, these data are not consistently disaggregated by race and ethnicity and typically lack measures of wellbeing that would inform an equity analysis. Public access to these data is typically limited.[viii]

Consumers

MDCEP identified three sources of information on HCBS consumers:

- In the **Fiscal and Policy Note for HB 489 of 2023**, the Department of Legislative Services (DLS) states that in FY 2021, the Maryland Department of Health (MDH) paid for personal assistance services (a subset of HCBS) provided to 14,562 Medicaid participants.[ix]
    - In addition to services covered by this analysis, this number likely also includes Medicaid-funded services provided through the Behavioral Health Administration (BHA) or Developmental Disabilities Administration (DDA), which are outside the scope of this analysis.
    - The fiscal and policy note does not include any further information on participants' characteristics.
- The **Hilltop Institute**, a research organization at the University of Maryland, Baltimore County, hosts an interactive data tool on its website with information on HCBS consumers.[x]
    - According to the Hilltop data tool, in FY 2022, 4,661 consumers used services under the Community Options Waiver, the primary program (outside BHA and DDA) providing Medicaid-funded HCBS.[xi]
    - 23% of FY 2022 Community Options Waiver consumers were at least 85 years old and 69% were at least 65 years old. Meanwhile, 6% of consumers are under 45 years old.
    - 63% of FY 2022 Community Options Waiver consumers were women and 37% were men. Hilltop does not provide data for other gender categories.
    - The publicly available Hilltop data tool does not disaggregate consumers by race and ethnicity. MDCEP is unaware of whether disaggregated data are available to authorized internal or academic research users.
    - However, the geographic distribution of consumers suggests that this population may be disproportionately Black. For example, Baltimore City accounted for 23% of consumers in 2022, compared to only 9% of the state population. About 62% of Baltimore City residents are Black, compared to 32% of the statewide population.[xii]

    - In addition, 17% of consumers live in Baltimore County, 14% live in Montgomery County, and 13% live in Prince George's County. Another 17% live in other Central Maryland counties, 7% live on the Eastern Shore, 4% live in Southern Maryland, and 3% live in Western Maryland.
- A **2023 article in the *Journal of Applied Gerontology* (Fabius et al. 2023)** analyzes characteristics of 1,144 HCBS consumers served by 25 residential service agencies in Maryland.[xiii]
    - The analysis excluded participants under 65 years old. Among those 65 or older, 39% of participants were at least 85 years old, while 22% were ages 65 to 74.
    - 73% of participants were women and 27% were men. The analysis does not provide data for other gender categories.
    - Race and ethnicity:
        - 66% of participants were white
        - 17% of participants were Black
        - 14% of participants were Asian,
        - 3% of participants were Latinx or belonged to other racial or ethnic groups (not further disaggregated in the article).
    - Participants had an average score of 7.2 out of 11 on a composite scale of functional status (equivalent to 65 if scaled to a range from 0 to 100). This means that on average, participants required

Forthcoming Federal Regulations May Transform Delivery of Medicaid-Funded HCBS

The Center for Medicare and Medicaid Services in April 2023 published a notice of proposed rulemaking regarding developing changes to federal regulations regarding Medicaid-funded HCBS. The proposed regulations (CMS 2442-P, Ensuring Access to Medicaid Services) mirror many of the recommendations in this analysis and could significantly advance equity. However, the proposed regulations build in waiting periods varying between three and seven years before the new standards take effect.

Maryland should begin preparations to implement the new standards as soon as possible. Furthermore, policymakers should work to implement the proposed changes more quickly than the proposed federal timeline.

Key provisions of the proposed Ensuring Access to Medicaid Services regulations:

- The rule would require that at least 80% of Medicaid payments for HCBS go toward compensation of care workers.
- The rule would require states to establish *interested parties advisory groups* to advise on HCBS care worker compensation, with required membership including care workers and consumers.
- The rule would require states to report average hourly wages paid to care workers, as well as the percentage of Medicaid payments going toward compensation.
- The rule would make an existing set of voluntary HCBS quality measures mandatory and require certain measures to be disaggregated by race and ethnicity as well as other equity-relevant characteristics.
- The rule would require states to report data on access to care, including the length of any waiting lists, time consumers spend on waiting lists, and the percentage of authorized care hours actually delivered.
- The rule would require states to publish data online and establish accessibility requirements for the reporting website.

https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking

a significant amount of assistance with basic daily activities.
    - 54% of participants were living with dementia.
    - The sample for this analysis may not be representative of the HCBS population as a whole. The 25 agencies that completed the survey were part of an initial sample of 1,052 agencies that were initially contacted; 875 agencies did not respond or declined to complete the survey, and the remaining 152 agencies were excluded for other reasons.

Under HCBS eligibility rules, 100% of consumers have a disability or medical condition that seriously affects their ability to engage in activities of daily living, and 100% face economic hardship in the form of low income and assets or extremely high medical expenses.

Wait List Registrants

The Community Options Waiver maintains a wait list of individuals who have requested HCBS but are not currently approved to receive services. See Section 4 for a discussion of the reasons for this wait list. As of June 30, 2022, 23,730 individuals were registered on the Community Options Waiver wait list, according to DLS (409% more than the number who used services in FY 2022).[xiv]

The Hilltop Institute in 2020 published descriptive statistics on wait list applicants' characteristics, based on the wait list population as of September 30, 2020:[xv]

- The Hilltop analysis suggests that the characteristics of wait list registrants overall do not necessarily reflect that characteristics of individuals who would receive services if capacity were greater:
    - Only 40% of registrants satisfied medical eligibility requirements to receive services, based on the individual-level data Hilltop used for the analysis. Hilltop did not separately report characteristics of medically qualifying registrants.
    - Hilltop estimates that only 39% of medically qualifying registrants also satisfy financial eligibility requirements (16% of all registrants). The Hilltop data set did not include information needed to determine financial eligibility, so the analysis instead relies on historical enrollment rates among registrants invited to complete a full application. For this reason, Hilltop did not report characteristics of registrants meeting all eligibility requirements – the group that would benefit if services were more widely available.
    - Due to the nature of the eligibility rules, eligible registrants are expected to face more serious disabilities or health conditions and more severe economic hardship than the overall registrant population.
    - If the Hilltop assumptions are correct, about 3,700 individuals were eligible for services through the Community Options Waiver but not receiving services as of mid-2022. In other words, Maryland is currently serving only 56% of eligible individuals.
- Characteristics of full registrant population:
    - 39% of registrants were white, 36% were Black, 5% were Asian, and 20% belonged to other racial groups (including American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, more than one race, and registrants who race was unknown). The analysis does not report data on Hispanic origin.
    - 63% of registrants were women and 32% were men. Gender was "not specified" for 4% of registrants. The analysis does not report data on other gender categories.
    - 16% of registrants were at least 85 years old and 62% were at least 65 years old. Meanwhile, 11% of registrants were under age 50, and age was not specified for 8% of registrants.

    - 46% of registrants were Medicaid-eligible, indicating significant economic hardship.
    - 19% of registrants initially requested services in 2015 or earlier, indicating a wait time of at least (approximately) five years.

Home Care Workers

Data on home care workers in Maryland are **extremely sparse**. According to DLS, 758 residential service agencies provide personal assistance services as part of Medicaid HCBS.[xvi] As of March 2023, 310 agencies had submitted limited aggregate workforce data to the state as required under Chapters 775 and 776 of 2021, reporting that they in aggregate employed 7,208 personal care aides.[xvii] DLS reports that agencies have classified 78% of these personal care aides as employees and 22% as independent contractors (see discussion in Section 4), but does not report any other worker characteristics.

Due to the lack of disaggregated or otherwise detailed administrative data, MDCEP relied on data from the American Community Survey (ACS) for 2017–2021:[xviii]

- MDCEP identified home care workers using a definition from a 2021 report from the Economic Policy Institute. A respondent was classified as a home care worker if they belonged to **both the occupation groups and industry groups** below (data codes in parentheses):
    - **Occupation:** Home health aides (3601), personal care aides (3602), nursing assistants (3603), or orderlies and psychiatric aides (3605); about 48,900 workers estimated statewide
    - **Industry:** Home health care services (8170), individual and family services (8370), or private households (9290); about 56,700 workers statewide
    - At the intersection of these groups, **about 16,100 home care workers** provide care in Maryland.
- Small sample sizes limit the level of detail possible in this analysis. ACS data for 2017–2021 include only 647 respondents identified as home care workers providing care in Maryland.
    - Sample sizes by race/ethnicity range from two respondents ("other race") to 323 respondents (Black).
    - For this reason, in some cases this analysis reports estimates for combined racial groups. Because these groups are highly heterogeneous, such estimates should be taken with extreme caution.[xix]
- Race and ethnicity:
    - 26% of home care workers in Maryland are white (compared to 54% of all Maryland workers)
    - 60% of home care workers are Black (26% of all workers)
    - 5% of home care workers are Latinx (10% of all workers)
    - 6% of home care workers are Asian or Pacific Islander (7% of all workers)
    - 3% of home care workers belong to multiple racial/ethnic groups (3% of all workers)
    - Less than 1% of home care workers are American Indian/Alaska Native or belong to racial/ethnic groups not specifically identified in ACS data (less than 1% of all workers)
- Gender:
    - 84% of home care workers are women (49% of all workers)
    - 16% of home care workers are men (51% of all workers)
    - ACS does not include data for other gender categories
    - 48% of home care workers are Black women (14% of all workers) and 61% are women of color (23% of all workers)
- Other characteristics:

    - 28% of home care workers are parents caring for children under 18 (32% of all workers)
    - 42% of home care workers were born outside the United States (20% of all workers), and 20% are not United States citizens, regardless of documentation status (8% of all workers)
    - 11% of home care workers report a disability (6% of all workers)
- U.S. Census Bureau data on home care workers are likely affected by undercount issues, as research has found that the 2020 decennial census undercounted Black Americans and certain Americans born outside the United States.[xx]

Informal Caregivers

Less is known about informal caregivers than any other stakeholder group. According to the U.S. Census Bureau's Household Pulse Survey, between June 28, and July 10, 2023, **about 55,000 Maryland adults were not employed because they were caring for an elderly person** (6% of adults who were neither employed nor retired and reported that they wished to be employed).[xxi] This does not include people caring for a non-elderly person with a disability, informal caregivers who are also employed, or informal caregivers for whom this is not the primary reason they are not employed.

Fabius et al. (2023) include limited measures of informal caregivers' wellbeing, but no demographic characteristics of caregivers.

2. **ENGAGING STAKEHOLDERS Have stakeholders from different racial/ethnic groups— especially those most adversely affected—been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?**

Stakeholder Engagement for Racial Equity Analysis

MDCEP conducted interviews with eight subject-matter experts to inform this racial equity analysis.

- While HCBS stakeholder groups do not have mutually exclusive interests (see discussion of overlapping interests in Section 4), some focus primarily on workers' concerns, while other focus on consumers' concerns. MDCEP has engaged with four worker advocates (three nonprofit advocates and one labor union staffer), three consumer advocates, and one home care worker.
- The interview subjects included one man and seven women. Three are white, one is Middle Eastern/North African, and three are Black.
- One interviewee reported a disability. One is the parent of a consumer, who has a disability.
- In addition to conducting interviews, MDCEP staff reviewed a panel discussion by several subject matter experts on the state of long-term care data in Maryland.

Several recurring themes have emerged in the course of stakeholder engagement:

- Data on the home care workforce are deeply inadequate, leaving policymakers without sufficient information to make effective and equitable choices.
- Data on the cost of care and agencies' use of funds are inadequate, undermining any assessment of the sufficiency of Medicaid reimbursement rates.

- Low wages and poor benefits hinder efforts to attract or retain home care workers, undermining access to care and quality of care.
- Widespread misclassification of home care workers as independent contractors is an important contributor to low wages and poor benefits (see discussion in Section 4).
- Home care workers do not consistently receive the training necessary to provide quality care and ensure safety.
- While the state conducts limited engagement with the consumer community, policymakers have made no effort to engage with home care workers or worker advocates.

Stakeholder Engagement in Policy

The state's primary venue for HCBS stakeholder engagement is the Community Options Advisory Council, which meets quarterly to "discuss policy, planning and issues with stakeholders, advocates, providers and participants."[xxii]

- Consumers form the majority of the council's membership, as required under federal regulations.
- Although "provider representatives such as labor unions or professional organizations" as well as "other interested community members" are eligible to serve on the council, there is no requirement for worker representation. At least one worker advocate reports having an application for membership denied.
- **Public information on the council's activities is severely limited.** The council's website does not appear to have been updated since 2021, and minutes of past meetings are available only through 2018. MDCEP was unable to locate a list of current members, past members, or meeting attendees on the council's website or in meeting agendas or minutes.

Historically, the state operated an independent provider program, a form of consumer-directed care in which consumers directly hire and work with home care workers. Workers in this program were able to influence policy through collective bargaining, represented by the American Federation of State, County, and Municipal Employees. The state discontinued the independent provider program in 2015, shifting to an agency-only model (see endnote x). MDCEP is not aware of any home care agencies in Maryland with collective bargaining. Agency workers would be able to bargain only with individual agencies, limiting their opportunity to influence state policy. Moreover, the domestic setting of home care may exclude workers from coverage under the National Labor Relations Act.[xxiii]

3. IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

The inadequate state of data on HCBS consumers and home care workers significantly hinders assessment of racial inequities.

Consumers

Little publicly available information exists on consumers' access to care, quality of care, or general wellbeing. Fabius et al. (2023) discuss a set of questionnaires administered to at least some HCBS consumers, which include demographic information (including race and ethnicity) as well as health

outcomes and several measures of general wellbeing. While these data are available to researchers with appropriate privacy protections, there is little evidence that the state regularly analyzes or publishes de-identified statistics within the bounds of applicable law.

The Managing for Results reports published annually with the governor's budget proposal include one relevant measure, the percentage of long-term services and supports consumers who receive state-funded services in community alternatives rather than nursing facilities. In light of the evidence that community-based care improves consumers' wellbeing (see discussion in Section 5), this is an important measure of the state's success in caring for older adults and people with disabilities. However, this remains a deeply incomplete picture. Moreover, these data are not disaggregated by race/ethnicity or any other consumer characteristic, making it impossible to assess *equity* in access to community-based care.

Wait List Registrants

The best data on wait list registrants' characteristics and wellbeing comes from the Hilltop Institute's 2020 analysis.

- A person's presence on the wait list is in itself an indicator of harm, as it indicates an unmet need for care. This is especially true for medically eligible registrants, who are known to have serious disabilities or functional limitations. Most of all, registrants who meet both medical and financial eligibility requirements are known to face serious functional limitations as well as economic hardship, and would be receiving services if more capacity existed. The analysis does not report characteristics of these subgroups.
- The wait list's racial composition indicates racial inequity:
    - 36% of wait list registrants at the time of the analysis were Black, compared to 30% of Maryland residents overall in 2020[xxiv]
    - Up to 61% of registrants were people of color, compared to 51% of Maryland's 2020 population[xxv]
- The analysis also indicates gender inequity, as 63% of wait list registrants are women. The analysis does not disaggregate by gender within racial/ethnic groups.
- 46% of registrants were Medicaid-eligible, indicating significant economic hardship.
- Overall, 19% of registrants initially requested services in 2015 or earlier, indicating a wait time of at least (approximately) five years. Moreover, there appears to be racial inequity in wait times:
    - 15% of white registrants had waited at least five years without receiving services
    - 18% of Black registrants
    - 18% of Asian registrants
    - 29% of all other registrants

Home Care Workers

As with wait list registrants, there are two dimensions of racial inequity affecting home care workers:

- Racial inequities arising from the poor conditions facing *most* home care workers, combined with the concentration of workers of color (especially women of color) among home care workers
- Racial inequities *among* home care workers

Taken as a whole, home care workers in Maryland face considerable hardship:

- In 2022, Maryland home health and personal care aides – an occupational category that strongly overlaps with home care workers – typically took home only $15.26 per hour.
    - This is 38% below the 2022 statewide median hourly wage and only 22% higher than the minimum wage.
    - To afford a basic living standard in Maryland, a single adult working full time and not caring for children would need to take home between $16.75 (Allegany County) and $28.88 (Charles County) per hour in 2022.[xxvi]
- An analysis by the Economic Policy Institute (EPI) found that average hourly wages for home health care workers in Maryland were among the most inadequate nationwide in 2020.[xxvii]
    - Averaging two estimates, Maryland wages were just over half of a benchmark wage recommended by EPI, third-worst among the 50 states.
    - Only Virginia, Texas, and the District of Columbia fared worse by this metric.
- 12% of home care workers in Maryland had family income below the federal poverty line ($30,000 for a family of four in 2023) between 2017 and 2021, triple the poverty rate among people working in Maryland overall.[xxviii]
    - 5% of home care workers in Maryland face "deep poverty," with income less than half the poverty line. This is also triple the deep poverty rate among all Maryland workers.
    - 31% of home care workers in Maryland have family income less than double the federal poverty line, about 2.5 times the rate for Maryland workers overall.
- 10% of home care workers in Maryland do not have health insurance coverage, compared to 6% of Maryland workers overall.
    - Only 44% of home care workers have employer-based health insurance, compared to 75% of Maryland workers overall
- 54% of home care workers in Maryland own their home, compared to 71% of Maryland workers overall.

Data also suggest that important racial and other inequities exist among home care workers. However, these estimates should be treated with caution because they are in some cases based on small sample sizes:

- Black home care workers are twice as likely to have family income below the federal poverty line as white workers
- Men and women who provide home care face similar poverty rates, but the data suggest that women may face near-poverty conditions at higher rates than men, with 20% of women having income between 100% and 199% of the federal poverty line, compared to 12% of men. This estimate should be treated with caution in light of the small sample size for men.
- There are wide disparities in health insurance access among home care workers. One in four Latinx home care workers in Maryland is uninsured (26%), six times the uninsured rate among white workers (4%).
- 74% of white home care workers own their home, compared to only 40% of Black workers.
- 75% of home care workers in other racial/ethnic groups own their homes, but this group is heterogeneous and the estimate is based on a small sample size.

Informal Caregivers

Fabius et al. (2023) include three measures of caregivers' wellbeing, disaggregated by participants' dementia status but no other characteristics:

- 13% of caregivers reported feeling overwhelmed.

- 5% of caregivers reported feeling distressed, angry, or depressed.
- 5% of caregivers reported that they were unable to continue caregiving.

A 2020 article in the journal *The Gerontologist* (Fabius, Wolff, and Kasper 2020) analyzed experiences of white and Black respondents to the 2015 National Study of Caregiving.[xxix] While this analysis was based on a national sample, at may shed limited light on experiences of caregivers in Maryland.

- Black caregivers were younger on average, with 28% of Black caregivers at least 65 years old, compared to 43% of white caregivers.
- White and Black caregivers were equally likely to be employed.
- 54% of Black caregivers reported providing at least 40 hours of care per week, compared to 39% of white caregivers. Only 24% of Black caregivers reported providing 20 or fewer hours of care per week, compared to 39% of white caregivers.
- 83% of Black caregivers reported receiving help with caregiving from family or friends, compared to 76% of white caregivers.
- 16% of Black caregivers reported financial difficulties due to caregiving, compared to only 10% of white caregivers.
- However, Black caregivers were more likely than their white counterparts to report positive personal impacts of caregiving, such as increased confidence or closeness with the care recipient. Black caregivers were also less likely to report that their responsibilities caused emotional difficulties or limited their ability to visit with family or friends.

4. EXAMINING THE CAUSES What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

The current state of Medicaid-funded HCBS exposes different stakeholder groups to different kinds of racialized harm:

- Consumers, wait list registrants, and informal caregivers are harmed by inadequate access to care, continuity of care, and potentially quality of care.
- Home care workers are harmed by poor wages, benefits and working conditions; inadequate training; and a lack of voice in the workplace.

Evidence from MDCEP's expert interviews and existing research makes clear that these harms are closely linked:

- Inadequate access to care is overwhelmingly the result of a severe **home care workforce shortage**.
- The workforce shortage is overwhelmingly the result of **low job quality, most importantly poor compensation**.

Three direct proximate causes are responsible for poor compensation of home care workers, along with a fourth contributing cause:

- **Lack of compensation standards:** Policymakers have not adopted any specific standards for pay or benefits in Medicaid-funded HCBS, in contrast to multiple other domains of state procurement and contracting.
- **Potentially inadequate reimbursement rates:** Medicaid payment rates must cover home care worker wages and administrative costs, and the agency model builds in an expectation of profit. However, not enough data exist to determine whether current payment rates are sufficient to support better wages.
- **Independent contractor misclassification:**
    - A significant number of residential service agencies classify at least a subset of home care workers as independent contractors rather than employees. At the subset of agencies that had submitted legally require aggregate workforce data to the state as of March 2023, 22% of home care workers were classified as independent contractor.[xxx]
    - Guidance from the Maryland Attorney General indicates that this classification is likely inappropriate in the majority of cases, due to the control agencies exercise over terms of employment. Under federal and state law, if the economic reality of the relationship between an agency and a home care worker has the characteristics of employment, the agency must classify the worker as an employee.
    - Misclassification enables agencies to avoid multiple responsibilities. These include minimum wage protections, overtime protections, pay for travel time between clients, and employer-side payroll taxes. Tax shifting alone subjects workers to a hidden 8.3% effective pay cut.[xxxi]
- **Lack of reliable cost data:** Neither the state nor the federal government currently require residential service agencies to report cost data such as home care worker wages, administrative costs, executive compensation, profits, or payments to related entities. This stands in contrast to significantly more detailed federal reporting requirements for Medicaid-funded nursing home care. Without these data, policymakers cannot reliably determine the level of home care worker compensation sustainable under current or proposed payment rates.

A full understanding of the racial inequities in Medicaid-funded HCBS requires an analysis of the historical and cultural forces that led to current policy choices. A 2021 report from the Economic Policy Institute (Banerjee, Gould, and Sawo (2021)) examines these forces:[xxxii]

- **Gendered and racialized devaluation of care work:**
    - Similar to other forms of paid and unpaid care work, home care is overwhelmingly provided by women. Based on 2017–2021 ACS data, 84% of home care workers in Maryland were women, including 49% who were Black women and 12% who were other women of color.
    - Banerjee, Gould, and Sawo explain that care work "has been traditionally treated as 'women's work' and given little to no status," subject to "suspicion regarding whether [care occupations] are 'skilled' jobs," and "treated as having little social value … despite how essential it is."
    - Furthermore, "care work being predominantly borne by women of color dates back to slavery," and after the Civil War, "Black, Mexican American, and Chinese American women served as inexpensive sources of labor in a growing market for workers to do the in-household care work that formerly enslaved people used to do."
- **Devaluation of people with disabilities:**
    - Cultural devaluation of people with disabilities also contributes to poor compensation in home care: "Those who are dependent on care because of disability are not seen or

treated as equal members of society and are marginalized based on how much they are viewed to contribute to the productive structure of the economy."

- **Racist policy choices:**
    - United States employment law – as well as state laws modeled on federal law – contains multiple carveouts that deny protections such as the minimum wage, unemployment insurance, and collective bargaining rights to workers in occupations and industries that at the time were disproportionately Black.
    - Policymakers included these carve-outs in order to secure the support of racist southern Democrats in Congress whose votes were necessary to enact these protections.
    - Policymakers in 1938 excluded domestic workers from the federal Fair Labor Standards Act, which encodes minimum wage and overtime protections and serves as the model for Maryland's wage and hour law. Lawmakers removed this statutory exclusion in 1974, but for decades Labor Department regulations continued to deny protection to home care and similar workers.
    - Although the Obama Labor Department reversed this exclusion, other areas of employment law such as collective bargaining rights and inadequate wage and hour enforcement continue to harm home care workers.
- **Harmful immigration policies:**
    - Based on 2017–2021 ACS data, 42% of home care workers in Maryland were born outside the United States, and 20% are not United States citizens, regardless of documentation status. Migrants are also overrepresented in other forms of care work.
    - Policies such as visas that tie workers to a single employer, failure to recognize professional credentials issued in other countries, and harsh immigration enforcement combine to combine to restrict immigrant workers' opportunities and strip them of bargaining power, with low wages as a predictable result.

5. CLARIFYING THE PURPOSE What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

Purpose and Impacts of Medicaid-Funded Home- and Community-Based Services

Home- and community-based services advance three major policy goals:

- Provide needed assistance to Marylanders who because of age or a disability have difficulty performing activities of daily living (such as walking, eating, or using the bathroom) or instrumental activities of daily living (such as shopping, cooking and eating).
- Make needed assistance available to Marylanders whose income and assets are not sufficient to pay for extremely high long-term care costs, including Marylanders who do not meet traditional Medicaid eligibility requirements.
- Enable consumers to receive assistance while continuing to live in their own home rather than a nursing home or other residential facility, thereby improving quality of life, self-determination, and potentially health outcomes.

The *existence* of Medicaid-funded HCBS intrinsically advances equity along multiple dimensions (provided that the services are delivered with at least a minimum level of effectiveness):

- **Disability:** Medicaid-funded HCBS assist Marylanders with disabilities in meeting their basic needs while remaining in their own homes.
- **Income and wealth:** Medicaid-funded HCBS make assistance available to Marylanders who cannot afford to pay for long-term care out of their income or assets.
- **Race and ethnicity:** Because the vast array of structural barriers facing Black and indigenous Marylanders and other Marylanders of color include multiple social determinants of health, these populations experience higher disability prevalence than their white counterparts, and therefore may have greater need for HCBS. Moreover, because Black Marylanders and other Marylanders of color on average have lower incomes and fewer assets than their white counterparts, improvements in income and wealth equity also translate into improved racial and ethnic equity.
- **Gender:** Medicaid-funded HCBS eases significant care responsibilities for informal caregivers, improving their quality of life and enabling those who wish to do so to advance their paid careers. Evidence from existing research indicates that women are strongly overrepresented among informal caregivers. Furthermore, data on consumers and wait list registrants suggest that women may have greater need for HCBS than men.[xxxiii]

Purpose and Impacts of the FY 2024 Adopted Budget and Implementation Policies

The most notable policy change in the FY 2024 budget is the inclusion of $207 million in additional funding (including $109 million in general funds) for various health care providers, including a significant portion for Medicaid-funded HCBS.[xxxiv] These funds support an 8% increase to certain Medicaid provider reimbursement rates beginning in January 2024, intended to offset increased wage costs under the Governor's Fair Wage Act (HB 549/SB 555), which as enacted will accelerate the state's minimum wage phase-in to reach $15 per hour beginning January 1, 2024.

While the Fair Wage Act is separate from the annual budget, the two are closely linked because budget language makes the additional rate increases contingent on passage of the Fair Wage Act. Taken together, the FY 2024 budget and the Fair Wage Act have potential to advance racial and ethnic equity:

- The Fair Wage Act is expected to temporarily increase wages for a large number of Maryland workers.
    - The governor's original proposal to increase the minimum wage effective October 1, 2023, would have raised wages for about 175,000 workers.
    - Because the prior law already scheduled an increase in the minimum wage effective January 1, 2024 (to $14.00 per hour for large employers, $13.40 for small employers), the number of workers seeing higher wages under the enacted Fair Wage Act may be significantly lower.
    - Of those projected to benefit from the Fair Wage Act as introduced, about 37% are Black, 15% are Latinx, 4% are Asian or Pacific Islander, and 3% belong to other racial and ethnic groups.[xxxv] Overall, about 59% of workers expected to benefit are workers of color.
    - The demographic makeup of workers benefiting from the Fair Wage Act as enacted may differ due to the law's later effective date. However, these differences are likely to be small.
- The rate increase in the FY 2024 budget has potential to advance racial and ethnic equity, to the extent that it translates into higher wages. The Fair Wage Act will likely increase wages for thousands of home care workers, predominantly women of color. Workers who are misclassified as independent contractors may see a small or no wage increase.
- Existing cost data are insufficient to assess the necessity or sufficiency of the governor's proposed 8% additional rate increase. Moreover, if the increase is greater than the amount needed to

support required wage increases, the lack of specific wage standards means that excess funding may not reach workers, leaving achievable equity gains unrealized.

- Impacts on access to care are ambiguous:
    - Considered alone, increased pay for home care workers would likely increase the supply of workers and reduce turnover.
    - However, because a general increase in the minimum wage is the only mechanism raising home care wages, the proposal will do nothing to make home care jobs more competitive, limiting the impact on access to care.
    - To the extent that workers misclassified as independent contractors do not see higher wages as wages in other low-wage jobs increase, the proposal could reduce access to care.
    - Moreover, both the wage increase under the Fair Wage Act and the rate increase in the governor's budget are temporary, reducing the likely impact on labor supply.

6. CONSIDERING ADVERSE IMPACTS What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

Two aspects of the proposal adversely affect racial and ethnic equity by leaving achievable gains unrealized:

- The governor and General Assembly's choice not to include specific wage standards or other worker protections for home care workers limits the proposal's ability to increase wages, especially for misclassified workers and in the long term. This directly perpetuates racialized harms done to home care workers and limits the proposal's ability to strengthen the workforce and improve access to care.
- The governor and General Assembly's choice not to improve data and reporting standards continues a severe data shortage, denying policymakers and the public of the information needed to advance equity. Specifically:
    - The state will continue to lack demographic data – particularly racially disaggregated data – on consumers, current wait list registrants, home care workers, and informal caregivers.
    - The state will continue to lack data on home care workers' wages and benefits as well as hours of care needed and received by consumers.
    - The state will continue to lack data on residential service agencies' cost structures, preventing accurate assessment of the sufficiency of current payment rates.

7. ADVANCING EQUITABLE IMPACTS What positive impacts on equality and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

Potential positive impacts of the proposal on racial and ethnic equity are discussed in detail in Section 5. These include:

- Temporarily increased wages for home care workers who are properly classified as employees (at least 5,600 workers, potentially up to 13,700)

- Possible temporary wage increases for home care workers misclassified as independent contractors (at least 1,580 workers, likely significantly more).
- Possible but highly uncertain improvements in access to care, to the extent that temporarily increased wages due to a general minimum wage increase strengthen the home care workforce.
- Fair Wage Act: Temporarily higher wages for up to 100,000 workers of color across the economy.

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

This section recommends two groups of improvements for policymakers' consideration. Some of these may be achievable through budget language or administrative action, while others would likely require separate legislation.

The governor and General Assembly should consider four improvements to improve home care wages and benefits, which could strengthen the home care workforce, improve access to care, and reduce racialized harms to all stakeholder groups:

- Adopt wage and benefit standards specific to Medicaid-funded HCBS, above and beyond the temporary wage increase under the Fair Wage Act.
- Restrict Medicaid reimbursement of residential service agencies for HCBS to only services provided by workers properly classified as employees.[xxxvi]
- Strengthen home care workers' collective bargaining rights. This could involve reinstating the previous independent provider program, establishing the state as a joint employer of agency home care workers for collective bargaining purposes, or granting private home care workers collective bargaining rights under state law.[xxxvii]
- Increase resources, staffing, and infrastructure for enforcement of worker protections. The most effective enforcement system would include active collaboration between the Maryland Department of Health and the Maryland Department of Labor. MDH's responsibility to provide care to Marylanders needing and eligible for Medicaid-funded HCBS includes a responsibility to take actions necessary to foster a sufficient workforce.

The governor and General Assembly should also consider six improvements to data practices in Medicaid-funded HCBS:

- Require residential service agencies to report individual-level data on home care workers to the state, including wage, classification, benefits, and other appropriate and relevant information.
- Collect race and ethnicity data as well as other demographic information on home care workers, either through agency reporting or direct data collection by the state. Ideally, these data would be linked to compensation and classification data to facilitate analysis of job quality equity. These data should include *at least* the race and ethnicity categories required under the federal Office of Management and Budget data disaggregation standards.[xxxviii]
- Require residential service agencies to report detailed cost data including home care worker wages, administrative wages and expenses, executive compensation, profits, and payments to related entities.
- Administer recurring surveys of consumers, wait list registrants, and informal caregivers, including race and ethnicity, other demographic data, and indicators of wellbeing and unmet need.

- Build capacity for effective data collection and analysis. MDH should actively collaborate with MDL to facilitate collection and analysis. MDH's responsibility to provide care to Marylanders needing and eligible for Medicaid-funded HCBS includes a responsibility to understand the home care workforce and consumer population.
- Presumptively make data public and readily accessible, with the most-detailed degree of data disaggregation appropriate. Data publication should be subject to appropriate legal and privacy guardrails.

9. ENSURING VIABILITY AND SUSTAINABILITY Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement. Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

Available data suggest that the funding amounts appropriated in the adopted budget (contingent on passage of the Fair Wage Act) are sufficient to support the rate increases included in the budget. Much less certain is the necessity or sufficiency of these rate increases to enable agencies to comply with the Fair Wage Act. The state currently does not collect sufficient cost data to assess whether the rate increase is necessary or sufficient to support compliance with the Fair Wage Act.

The FY 2024 budget makes no changes to enforcement, data collection, public reporting, stakeholder participation, or public accountability. The status quo leaves room for improvement along each of these dimensions:

- Nearly all state agencies are experiencing significant staffing shortages, which is likely to hinder effective administration of Medicaid-funded HCBS within MDH as well as effective enforcement of the Fair Wage Act within MDL. General staffing and compensation increases in the adopted budget are likely to gradually lower these obstacles.
- Based on stakeholder interviews, MDH largely considers the home care workforce, wages and benefits, and enforcement of worker protections to be the purview of MDL. A proactive approach to workforce issues would better enable MDH to ensure sufficient access to quality care.
- The state currently collects very little data on HCBS participants, wait list registrants, informal caregivers, or home care workers. The lack of robust data limits policymakers' understanding of the workforce shortage, access to care, job quality, and disparate impacts. The lack of data also prevents public reporting and accountability.
- The steps necessary to improve equity in HCBS, such as higher wages and more robust data collection, would require additional state investments. While federal funds would likely cover a portion of these costs, the state share may require either reductions to other budget areas (which would likely have equity impacts) or additional revenue.

10. IDENTIFYING SUCCESS INDICATORS What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

The first step to track progress in improving equity around Medicaid-funded HCBS is to strengthen data collection and reporting requirements. Section 8 of this analysis discusses data system improvements in detail. Recommendations include:

- The state should collect individual-level data on home care workers, including indicators of job quality such as wage, employee classification, and benefits. These data should be disaggregated by race and ethnicity, using racial and ethnic categories *at least* as detailed as those required under the federal OMB data disaggregation standards.
- The state should collect detailed cost data from residential service agencies in order to assess the adequacy of Medicaid reimbursement rates.
- The state should administer recurring surveys of consumers, wait list registrants, and informal caregivers, including race and ethnicity, other demographic data, and indicators of wellbeing and unmet need.

With a sufficiently robust data system in place, the state should add measures of job quality, labor supply, and access to care to the Managing For Results performance measures published with the MDH budget each year. Performance measures should generally be disaggregated by race and ethnicity. Potential performance measures include:

- Median hourly home care wages, and the ratio of the median home care wage to the statewide median hourly wage
- The share of home care workers receiving insurance, retirement, and other benefits, and the share classified as employees
- Vacancies and turnover at residential service agencies
- The share of authorized HCBS service-hours actually provided
- The length of the HCBS wait list, ideally including the number of registrants actually eligible for services

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[i] For detailed discussion, see Christopher Meyer, "Budgeting for Opportunity: Racial Equity Analysis as a Tool to Advance Justice through Fiscal Policy," Maryland Center on Economic Policy, 2023, https://www.mdeconomy.org/budgeting-for-opportunity-fiscal-policy/

[ii] Terry Keleher, "Racial Equity Impact Assessment," Race Forward, 2009, https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf

[iii] As a built-in part of the budget process, racial equity analysis would ordinarily occur during legislative consideration of the budget, and would therefore be based on the governor's January budget proposal. To avoid confusion and reflect the current policy landscape, this case study instead analyzes impacts of the FY 2024 adopted budget.

[iv] Anne Wagner, "2024FY – Operating Budget Analysis – M00Q01 – MDH Medical Care Programs Administration," Department of Legislative Services, 2023, https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2024fy-budget-docs-operating-M00Q01-MDH-Medical-Care-Programs-Administration.pdf

[v] Keleher, 2009.

[vi] DLS budget analysis, MDH Overview FY 24 https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2024fy-budget-docs-operating-M00-MDH-Overview.pdf

[vii] MDCEP analysis of home care wage estimates from Robertson, Sawo, and Cooper, 2022, and EPI estimates of hourly wage percentiles by state and demographic groups.

[viii] Privacy concerns and legal standards are a legitimate reason for limiting public data access. For an equity analysis performed by state personnel or a contractor, agencies should balance legitimate privacy concerns against the public interest in informed, equitable policymaking, while adhering to applicable law.

[ix] Jennifer Chasse, Fiscal and Policy Note: House Bill 489, Department of Legislative Services, 2023, https://mgaleg.maryland.gov/2023RS/fnotes/bil_0009/hb0489.pdf

[x] Maryland Medicaid Data Port, Hilltop Institute, https://www.hilltopinstitute.org/data/dataport/

[xi] See "Community Services for Older Adults and People with Disabilities," Maryland Department of Health, https://health.maryland.gov/mmcp/longtermcare/Pages/Community-First-Choice.aspx

[xii] U.S. Census Bureau 2022 Population Estimates

[xiii] Chanee Fabius, Roberto Millar, Erick Geil, Ian Stockwell, Christin Diehl, Deircre Johnston, Joseph Gallo, and Jennifer Wolff, "The Role of Dementia and Residential Service Agency Characteristics in the Care Experiences of Maryland Medicaid Home and Community-Based Service Participants and Family and Unpaid Caregivers," *Journal of Applied Gerontology 42*(4), 2023, https://journals.sagepub.com/doi/10.1177/07334648221128286

[xiv] Morgan Smith, "Maryland Department of Health Fiscal 2024 Budget Overview," Department of Legislative Services, 2023, https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2024fy-budget-docs-operating-M00-MDH-Overview.pdf
[xv] "Expanding Access to Long-Term Services and Supports through Home- and Community-Based Services, The Hilltop Institute, 2023, https://health.maryland.gov/mmcp/Documents/JCRs/2020/HCBSexpansionJCRfinal1-21.pdf
[xvi] Maryland currently provides Medicaid-funded home care through an agency-based model in which the state reimburses private residential service agencies for services provided by home care workers employed by the agency.
[xvii] "Personal care aide" is a term defined in Maryland law that can be considered roughly equivalent to "home care worker." Note that "personal care aide" is also a detailed occupation under the Standard Occupational Classification and includes a large subset of home care workers, but the SOC definition is not necessarily equivalent to the definition in Maryland law.

If agencies that had not yet submitted the required data on average employ the same number of personal care aides as those that submitted data, this indicates about 17,600 personal care aides providing Medicaid HCBS altogether. While the Fiscal and Policy Note does not discuss the characteristics of reporting and non-reporting agencies, it is plausible that larger agencies have better-established data and compliance processes, enabling them to submit the required data more promptly. If this is true, the true number of personal care aides may be lower.
[xviii] MDCEP analysis of IPUMS 2017–2021 American Community Survey microdata.
[xix] See discussion in Meyer, 2023.
[xx] "Census Bureau Releases Estimates of Undercount and Overcount in the 2020 Census" (press release), U.S. Census Bureau, March 10, 2022, https://www.census.gov/newsroom/press-releases/2022/2020-census-estimates-of-undercount-and-overcount.html
Robert Warren, "2020 American Community Survey: Use with Caution, An Analysis of the Undercount in the 2020 ACS Data Used to Derive Estimates of the Undocumented Population," *Journal on Migration and Human Security 10*(2), 2022, https://journals.sagepub.com/doi/full/10.1177/23315024221102327
[xxi] Household Pulse Survey, Week 59, Employment Table 3a, https://www.census.gov/data/tables/2023/demo/hhp/hhp59.html
[xxii] "Community Options Advisory Council," Maryland Department of Health, https://health.maryland.gov/mmcp/longtermcare/Pages/Community-Options-Advisory-Council.aspx
[xxiii] "Employee Rights under the National Labor Relations Act," National Labor Relations Board, 2011, https://www.nlrb.gov/sites/default/files/attachments/basic-page/node-3788/employee_rights_fnl.pdf
[xxiv] Maryland State Profile, U.S. Census Bureau, 2021 https://www.census.gov/library/stories/state-by-state/maryland-population-change-between-census-decade.html
Note: These estimates include residents regardless of Hispanic or Latinx origin, to facilitate comparison to the Hilltop analysis.
[xxv] The true share of people of color is unknown, as the "other" group in the Hilltop analysis (20% of registrants) includes registrants for whom race data are missing alongside those belonging to several smaller racial/ethnic groups. The true share depends on the number of white registrants with missing race data.
[xxvi] EPI Family Budget Calculator (with inflation adjustment by MDCEP), 2022, https://www.epi.org/resources/budget/
[xxvii] MDCEP analysis of home care wage estimates from Robertson, Sawo, and Cooper, 2022, and EPI estimates of hourly wage percentiles by state and demographic groups.
[xxviii] Unless otherwise noted, statistics on home care workers in this section are based on MDCEP analysis of IPUMS 2017–2021 American Community Survey microdata.
[xxix] Chanee Fabius, Jennifer Wolff, and Judith Kasper, "Race Differences in Characteristics and Expriences of Black and White Caregivers of Older Americans," *The Gerontologist 60*(7), 2020, https://academic.oup.com/gerontologist/article/60/7/1244/5836537
[xxx] The true proportion of misclassified home care workers may be greater than 22%, if the agencies that had submitted required data as of March 2023 on average place a higher priority on legal compliance than those that had not.
[xxxi] Because misclassified workers are responsible for both employee- and employer-side Social Security and Medicare taxes, payroll taxes total 15.30% of a misclassified worker's gross pay, leaving 84.70% net pay. A properly classified W-2 employee pays only the 7.65% employee-side tax, leaving 92.35% net pay. 84.70% divided by 92.35% equals 91.72%, for an 8.28% effective pay cut. This estimate does not account for income tax, which would likely widen the gap between misclassified and properly classified workers.
[xxxii] Asha Banerjee, Elise Gould, and Marokey Sawo, "Setting Higher Wages for Child Care and Home Health Care Workers Is Long Overdue," Economic Policy Institute, 2021, https://www.epi.org/publication/higher-wages-for-child-care-and-home-health-care-workers/
All quotes in these bullet points, as well as facts not otherwise attributed, are from Banerjee, Gould, and Sawo, 2021.
[xxxiii] Existing data sources do not include information on other gender groups.
[xxxiv] To avoid confusion and reflect the current policy landscape, this case study focuses on the FY 2024 adopted budget. However, if DLS or another state agency conducted racial equity analysis as a built-in part of the budget process, this would occur during legislative consideration of the budget and would therefore focus on the governor's January budget proposal.
[xxxv] "Other racial and ethnic groups" includes American Indian/Alaska Native workers, multiracial workers, and workers belonging to racial groups not specified in census data. Small sample size precludes reporting impacts for these groups individually. Note that this group is particularly heterogeneous, and the aggregate estimate does not necessarily represent the experiences of individual subgroups.
[xxxvi] House Bill 489 of 2023 would have done this.
[xxxvii] For workers denied collective bargaining rights under the National Labor Relations Act, this likely would not be subject to federal preemption.
[xxxviii] The U.S. Office of Management and Budget's Directive No. 15 defines the federal governments standards for disaggregation of data by race and ethnicity. In collaboration with the Census Bureau, OMB is in the process of updating these standards, with proposed changes including the introduction of a Middle Eastern/North Africa race category and consolidation of the race and Hispanic origin questions into a single question. Experts expect these revisions to improve the quality of race and ethnicity data. In all cases, federal standards should constitute a floor, not a ceiling, on the state's responsibility to thoughtfully disaggregate data. See Karin Orvis, "Initial Proposals for Revising the Federal Race and Ethnicity Standards," U.S. Office of Management and Budget, 2023, https://www.whitehouse.gov/omb/briefing-room/2023/01/26/initial-proposals-for-revising-the-federal-race-and-ethnicity-standards/