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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

State Efforts to Improve Direct Care Workforce Wages: State Case Studies Report

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services

by
RTI International

January 2024

Office of the Assistant Secretary for Planning and Evaluation

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This research was funded by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation under Contract Number #HHSP233201500039I and carried out by Research Triangle Institute. Please visit https://aspe.hhs.gov/topics/long-term-services-supports-long-term-care for more information about ASPE research on long-term services and supports (LTSS).

STATE EFFORTS TO IMPROVE DIRECT CARE WORKFORCE WAGES: STATE CASE STUDIES REPORT

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January 9, 2024

Prepared for

Office of Behavioral Health, Disability, and Aging Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHSP233201500039I

Contents

Exhibits

ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ARP	American Rescue Plan
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CNA	Certified Nursing Assistant
COVID-19	Novel Coronavirus
DCW	Direct Care Worker
EVV	Electronic Visit Verification
FFCRA	Families First Coronavirus Relief Act
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
IHSS	In-Home Supportive Services
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MLTSS	Managed Long-Term Services and Supports
NASHP	National Academy for State Health Policy
QuILTSS	Quality Improvement in Long-Term Services and Supports
VA	U.S Department of Veterans Affairs
VBP	Value-Based Purchasing

EXECUTIVE SUMMARY

Direct care workers (DCWs) such as nursing assistants, home health aides, and personal care assistants play an essential role in the health and well-being of over 20 million Americans. Yet wages for these workers lag behind those of other workers with comparable job requirements. Some states have tried to address these issues by implementing policies aimed at improving DCW wages. The purpose of our case studies was to learn from stakeholders across six states--California, Michigan, New York, South Dakota, Tennessee, and Washington--about the key elements of various policies aimed at improving DCW wages. We also sought to understand barriers to improving wages and other aspects of direct care work (including recruitment and retention, job quality, and job satisfaction), and elicited suggestions for what could be done to improve these jobs. To accomplish this, we interviewed stakeholders representing state Medicaid and long-term services and supports (LTSS) offices, residential and home and community-based services (HCBS) provider associations, and worker groups.

Key Elements of Direct Care Worker Wage Policies

Two key elements of wage policies most commonly noted by stakeholders were funding for policies and processes that ensured funds intended for wages made it to workers. Stakeholders discussed the importance of state policies to continue wage increases over longer periods of time as a key element to successful wage policies. This helped avoid the need to continually re-authorize wage polices. Mirroring this, stakeholders consistently noted the challenges posed by lack of or inconsistent funding. Across the six states, the most prevalent challenge discussed was a lack of commitment to increase funding (i.e., Medicaid funding) that would translate into increased DCW wages.

Audit policies that verified that state funds allocated to wages made it to DCWs were noted by multiple stakeholders as important. In their absence, it was not always clear if funds actually reached DCWs. Some stakeholders also noted that variations in defining the types of staff included in the umbrella term “direct care workers” affected who was impacted by policies.

Effects of Policies on Wages

Stakeholders across states agreed that policies have not done enough to improve wages and wages were still too low to retain existing staff and recruit new DCWs. Although most agreed that wages had improved over time (especially recently because of pandemic-related pay increases), most also agreed that there was a long way to go. All stakeholders across all states also agreed that recruitment and retention of DCWs was difficult given competition from other industries. Stakeholders in some states reported that increases in the minimum wage affecting all workers actually worsened the situation, because jobs involving less stressful and strenuous work now pay as much or more than direct care work.

Barriers to Improving Wages and Other Aspects of Direct Care Work

Despite the fact that the states have implemented differing policies to improve DCW wages and other aspects of direct care work, stakeholders repeatedly noted similar barriers. Medicaid reimbursement rates were universally reported to be too low to meaningfully change DCW wages. States also continue to face a workforce shortage due to competition from other low-wage jobs, and COVID-19 has intensified this problem in many states. Several states noted complexities in their policymaking at the state level, including the need to gain buy-in from multiple stakeholder groups. Others noted that efforts to professionalize the field may have unintentionally added barriers to workforce entry by increasing the time and costs of training for potential DCWs to enter the field.

Suggestions for Improving Direct Care Work

Stakeholders consistently noted that direct care work needs to be professionalized in ways that do not overburden workers, and DCWs need to be recognized for the important work they do in the health care system. In addition to improving wages, the top suggestions from stakeholders across states for improving direct care work were as follows:

- **Professionalizing the Field.** This includes ways to help develop workers over time and advance them in their careers, such as opportunities for DCWs to gain skills, move up a career ladder, and receive increased wages as they gain experience.
- **Marketing the Importance of the Work.** This would be accomplished through sustained marketing efforts that highlight the important work of DCWs.
- **Providing Competitive Benefits.** In addition to improved wages, this includes health care benefits, consistent hours, and full-time employment.
- **Creating a Pool of Applicants**. This would include improving the the entrance pipeline to direct care work via sustained recruitment efforts with high schools and community colleges and immigration reform that could provide more workers.

SECTION 1
INTRODUCTION

Direct care workers (DCWs) such as nursing assistants, home health aides, and personal care assistants play an essential role in the health and well-being of over 20 million Americans who receive long-term services and supports (LTSS) at home, in nursing facilities, and in other settings. These workers assist older adults and people with disabilities in completing self-care and other daily tasks. In 2020, 2.4 million DCWs provided care in people's homes, 675,000 provided care in residential care settings, such as group homes and assisted living, and 527,000 provided care in nursing homes (Campbell et al., 2021). This work requires considerable technical and interpersonal skills, but these essential workers receive low pay, rarely receive benefits, and experience high injury rates (Institute of Medicine, 2008; Weller et al., 2020). They typically work inconsistent or part-time hours for multiple employers (Scales, 2021). DCWs are predominately female (86%) and persons of color (59%) and a substantial share of them are immigrants (26%); thus, gender and racial equity are central concerns among this workforce (Campbell et al., 2021). The COVID-19 pandemic has highlighted the essential contributions of DCWs and has exacerbated persistent challenges: low pay, high turnover, competition for workers from other industries, and a high demand for home care services amidst a shrinking pool of workers (Tyler et al., 2021).

Despite the rising demand for services, DCWs continue to earn poverty-level wages. Almost one-half of the direct care workforce (45%) live below the federal 200% poverty level and a similar proportion (47%) rely on public assistance (Scales, 2021). In 2020, national median pay was $13.02 per hour, or $27,080 per year, for home health and personal care aides; and $14.82 per hour, or $30,830 per year, for nursing assistants (U.S. Bureau of Labor Statistics, 2021a, 2021b). Although states have used a variety of methods to meet the growing demand for and to retain DCWs, limited investment in workers' wages across settings remains a major contributor to workforce shortages, high turnover, and poor quality of care (Gandhi et al., 2021; PHI, 2012; Ruffini, 2020).

Wages for DCWs lag behind those for workers in other industries with similar entry-level requirements--such as janitors, retail salespersons, and customer service representatives--which worsens the challenges in recruitment and retention of DCWs (Ong et al., 2002; PHI, 2020; Institute for the Future of Aging Services, 2002). Many DCWs are lost to other sectors that offer similar or higher wages and more flexible schedules, more hours, and other benefits (Campbell et al., 2021).

Some states have tried to address these issues by implementing policies aimed at improving DCW wages. For example, states have used wage pass-through policies, which allocate increases in state Medicaid reimbursement rates directly toward DCW compensation. These policies have targeted the wages of home health aides, personal care aides, and nursing assistants. Some studies have found that wage pass-through policies have minor impact (Yearby

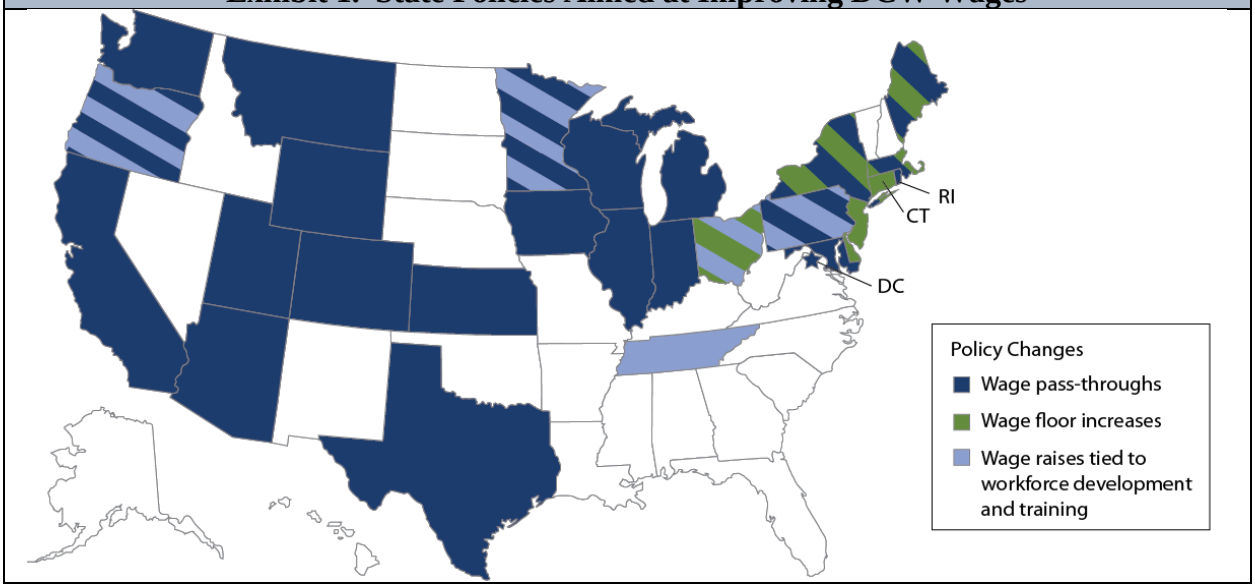
et al., 2020), whereas others show that they have the intended effect of increasing DCW wages (Baughman & Smith, 2010). States have also implemented wage floor policies that dictate the minimum allowable starting wage for DCWs. These policies have primarily targeted the wages of home health and personal care aides. Increasing wages for DCWs after completion of various certifications or training programs has also been tried in a few states.

This report presents results of case studies in six states (California, Michigan, New York, South Dakota, Tennessee, Washington) that have policies specifically aimed at increasing DCW wages, including wage pass-throughs, wage floor (i.e., minimum wage) increases for DCWs, and raises tied to workforce development and training. The purpose of the case studies was to better understand how wage policies have been implemented in states, including the key elements of policies, as well as how these policies may have affected DCW wages, job quality, recruitment, and retention. The appendices include more detailed reference information about each state case study summary.

SECTION 2
METHODS

RTI conducted case studies in six states--California, Michigan, New York, South Dakota, Tennessee, Washington--to explore and better understand their use of policies aimed at improving DCW wages. We selected states based on: (1) an environmental scan that identified past and current state policies and programs aimed at improving DCW wages (see Exhibit 1); and (2) previously conducted interviews with nine subject matter experts including LTSS policy experts, provider associations, worker advocates, and researchers to gain more insight into policies that may influence the wages of DCWs. States were selected in consultation with the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) to reflect an array of policy landscapes.

Exhibit 1. State Policies Aimed at Improving DCW Wages



For the case studies, we conducted interviews in each state with a variety of stakeholders, including state Medicaid and LTSS representatives, representatives from provider groups (including HCBS and residential care) and worker associations. Each state case study included interviews with up to five individuals. RTI drafted interview protocols for each stakeholder type (state and provider/worker associations) and these were reviewed by ASPE to ensure all topics of interest were covered. These included:

- Successes of policies aimed at improving DCW wages.
- Challenges of policies aimed at improving DCW wages.
- The effect of wage policies.

- Barriers to improving wages and other aspects of direct care work, including recruitment and retention, job quality, and job satisfaction.
- Suggestions for other potential improvements to these jobs.

We summarized each state case study and highlighted the state policies or practices identified, the effectiveness of these policies and practices for improving DCW wages, and the key factors related to effectiveness (Appendix A).

2.1 Limitations

The environmental scan was limited to information that is publicly available about state policies aimed at improving DCW wages and did not include a formal analysis of state legislation. This may have limited the information we were able to find about state wage policies and biased which states were selected for the case studies. Our stakeholder interviews are not generalizable and included only six states. Stakeholders that agreed to participate in these interviews may have been different from those who did not participate. In addition, some stakeholders we spoke to were not in their positions when policies were implemented or were unable to provide details about older policies that were no longer impacting wages.

SECTION 3
STATES SELECTED

Below we describe the wage policies in the states included in our case studies. These are also shown in Exhibit 2.

3.1 California

Since the late 1990s, California has implemented a variety of regulations focused on improving wages for DCWs. Beginning in 2016, California has used wage pass-throughs to provide funding to enhance the wages and benefits of DCWs. The in-home supportive services (IHSS) program uses a wage supplement to keep the wages of workers above the minimum wage. California Proposition 56 funding supports various health care programs and has been used to temporarily increase provider rates and supplement payments to DCWs (Yearby et al., 2020).

Federal COVID-19 relief funding available to facilities and home care providers during the pandemic was often put toward DCW pay. California has also claimed the additional Federal Medical Assistance Percentage (FMAP) funding through the American Rescue Plan (ARP) and the state's spending plan for these funds includes increased training opportunities for DCWs (California Legislative Analyst's Office, 2021).

In 2017, California implemented a statewide minimum wage for all workers that will reach $15 per hour in 2023 (California Department of Industrial Relations, 2022).

3.2 Michigan

Michigan implemented a $2.35 wage add-on in response to the COVID-19 pandemic. This wage add-on applies to some DCWs, including those that work in Medicaid HCBS agencies and nursing homes. As discussed in more detail below, the state's definition of DCWs has excluded some workers, such as those working for private pay clients and those working for the U.S. Department of Veterans Affairs (VA), from the wage add-on (Denny-Brown et al., 2020; Michigan Legislature, 2021; NASHP, 2021; WLNS.com, 2021).

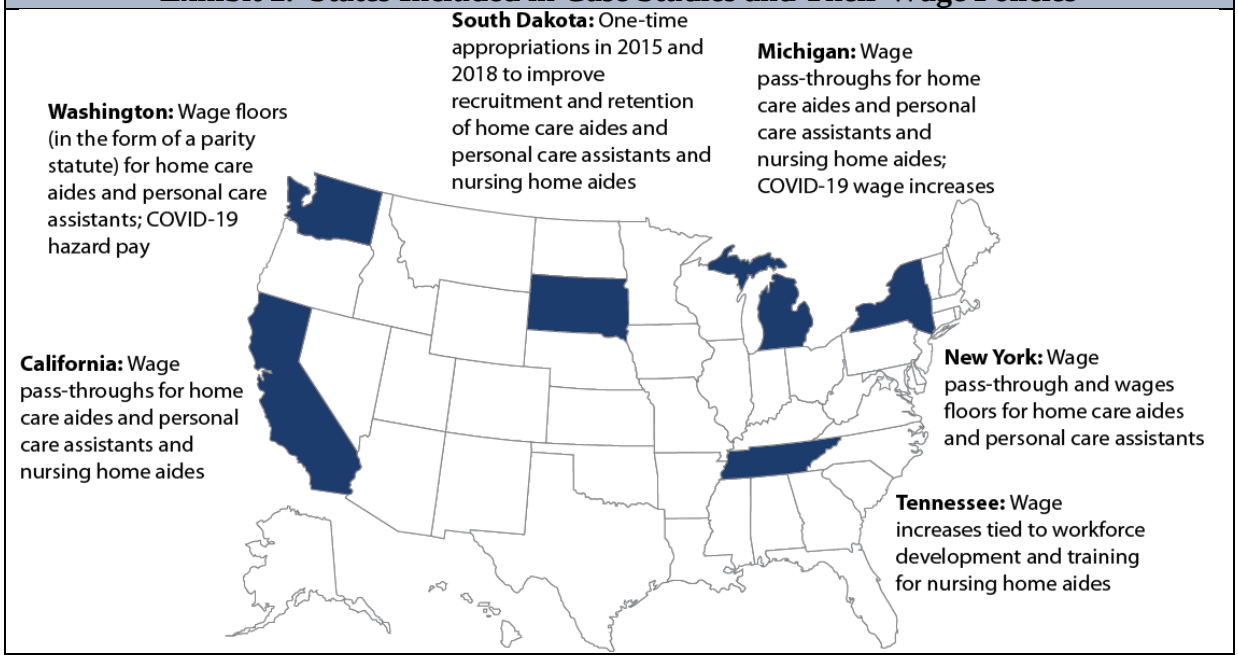
Preceding the pandemic, Michigan had other wage increases in the form of wage pass-throughs, but these policies historically only applied to some types of DCWs in some settings and had a minimal impact on DCW wages. For example, in 2017 the Michigan Legislature appropriated $45 million in state and federal funds to increase DCW wages by 50 cents an hour for workers serving people with developmental disabilities, mental illness, and substance use disorders. The state contractually required providers to use the funds for this purpose, and providers had to report on the use of the funds and the range of wages paid (Montana Legislative Services Division & O'Connell, 2018; Scales, 2017; Yearby et al., 2020).

3.3 New York

New York has used wage pass-through policies to improve wages for home care and personal care aides. Because New York has a managed long-term services and supports (MLTSS) system, wages are passed through managed care organizations (MCOs) to agencies, and then to workers. New York has also used a wage floor--which they refer to as wage parity--in the New York City region. The purpose of the wage parity policy has been to set a minimum compensation package for all personal care and home care aides to address historic imbalances in their compensation that resulted from differences in funding across different home care programs in the state (Yearby et al., 2020). Wages received by DCWs as a result of both wage pass-throughs and wages floors have varied by year, by region of the state, and by LTSS setting.

Legislation passed in late 2021 will require nursing facilities to utilize 70% of their revenue on resident care, and 40% of that amount must be used for DCW wages and benefits (New York State Senate, 2022). As of the date of publication of this report, this policy had not yet been implemented and is being challenged in court (mcknights.com, n.d.).

Exhibit 2. States Included in Case Studies and Their Wage Policies



3.4 South Dakota

South Dakota has issued several short-term policies in recent years to improve DCW wages and job quality. In 2015 and 2018, South Dakota passed one-time appropriations to improve recruitment and retention of DCWs by providing additional Medicaid funding to providers for this purpose (LegiScan, 2015; Montana Legislative Services Division & O'Connell, 2018). They also approved a 10% increase in Medicaid reimbursement rates for nursing facilities for fiscal year 2020. During the COVID-19 pandemic, the state government

issued two rounds of grant funding for nursing facilities with monies from the CARES Act that was used to cover some increased DCW wages, including hazard pay. The South Dakota Department of Social Services has stated they plan to use increased FMAP funding available through the ARP Act to increase DCW wages in future years (South Dakota Department of Social Services, 2021).

3.5 Tennessee

Tennessee has implemented DCW wage enhancements linked to increased training through their Quality Improvement in Long-Term Services and Supports (QuILTSS) value-based payment program. This program rewards nursing facilities for outcomes and has programs focused on workforce development. DCWs in HCBS are excluded from the program (Gifford et al., 2018; Gifford et al., 2019; Hostetter & Klein, 2021; Tennessee Division of TennCare, n.d.).

Tennessee has used Medicaid FMAP funds associated with ARP to institute a pilot program to increase DCW wages through training programs in hopes of increasing wages and decreasing workforce turnover. Tennessee was approved to use additional ARP funding to pass funds to providers with the condition that all funding be used to increase DCW wages. The Tennessee Medicaid department has verbally committed to seek recurring funding for those increases beyond the period funded by the ARP (LeadingAge, 2020; NASHP, 2021).

3.6 Washington

Washington State has a parity statute, passed in 2006, mandating that wage increases gained through collective bargaining for DCWs in self-directed programs, also known as individual providers, also apply to DCWs employed by agencies. This parity policy creates a statewide standardized compensation rate for all Medicaid home care workers (Yearby et al., 2020). Washington also implemented a wage pass-through law from 2017 through 2019 that increased rates to home care agencies to be used exclusively for improving DCW wages and benefits.

Washington has used funds received from the Families First Coronavirus Relief Act (FFCRA) for a COVID-19 related hazard pay wage enhancement, resulting in a wage increase of approximately $2.40 per hour for all DCWs who work for agencies serving Medicaid beneficiaries. This policy began in April 2020 and remains in effect as of March 2022 (ATI Advisory, 2020; Musumecia et al., 2020; NASHP, 2021). Washington also passed a ballot initiative in 2011 requiring increased training, background checks, and home care aide certification (PHI, 2020).

SECTION 4
CASE STUDY FINDINGS

4.1 Overview

We conducted 28 stakeholder interviews across the six states, and stakeholders consistently identified funding and methods for ensuring funds reached DCWs as the key elements of successful wage policies. Stakeholders discussed the importance of state policies that ontinued wage increases over longer periods of time as this helped avoid the need to continually re-authorize wage polices. Mirroring this, stakeholders also consistently noted the challenges posed by lack of or inconsistent funding. Across the six states, the most prevalent challenge discussed by stakeholders was the lack of commitment to increase funding (i.e., Medicaid reimbursement rates) that would translate into increased DCW wages.

Stakeholders also reported that auditing processes that ensure DCWs receive funds as intended have been a key element contributing to the success of wage policies. Without such processes it was not clear if funds intended for DCWs made it to those workers.

Although stakeholders reportedly believed that DCW wages had improved over time, primarily due to market trends, most agreed that much greater improvement was needed in this area. Some stakeholders reported their state's policies improved wages temporarily but did not provide sustained improvement. In addition, many reported that competition in pay from other industries had increased, especially in the wake of the COVID-19 pandemic. Other entry-level jobs now pay as much as or more than direct care jobs. In some states, stakeholders said this was because the minimum wage had been increased for all workers in their state, but DCW wages did not increase because their wages were already above the new minimum.

We also asked stakeholders what barriers existed to improving worker wages and other aspects of direct care work, such as retention and recruitment, job quality, and job satisfaction. The most commonly reported barriers were low Medicaid reimbursement rates, cumbersome processes (i.e., competing policy objectives) and conflicting policies (i.e., competing budget priorities), worker availability, and barriers to workforce entry.

When asked what else could be done to improve direct care work and attract the workers that are currently needed in this field and will increasingly be needed in the future, stakeholders consistently said:

- Professionalizing direct care work.
- Marketing the importance of the work.
- Providing competitive benefits.
- Creating a pool of applicants.

These findings are detailed in the sections below.

4.2 Key Elements of Policies

Case study stakeholders were asked to reflect on the key elements of the wage policies that have been implemented in their state, including successes and challenges related to those key elements. Stakeholders discussed the importance of consistently funding DCW wage policies over longer periods of time and the challenges that arise when funding is inconsistent. They also noted the importance of auditing policies that ensure funds intended for DCWs reach those workers. Some stakeholders discussed the need to define "direct care worker" uniformly across policies.

4.2.1 Funding for Wage Increases

California, Michigan, and South Dakota stakeholders all discussed the importance of state policies that were implemented to continue wage increases over longer periods of time as a key element of successful wage policies. State and provider group stakeholders in California said that although wages had increased over time the general approach had been to increase wages in a Medicaid wage pass-through every few years. Likewise, in Michigan a worker group stakeholder described being pleased with the recent addition of a permanent annual wage add-on in their fiscal year 2022 state Medicaid budget. This removes the need to re-authorize the add-on every quarter, as was done through 2020 and 2021. A South Dakota state representative added that increases in Medicaid reimbursement are a long-term solution because raising Medicaid rates can be more sustainable than one-time wage increases.

> *It's nice to get that [one-time appropriation] and it sure helps, but when it's gone, it's gone. It's not the long-term solution unless they [state legislators] want to do that every year."*
>
> *- South Dakota Provider Association Representative*

In two states, Michigan and South Dakota, many stakeholders noted that the funding resulting from the public health emergency (e.g., CARES Act) had been of great assistance to them during the pandemic. They agreed that the increase in funding as a result of the public health emergency had sustained providers' ability to offer higher wages. Michigan stakeholders added that the funding helped to maintain staffing levels and to recruit new workers. A Michigan provider group stakeholder also noted that funds are reimbursed for the add-on in a timely manner, generally within two weeks. A provider group from South Dakota described how the added funding helped facilities to maintain their operations throughout the pandemic.

Stakeholders in Washington, however, worried that DCWs and providers have become accustomed to the temporary pay increase, and that the removal of this wage enhancement would disrupt the workforce and cause an exodus to jobs in other sectors that may pay similarly and be less demanding. Stakeholders from California, Michigan and Tennessee added that pandemic rescue funds were not long-term solutions and should be expanded so that provider and workers

view the funding as sustainable. Likewise, stakeholders in California and Michigan feared the temporary nature of the COVID-19 add-on rates during the pandemic could potentially decrease retention of workers as the pay increase could be viewed as unstable. A New York provider group stakeholder also added that nursing homes where the staff are unionized, and typically offer a higher wage, still had to offer yet higher wages because no provider could opt out of the wage add-on.

A challenge related to funding discussed across all states was the lack of commitment to increase funding (i.e., Medicaid funding) that would translate into increased DCW wages. Stakeholders from five states--California, New York, Michigan, Tennessee, and South Dakota--commented on the need for greater state commitment to increases in Medicaid funding to support wage increases. California provider group stakeholders added that consumers end up paying for the lack of funding because DCW wage increases are passed onto them as a result. Stakeholders added that more families are starting to turn to "under-the-table care" (i.e., making cash payments directly to workers for care services) where staff and client protections are not ensured. Longer-term, these providers questioned the viability of their operations.

> *"They're asking you to commit to this program and increase wages for individuals without any commitment of dollars on the back end."*
>
> *- Tennessee Provider Group Representative*

4.2.2 Ensuring Funds Reach Direct Care Workers

New York, Michigan, and Washington stakeholders described monitoring and auditing processes as a positive strategy to ensure the wage pass-through (New York) and wage add-on (Michigan, Washington) made it to the workers and increased their pay. In New York, an MLTSS state, monitoring is important for ensuring the payment makes it to the worker via the MCO and home care agency. However, some stakeholders in New York noted that the MLTSS design has complicated efforts to improve DCW wages since funds go to MCOs and then to the providers. Due to this, the state has no oversight or recourse to tell the MCOs what to pay providers as they must negotiate hourly rates. State representatives also experience a similar challenge with value-based purchasing (VBP) payments being passed to providers first, but noted they do not always get passed onto DCWs in the form of higher wages. Conversely, New York provider group stakeholders said that flexible policies that allowed funds to be used for things other than just wages (e.g., training, transportation costs) were more successful because they enabled employers to create packages that best suited individual DCWs.

In Michigan, state monitoring started from the beginning of the wage add-on at the start of the pandemic and ensures that the money goes to the DCWs. Stakeholders in Washington similarly noted that their add-on wages require auditing and tracking that ensure workers receive the increased wages. On the other hand, South Dakota representatives described limitations to the design of their policies that would ensure workers receive the funding. Specifically, Medicaid

reimbursement rate increases have been intended to increase DCW wages, but policies have not actually required funds to be spent on wages.

4.2.3 Definitions of Direct Care Workers

Defining the types of staff included in the umbrella term "direct care workers" was cited as a key element of policies. Stakeholders in Michigan, New York, and Tennessee noted variations and limitations in the definition of DCWs as a challenge. Michigan stakeholders discussed disparities in the applicability of their COVID-19 add-on rate because all DCWs in the state had not been included in the policy definition. Some described how the policy was written only to apply to workers providing services to Medicaid-eligible clients, excluding DCWs working in VA settings or those working for private pay agencies or clients. In addition, one Michigan stakeholder described that the policy governing the COVID-19 add-on rate also excluded supervisors of DCWs potentially disincentivizing supervisors to continue in their jobs if they were making less than the staff they supervise. Stakeholders in Michigan also reported the lack of uniformity of the definition of DCWs across payer types (e.g., private pay, Medicaid and Medicare) led to increased burden to parse out which workers were eligible vs. ineligible for the COVID-19 add-on wage.

> *"You might have two direct care workers working side by side, and one's getting the premium pay and one isn't."*
>
> *- Michigan Worker Advocacy Organization*

Likewise, New York stakeholders indicated their COVID-19 wage add-on had similar difficulties and that this same challenge had occurred when the state adopted their wage pass-through policy. A Washington worker group stakeholder referenced the absence of nursing home workers from the state's parity statute as a challenge. Consequently, nursing home DCWs are subject to more sporadic, less standardized pay increases.

4.3 Effect of Policies on Wages, Retention/Recruitment, Job Satisfaction

Stakeholders across all states generally agreed that wages were too low to both retain existing and recruit new DCWs, although most agreed wages had improved over time, especially more recently because of the additional funding and demand for workers due to the COVID-19 pandemic. All stakeholders, across all states, agreed that recruitment and retention of DCWs has become even more difficult given competition from other industries in the wake of the COVID-19 pandemic.

4.3.1 Effect on Wages

Wages have increased over time, according to stakeholders in most case study states, but most evidence demonstrating this success is anecdotal. In Michigan, stakeholders noted that no formal evaluation of their wage pass-throughs in 2010 or 2017 had ever been completed while a

state representative confirmed it was too early to know the impact of the wage add-on introduced during the COVID-19 pandemic.

> *"The wages or the rates per day are still very low relative to the to the demand and the need."*
>
> *- California Provider Group Stakeholder*

Stakeholders from most case study states (California, Michigan, South Dakota, Tennessee, and Washington) agreed that, due primarily to market forces and competition for workers, substantial wage increases have occurred more recently. South Dakota described increases of about $4 per hour over the past three years as result of one-time appropriations in response to a spate of nursing home closures and increased funding available to the state from COVID-19 relief funding. However, this wage increase was specific to certified nursing assistants (CNAs) in nursing homes. In Michigan and Washington, COVID-19 add-on wage increases provided an additional $2.35/hr. and $2.40/hr., respectively. Some Michigan provider group stakeholders added that this assistance enables them to provide a wage of $15-20 per hour. One Tennessee provider group stakeholder noted they have increased DCW wages by about 10% as a result of the FMAP funding available to the state from COVID-19 releief funding. Both California and South Dakota stakeholders commented that, though wages have increased, wages have not increased at a rate that significantly impacts workers due to commensurate increases in cost of living. They also mentioned that Medicaid reimbursement rates do not incentivize wage increases by providers. A Washington provider group stakeholder credited the 2011 ballot initiative requiring additional DCW training and credentialing with raising wages.

Provider group stakeholders in Tennessee described the limited effect the state's VBP program (QuILTSS) has had on DCW wages. One provider stakeholder explained the low level of wage increases resulting from the program noting that "the incentive to participate, it's just not compelling enough" and added "… it's like a 50 cent pay increase [tied to] completion of a number of [required training] modules."

4.3.2 Effect on Recruitment and Retention and Job Satisfaction

Stakeholders across case study states described the difficulty they have competing with other industries that are offering higher starting hourly wages. In California, provider group stakeholders described how their members pay well over the minimum wage but still have challenges with turnover. Provider and worker group stakeholders also commented that DCW benefits, including paid sick time, overtime rules, meal and rest periods, and requirements that employers provide health insurance, help to reduce attrition and attract new workers.

A Michigan provider group stakeholder stated that the add-on wage had helped members to pay DCWs and had assisted with retention but that recruitment challenges remain. In New York, the recent minimum wage increase for all workers in the state had increased competition to both recruit new workers and retain current DCWs, according to stakeholders.

> *"… there's less reason to be a CNA if you can leave and go work in fast food or retail for a similar amount of money."*
>
> *- New York Worker Group Stakeholder*

A state representative from South Dakota voiced similar concerns about DCW recruitment and retention but explained this is because of the state's low Medicaid reimbursements rates, which lag behind surrounding states. Two South Dakota provider group stakeholders also noted that the one-time appropriations help with staff retention, if only for six months, because they often go towards bonuses for DCWs. Multiple stakeholders in Washington mentioned state minimum wage laws, enacted in 2017 (Washington State Department of Labor and Industries, n.d.), and the higher Seattle minimum wage law, as possibly having a positive effect on DCW wages, recruitment, and retention.

4.3.3 Other

California state officials and worker group representatives reported that because IHSS workers are unionized, they are able to negotiate higher wages at the county level. In response to disability rights advocates, changes were also made to the IHSS program allowing this group of DCWs to perform non-invasive medical tasks, like medication management, which are linked to higher wages.

A Washington worker group stakeholder cited the presence of collective bargaining for the state-paid DCWs in self-directed programs as a major source of higher wages--something both public and private DCWs benefit from as a result of the parity statute.

4.4 Barriers to Improved Direct Care Worker Wages, Recruitment, and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work during case study interviews. While each state has its own barriers, several themes emerged.

4.4.1 Insufficient Medicaid Reimbursement Rates

The most commonly mentioned barrier was insufficient Medicaid reimbursement rates. All state representatives and a majority of stakeholders reported this as a barrier for improving wages. Even states that reported regular increases in reimbursement rates said that these increases have not kept up with the actual costs of providing care. In California, for example, reimbursement rates are based on cost reports that are two years old. A stakeholder in New York reported that the trend factor for home care rates had not been increased in over 11 years. South

Dakota noted that while they have had significant increases in recent years, their reimbursement rates are still far below those of neighboring states. Providers depend on Medicaid reimbursement as a major source of revenue, so they reported that when reimbursement rates are not adequate, they are unable to raise wages in a way that positively impacts their direct care workforce. This is especially true if providers do not have clients with a mix of private insurance and public benefits.

> *"If Medicaid reimbursement is woefully inadequate, how do you offer a wage that's going to compete with hospitals and clinics and doctor's offices? You can't."*
>
> *- Washington Provider Group Stakeholder*

4.4.2 Cumbersome Processes and Conflicting Policies

Stakeholders in several states reported that the decision-making processes within their states hinder them from improving the field of direct care work. Provider group stakeholders in California thought there are "too many voices" involved in decisions related to the direct care workforce, which slows growth and leads to overregulation. For example, a provider group representative reported that the union has come out against the state creating a feeding assistant position. One provider group stakeholder in New York noted that policymakers have implemented policies that shift care into the community without also creating policies to attract and support the workers needed to implement that care. This ignores that fact that money saved through systemwide change could be used to improve the wages of DCWs. Two states--Michigan and New York--acknowledged the competing budget priorities officials must overcome when considering additional funding to strengthen wages for this workforce. In a state like New York with a large Medicaid program, for example, increases in DCW wages through reimbursement rates have an enormous fiscal impact on the budget as a whole.

4.4.3 Low Worker Availability

Four states--California, South Dakota, Tennessee, and Washington--noted low worker availability as a challenge for improving aspects of direct care. Stakeholders from these states talked about how they are recruiting from the same pool of workers as other low-wage jobs, such as hospitality and retail. These other kinds of jobs have similar wage opportunities but are notedly less physically and emotionally demanding than direct care work. Stakeholders also noted that other fields are able to offer perks--like work from home opportunities or tuition reimbursement--that the direct care field has a harder time offering due to the nature of the work and slim revenue margins. Stakeholders in New York and South Dakota talked about how DCWs need to be offered additional supports, such as career development opportunities, childcare, paid time off, and mileage, in order for the field to be competitive.

> *"It's hard for me to blame someone for thinking maybe I'd rather run the cashier somewhere than do this, especially if it pays the same."*
>
> *- South Dakota Provider Group Representative*

South Dakota officials noted additional issues with their workforce availability due to the rural nature of the state and low unemployment rates. Stakeholders there said that the rural parts of the state are emptying out and there are few job seekers from which to recruit. Tennessee stakeholders noted that their state lacks any sort of "pipeline" that can be used to get people interested in the work and into the field.

The COVID-19 pandemic has also made recruiting workers more challenging. Stakeholders in all states reported that while DCW availability may have been a longstanding issue, the pandemic has made it even more challenging. A stakeholder from California noted that workers in all fields were re-evaluating what they need and want from jobs, and that direct care work has not been able to meet those changing needs. Stakeholders in Michigan reported that vaccine mandates may put added burden on workers and cause challenges with recruitment.

4.4.4 Barriers to Workforce Entry

It can also be challenging for DCWs to enter the field. Stakeholders in California said that the training requirements for CNAs were "restrictive" and limit the number of people who are willing to go into and remain in the field. In Washington, the training and credentialing ballot initiative from 2011 increased DCW wages, but also created additional barriers to entry into the workforce in terms of training time and costs for potential DCWs. Stakeholders also talked about how a "lack of legitimacy" for this field poses challenges in recruiting and retaining workers in that potential DCWs do not see this as a long-term career. In California, one stakeholder said that there needs to be more awareness by elected officials and the general public as to what direct care work entails. A worker group stakeholder in Michigan stressed the need for a standardized and inclusive definition of DCW, stating this would make future policy reforms more seamless. States are working to "professionalize" the field as a way to increase wages and work quality, while at the same time balancing the burden it places on the workers.

South Dakota and Tennessee also mentioned several barriers that were specific to their states. A worker group stakeholder in South Dakota noted that state policies that limit or disincentivize unionization leave workers without the ability to negotiate for wage increases or advocate for policies aimed at recruiting or retaining the workforce. In Tennessee, several provider group stakeholders said their state's complicated Electronic Visit Verification (EVV) system, which includes three different EVV programs depending on the payer, creates unnecessary complexity and results in DCW dissatisfaction. State representatives also reported that some providers have not bought into Tennessee's state initiatives, like the QuILTSS program.

In summary, despite interviewing diverse states with a variety of policies in place intended to impact DCW wages and work, there were several barriers that came up repeatedly with stakeholders and states. Medicaid reimbursement rates were universally recognized as too low to impactfully change DCW wages. States also face a workforce shortage due to competition from other low-wage jobs. COVID-19 has intensified this problem in many states. Several states

noted complexities in their policymaking at the state level. Others noted that while it is important to professionalize the field, that can also add additional barriers to workforce entry.

4.5 What Else Could be Done to Improve Wages and Other Aspects of Direct Care Work

We asked stakeholders to suggest what else could lead to improvements in wages and other aspects of direct care work.

4.5.1 Professionalizing the Field

Stakeholders discussed different ways the field could be professionalized and the impact this could have on recruitment and retention of DCWs. Stakeholders from five of the six states we interviewed talked about ways direct care work could be transformed to help develop workers over time and advance them in their careers. Provider and worker group stakeholders agreed that to recruit people into the field, there need to be opportunities for DCWs to gain skills, move up a career ladder, and receive increased wages as they gain experience. The creation of these kinds of career ladders show DCWs there is value in and a reason to improve and advance skills.

One home care provider organization representative in California talked about the benefits of expanding the scope of work for home care aides. He noted that other states have allowed home care aides to receive training for and provide help with tasks like medication management, taking vital signs, and working with feeding tubes and catheters. This expansion of scope could help grow the job for DCWs, ease some burden for home health agencies, and improve quality of care.

> *"We find ourselves in a really unique opportunity right now to continue to demonstrate this workforce, both in institutional and home-and community-based settings, as part of the essential health care system."*
>
> *- California Worker Group Representative*

Another aspect of professionalization is the development of training and credentialing opportunities. In Michigan, a worker group stakeholder outlined the need for competency standards and mapping those standards to a credentialing program. According to this stakeholder, this would help ensure "a universal direct care worker has all of the competencies they need in order to work with any payer, any program, any population of care recipients." Credentialing would help create a common understanding of the types of tasks DCWs perform.

4.5.2 Marketing the Importance of the Work

Stakeholders from four states--California, Michigan, New York, and Washington--talked about the importance of a sustained marketing effort to shine a light on the important work of DCWs. While the pandemic may have provided the public with a short-term understanding of the kinds of care DCWs provide, stakeholders thought more could be done to demonstrate the value of the work. Michigan, for example, is working to increase visibility of DCWs through

media campaigns with the goal of increasing respect for DCWs. A worker group in California reported that they are trying to change the perception of the work. This stakeholder said elected officials and the general public think of direct care work as "glorified babysitting," but noted that there is "a really unique opportunity right now to continue to demonstrate this workforce, both in institutional and home and community-based settings, as part of the essential health care system."

4.5.3 Providing Competitive Benefits

Three states' stakeholders discussed ways this field could be more competitive with other sectors that provide similar wages. Michigan stakeholders noted that annual living wage increases could keep wages from falling behind other sectors. They also said that the provision of benefits and incentives like signing bonuses would help providers remain competitive and attract workers to these jobs. Stakeholders from Washington mentioned that making the temporary COVID-19 hazard pay wage enhancements permanent would drastically improve the long-term outlook of DCWs and providers. In Washington and New York, stakeholders thought improving DCW schedules by ensuring consistent hours and providing full-time work would help with retention.

4.5.4 Creating a Pool of Applicants

Stakeholders from California, New York, and Washington discussed the need for a larger pool of DCW applicants. California and New York stakeholders talked about the importance of improving the entrance pipeline to direct care work. A provider representative in California specifically noted creating sustained recruitment efforts with high schools and community colleges as part of that effort. Immigration reform was also noted as a need by both types of provider groups in California and Washington. They felt immigration reform could help bolster the direct care workforce in the United States by providing more workers.

4.5.5 Using Technology Solutions

Stakeholders in three states noted various ways the field could be improved by using technology. State representatives from New York suggested that providers could employ technology solutions to better match DCWs to clients. A home care provider organization in California talked about how some providers are using a gig economy model to allow workers to choose their own hours and clients. While not specific, a state official in South Dakota thought that there could be some technological innovations to help supplement direct care work or improve efficiency.

4.5.6 State-Specific Improvements

Stakeholders also had ideas about how to improve the field in their own states. A provider organization in California thought minimum staffing requirements in nursing homes should be more flexible as the state tries to pull out of the worker shortage. The worker group representative in South Dakota talked about the importance of unionization in improving wages

and other aspects of direct care work. Stakeholders in Tennessee thought there needed to be provider incentives for enrolling DCWs in programs such as QuILTSS, as well as decreased administrative burdens in direct care work.

4.6 Future State Plans to Address Direect Care Worker Challenges

The pandemic has forced states to rethink the value of DCWs and how to incentivize people to enter the field. Stakeholders in most states noted the use of ARP funds and FMAP increases will bolster the field moving forward, but with varying specificity.

4.6.1 California

Provider group stakeholders and state officials noted a continued focus on improving the direct care workforce in California. They pointed to the most recent budget (State of California, 2022) and HCBS spending plan (California Health and Human Services Agency, 2021) for a more detailed outline of what the state plans to do. The state has plans to increase funding for the health care workforce, including training opportunities, pilot programs, scholarships, loan repayment, and worker incentive payments.

4.6.2 Michigan

Michigan state officials reported that they will be looking more closely at career pathways that would allow DCWs to be able to use their work "as a ladder toward economic opportunity." A provider group stakeholder noted the work they are doing to build "consistent and robust training curricula for direct care workers" that is supported through the state, helps DCWs market their skills, and ties into a credentialing or certification program.

4.6.3 New York

Officials in New York noted the additional funding from the ARP will help them test innovations to improving the workforce. They plan to work directly with agencies to learn more about how they will spend ARP funds and then survey those agencies to measure success. Additionally, a provider group stakeholder said that the governor's proposed budget had a line item for $3,000 retention grants to workers.

4.6.4 South Dakota

Provider group stakeholders and state officials in South Dakota also noted the ARP when discussing future state plans. According to the state official, "55% of that money that the state will receive can be used for the purposes of worker bonuses and wages. I think that will be a big lift to the people in those sectors. That won't include our nursing homes, but it will include some assisted living and all the home care that happens in the state." A residential provider stakeholder noted that they were also hoping to access some of that money, but it was unclear if they would be able to.

4.6.5 Tennessee

Tennessee state officials noted the audit processes they are putting in place to ensure ARP wage funds are going to DCWs and said they are making sure they are "much more prescriptive" about how those funds can be used because it "builds in a much higher level of accountability."

4.6.6 Washington

Washington State officials noted a budget change related to the parity statute this year. They are attempting to correct disparities between self-directed home care workers and home care agency employees. Because many DCWs in the self-directed program are parents of the person being cared for, they receive some tax exemptions that home care agency employees do not receive. Therefore, home care agencies were having to use money that was intended for DCWs to pay their tax obligation. The budget is being adjusted to correct for this, so agency workers will receive the same pay as DCWs in the self-directed program.

SECTION 5
CONCLUSION

We interviewed 28 stakeholders in six states about policies aimed at improving wages for DCWs, including key elements of policies, the effect of policies on wages and other aspects of direct care work, barriers to wage improvement, recruitment and retention, and suggestions about ways to improve direct care work.

Consistent funding of wage policies through Medicaid reimbursement rate increases was repeatedly cited as directly related to successes, challenges, and barriers. It was noted as a successful element of policies when funding increases were continual, rather than requiring re-authorization year after year. It was reported as a challenge when funds were not adequate to continually support wage increases year over year. It were described as a barrier to DCW recruitment, retention, and job satisfaction when Medicaid reimbursement rates did not keep pace with market trends. Many stakeholders noted this was especially an issue in the wake of the pandemic with wages in other industries increasing and DCW wages unable to compete.

While stakeholders universally agreed that wages for DCWs need to be improved, they also suggested other aspects of direct care work that need improvement. Many discussed the need to professionalize the workforce in ways that improve opportunities for career advancement, such as through career ladders or training and credentialing. It was also suggested by many that direct care work needs to be better respected and that policymakers and the general public do not understand the important role these workers play in the health care system or how difficult the work is. Some suggested that marketing campaigns around these issues were needed.

Stakeholders across states also noted that, in addition to increased wages, DCWs need to receive benefits, such as health insurance and paid leave. In some cases, lack of these benefits was due to the inability to achieve full-time work with many direct care jobs being offered only as part-time positions. Relatedly, many DCWs have little control over their work hours and may lose hours when providers lose clients.

Finally, many stakeholders described the need for a pool of applicants for direct care jobs and suggested that programs needed to be developed to funnel potential workers into this field. However, with the issues of low wages, lack of benefits, and few opportunities for career advancement still outstanding, it is difficult to envision the field attracting the needed number of workers in the near future.

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APPENDICES

California Case Study Summary

DCW Wage Policies in California

Since the late 1990s, California has implemented a variety of regulations focused on improving wages for DCWs. Beginning in 2016, California has provided funding to enhance the wages and benefits of workers who provide direct care at least 75% of the time. The IHSS program uses a wage supplement to keep the wages of workers above the minimum wage. California Proposition 56 funding supports various health care programs and has previously been used to temporarily increase provider rates and supplement payments to DCWs. The Home Care Services Consumer Protection Act ensures home care workers are receiving appropriate wages.

All interviewees noted additional funding provided to facilities and home care providers during the COVID-19 pandemic was often put towards DCW pay. California has also claimed the additional FMAP funding through the ARP. All respondents also noted that the state has implemented a $15 minimum wage for all workers.

Improving the wages of DCWs has been a point of focus in California for many years due to an increasing aging population, according the state Medicaid office and two provider groups. One noted that California "was already seeing potential issues with our direct care workforce population and… [the pandemic has] really focused the prioritization on addressing those issues moving forward."

Stakeholders noted the following successful elements of these policies, as well as challenges with the policies.

Successful Elements of Policies

- State representatives and provider group stakeholders noted that DCW wages have increased over time. Although policies have raised wages, one provider group noted that they need a sustained increase rather than "just a one-time pass-through for a couple years."

Challenges with Policies

- Both the home-based and facility-based provider group stakeholders we spoke with noted that although providers are able to submit for reimbursement of up to 95% of the cost of DCW wages, the funding available through Medi-Cal is capped, which does not allow providers to get the full reimbursement amount to which they are entitled. According to one provider group, "for every dollar a skilled nursing facility adds to salaries and wages, they only get 93 cents back from the state on net."

- Provider and worker group stakeholders also noted that most rate increases have been temporary or require continual re-authorization by the state.

- There were mixed opinions on how successful the state has been in auditing the policies. One provider group that represents both home- and facility-based providers noted that

unions allege the money from these policies does not make it to workers. However, another facility-based provider group stakeholder reported that the state heavily audits these kinds of policies, and where the money goes is very transparent.

- Stakeholders from the home care provider groups noted how challenging these wage policies have been for providers trying to keep their businesses open. They reported the costs incurred by raising wages are passed on to consumers, which makes the hourly cost of care more than what many older adults can afford. The result of increased costs for consumers has more people turning to "under-the-table care," where neither workers nor consumers are protected.
- One provider group noted that the Medicaid reimbursements are based on two-year-old cost reports, which "in a rising wage environment, makes it even more difficult."

Effect of Wage Policies

Stakeholders spoke of the mixed results policies have had on wages and other aspects of direct care work. The state reported that there have been "significant increases in wages." However, provider and worker group stakeholders said that "the wages or the rates per day are still very low relative to the to the demand and the need." Although wages have increased, they have not done so at a rate that significantly impacts workers, and Medicaid reimbursement rates do not incentivize wage increases by providers.

Three provider group stakeholders reported that even though their members pay significantly over the minimum wage, they still have trouble competing with other low-wage jobs. One said "the biggest impact on wages and increases in wages for DCWs has been pressure from other fields."

The state and worker group reported that because IHSS workers are unionized, they are able to negotiate wages at the county level. This group of DCWs has also been able to negotiate the ability to do non-invasive medical tasks like medication management.

We also asked stakeholders what else effects wages, job quality, recruitment, and other aspects of direct care work. Provider and worker group stakeholders mentioned the various protections and benefits in place for DCWs, including paid sick time, overtime rules, meal and rest periods, and health insurance requirements.

Home and facility-based worker groups mentioned that the direct care workforce is impacted by the use of temporary or unlicensed workers in California. The shortage of workers has driven facilities to turn to temporary workers from registries to meet minimum staffing requirements. The prices charged by workers on registries are "extremely exorbitant" compared to the wages of permanent workers and paying these temporary workers "just takes money off the bottom line that they can't use for their permanent staff." Home care agencies are competing with "domestic referral agencies" which do not have to pay license fees or have insurance

because they are independent contractors. This allows them to be in the market at a lower cost than home care agencies that are licensed by the state.

Improving Wages, Job Quality, Worker Recruitment and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work, as well as what else could be done to improve wages and other aspects of direct care work.

Barriers to Improving Wages and Other Aspects of Direct Care Work

- The most common barrier noted by stakeholders is the lack of state funding in the form of Medicaid reimbursement rates.
- Provider group stakeholders thought there are "too many voices" involved in decisions related to the direct care workforce, which slows growth and leads to overregulation.
- Training requirements for CNAs were noted as "restrictive." These requirements limit the number of people who are willing to go into and remain the field.
- All stakeholders said staffing availability has worsened since the pandemic and thought that workers are re-evaluating what they want from a job, and direct care work does not offer some of the perks that other fields paying the same wage offer. The example that most often came up was that this work cannot be done remotely.
- The worker group noted that there is still a "lack of legitimacy" to the field, and there needs to be more awareness by elected officials and the general public as to what direct care work entails.

What Else Could be Done to Improve Wages and Other Aspects of Direct Care Work

- Moving forward, California could improve direct care work by creating a viable career path and opportunities for advancement. All provider and worker group stakeholders noted that to recruit people into the field, there need to be opportunities to gain skills, move up a career ladder, and receive increased wages as they gain experience.
- Stakeholders also noted the need for sustained recruitment efforts by working with high schools and community colleges.
- Immigration reform was noted as a need by both types of provider groups. They felt immigration reform could help bolster the direct care workforce in the United States.
- One home care group stakeholder noted they are working with the state to expand the scope of home care aides to include things like medication management, taking vital signs, and working with feeding tubes and catheters. He said that expansion of scope would help grow the job, ease some burden for home health agencies, and improve quality of care.
- One facility-based provider group stakeholder thought California could be more flexible with minimum staffing requirements as the field attempts to rebuild the workforce. This would help keep facilities afloat without needing to reduce their census.

Conclusion

California has been working for years to improve DCW wages and the field as a whole, with mixed results. Although wages and benefits have improved, competition with other low-wage jobs is high, and the tight margins at home care agencies and nursing facilities are intensified by wage increases. The state has recommitted to developing the workforce moving forward, as shown in the most recent budget and HCBS spending plan. Stakeholders are hopeful that the initiatives laid out will help to improve the health care workforce as a whole.

Michigan Case Study Summary

DCW Wage Policies in Michigan

Michigan implemented a $2.35 wage add-on in response to the COVID-19 pandemic. This wage add-on applies to some DCWs, including those that work in Medicaid HCBS agencies and nursing homes. The state's definition of DCWs has excluded some workers from the wage add-on. Stakeholders viewed these exclusions as problematic for worker retention and recruitment, and as an administrative burden because it does not universally apply to all payers.

Preceding the pandemic, Michigan had other wage increases in the form of wage pass-throughs, but few stakeholders discussed these policies because they have little impact at present. According to one state representative, these policies also historically only applied to some types of DCWs in some settings.

Stakeholders noted the following successful elements of these policies as well as challenges with policies.

Successful Elements of Policies

- Most stakeholders agreed the wage add-on has been popular among providers because it enables them to offer a competitive wage, maintain current staffing levels, and recruit new workers.
- Many stakeholders commented that the wage add-on has been extended and increased over the course of the pandemic, sustaining providers' ability to offer higher wages.
- According to stakeholders, the wage add-on is designed to go directly to the workers and is monitored by the state.
- A workers group stakeholder and a state representative explained that the fiscal year 2022 wage add-on was added to the state budget as permanent and would no longer be issued quarterly, though it still would need to be re-issued annually.
- A workers group stakeholder noted that their advocacy efforts were successful in expanding the definition of workers eligible for the wage add-on, but that some workers remain excluded.
- A state representative commented that media attention about the wage add-on helped to increase awareness about the direct care workforce.
- One provider group stakeholder noted that funds are reimbursed for the add-on in a timely manner, generally within two weeks.

Challenges with Policies

- All stakeholders commented that the limited number of workers represented in the state's definition of DCWs eligible for the wage add-on had been one of the biggest challenges. Although most stakeholders recognized the types of DCWs eligible for the add-on had

been expanded over time, some types of workers are still not included, such as private pay and those working for the VA.

- Stakeholders stated that the administrative workflow of parsing out eligible versus ineligible workers has presented some challenges (e.g., separate tracking and reporting). Additionally, they voiced concerns about how best to convey to some workers that they are not eligible when other of their peers are eligible. A workers group stakeholder explained, "You might have two DCWs working side by side, and one's getting the premium pay and one isn't."
- A state representative explained that the wage add-on had unintended consequences leading to DCW supervisors making less than the workers they supervised.
- A state representative commented that in fiscal year 2021, the wage add-on was issued in quarterly increments, creating concern among agencies that it would not continue. As a result, providers were "put on edge," worried that this could create a disincentive among their workers to continue.
- According to a state representative, agency reimbursements are delayed, disadvantaging some smaller agencies with fewer resources.
- One provider group stakeholder also added that union buildings that typically offer a higher wage still had to offer yet higher wages, because no provider could opt out of the wage add-on.
- For the state's wage pass-through policies, a state representative commented that, similar to the wage add-on, previous pass-throughs had not applied to all DCWs. This representative highlighted that the policies "led to inequity where you had the same types of workers working in different programs."

Effect of Wage Policies

Stakeholders had no concrete evidence of the effect of the wage add-on or previous wage pass-throughs. One state representative commented that there has not been enough time to assess the effects of the add-on. Some stakeholders did provide anecdotal evidence about how the wage add-on had increased the total wage providers offered. One state representative commented that it helped increase the hourly wage to almost $15 per hour, and a provider group stakeholder said the add-on helped some of their members get closer to $20 per hour. A provider group stakeholder added that, to their knowledge, no public evaluation of the wage pass-through program had ever been funded.

State and provider group stakeholders agreed that the wage add-on helps to retain workers and attract new recruits. Two of these stakeholders described how the increase promotes increased job satisfaction. One provider group stakeholder said "… [T]here's no doubt throughout the pandemic. The fact that Michigan has this in place has helped us. It has helped the sector be able to pay these higher wages again to retain what we have." A workers group

representative said, “I can tell you that the $2.35 wage increase did make a difference in terms of retention… if you talk to the providers, they will tell you ‘absolutely.’” That representative added that there are still recruitment challenges.

Improving Wages, Job Quality, Worker Recruitment and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work. We also asked stakeholders what else could be done to improve wages and other aspects of direct care work.

Barriers to Improving Wages and Other Aspects of Direct Care Work

- All stakeholders stated that lack of adequate funding is a primary challenge in improving DCW wages. One representative from a provider group said, “When you look at the margins in our industry, they're so slim that without having the increase in the reimbursement funds, there really just is no room to do anything independently.”
- A state representative commented that competing priorities in the state budget process sometimes have an impact on additional funding to strengthen wages for the workforce.
- Two provider group stakeholders discussed the effect the COVID-19 pandemic has had or will have on the workforce. One stakeholder discussed how vaccination policies vary across health care settings, creating confusion and a possible disincentive for workers to continue working in some settings.
- A worker group stakeholder stressed the need for a standardized and inclusive definition of DCW, stating this would make future policy reforms more seamless.

What Else Could be Done to Improve Wages and Other Aspects of Direct Care Work

- Some stakeholders commented that wages are still lagging. One provider group explained that the add-on still does not provide a living wage. A few stakeholders added that annual living wage increases would help.
- Multiple other stakeholders said that the provision of benefits and other incentives, such as signing bonuses, would help providers remain competitive and attract workers to these jobs.
- Beyond wages, the professionalization of DCWs is a key priority in Michigan. A state representative said, “I think there's a really strong business case for supporting the direct care workforce, because what we're seeing is as more and more people have aging family members, it is impacting workers in the fact that there's a lot of absenteeism related to caregiving responsibilities. So having a stronger direct care workforce will allow us to hopefully mitigate some of that absenteeism and lots of productivity for our businesses.”
- A provider group stakeholder said that there needs to be training and credentialing opportunities created. A workers group stakeholder outlined the need for competency standards and mapping those to a credentialing program. A statewide employer-led coalition has submitted a list of competency and professional ethical standards to

Michigan's Department of Health and Human Services to help ensure that "a universal direct care worker has all of the competencies that they need in order to work with any payer, any program, any population of care recipients."

- The state is also working to increase visibility of DCWs through media campaigns. The first campaign launched in 2021. The idea behind the campaign is to "elevate the value of direct care workers" through "increased respect and value."

Conclusion

Michigan has implemented a few different policies to increase wages through previous wage pass-throughs and the wage add-on in response to the pandemic. Despite these policies, providers commonly expressed concerns that different types of DCWs had unequal access to wage increases. Michigan is trying to create a universal DCW definition to help improve these policies. Beyond wage increases, stakeholders and the state are seeking to professionalize the workforce to improve retention and recruitment of new workers, and to raise the value of the workforce through media campaigns.

New York Case Study Summary

DCW Wage Policies in New York

New York has used wage pass-through policies to improve wages for home care and personal care aides. Because New York has a MLTSS system, wages are passed through MCOs to agencies, and then to workers. New York has also used a wage floor--which they refer to as wage parity--in the New York City region. The purpose of the wage parity policy has been to set a minimum compensation package for all personal care and home care aides to address historic imbalances in their compensation that resulted from differences in funding across different home care programs in the state. Stakeholders noted that Service Employees International Union championed both of these policies. State representatives also acknowledged a need to improve DCW wages.

Several stakeholders noted that New York has been increasing their statewide minimum wage over the past several years. This has proceeded at different rates across different regions, with the New York City area reaching a minimum wage of $15 first and other regions following.

Recently passed legislation will require nursing facilities to utilize 70% of their revenue on resident care, and 40% of that amount must be used for DCW wages and benefits. This policy has not yet been implemented and is being challenged in court. One stakeholder reported that a key reason for these legal challenges is that the requirement applies to all revenue and not just funds from the Medicaid program.

Stakeholders noted the following successful elements of these policies as, well as challenges with the policies.

Successful Elements of Policies

- Stakeholders, including state representatives, noted the importance of monitoring wage pass-throughs to ensure that the payment makes its way from the MCO to the agency and to the worker. New York has used certifications, attestations, and audits to monitor this.
- Provider group stakeholders said that flexible policies that allowed funds to be used for things other than just wages (e.g., training, transportation costs) were more successful because they enabled employers to create packages that best suited individual DCWs.

Challenges with Policies

- Stakeholders noted that the move to MLTSS in New York has complicated efforts to improve DCW wages. This is because funds go to MCOs, and the state does not have a mechanism to tell MCOs what to pay providers; providers must negotiate hourly rates.
- Provider group stakeholders noted that the negotiated hourly rate for home care must be used for wages, benefits, worker training, and other administrative and job supports. And they argue that there is little understanding of all that goes into that rate bundle.

- Provider group stakeholders also reported that laws meant to improve wages have not been accompanied by changes in Medicaid funding to support increased wages. One stakeholder noted this was despite a statute requiring adjustments to reimbursement rates so that providers can cover increased wage requirements.

- State representatives reported that different challenges arise from policies in different regions of the state.

Effect of Wage Policies

Stakeholders were unable to say if policy changes had an effect on DCW wages. However, the state pointed to the tremendous growth of their HCBS program since wage parity was instituted as a sign that policies were working.

Stakeholders spoke primarily of the effect the statewide increase in the minimum wage for all workers has had on DCW recruitment and retention. Stakeholders said that as wages have increased for workers across may industries, there is little financial reason for people to choose to enter or remain in direct care. As one stakeholder stated, "The rest of the workforce has been catching up with [DCWs] over the last several years as we've implemented this minimum wage." Another said, "As that gap [in wages] has now shrunk, there's less reason to be a CNA if you can leave and go work in fast food or retail for a similar amount of money."

Improving Wages, Job Quality, Worker Recruitment and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work. We also asked stakeholders what else could be done to improve wages and other aspects of direct care work.

Barriers to Improving Wages or Other Aspects of Direct Care Work

- Provider group stakeholders said that Medicaid reimbursement rates have not kept up with the marketplace. One reported that the trend factor for home care rates in New York has not been increased in over 11 years.

- Relatedly, state representatives and a worker group stakeholder noted that any efforts made to improve wages or other aspects of direct care work has enormous fiscal impact on the state budget due to the size of New York's Medicaid program. These stakeholders suggested that additional federal support may be needed.

- One provider group stakeholder suggested that a siloed view separating workforce policies from broader policies that drive demand for services was also an issue. In other words, policymakers have implemented policies that shift care from hospitals and other institutions into the community without also creating policies to attract and support the DCWs needed in that setting. This ignores that fact that money saved through systemwide change could be used to improve the wages of DCWs.

- Some stakeholders acknowledged that DCWs also need access to other supports, such as training, career development, transportation, and childcare.

What Else Could be Done to Improve Wages or Other Aspects of Direct Care Work

- Stakeholders said that policymakers need to make a commitment to this workforce because they save the system money overall by keeping people in their homes. This commitment could be in the form of:
  - Promoting the value of the occupation.
  - Improving the entrance pipeline to direct care work.
  - Building career ladders.

- State representatives also suggested ways that providers could improve this work:
  - Helping DCWs achieve full-time work so they qualify for benefits.
  - Employing technology solutions to better match DCWs to clients.

Conclusion

New York has used wage pass-through and wage floor policies to try to improve DCW wages, especially among home care workers. There is little evidence that these policies have had the intended effect on wages or other aspects of direct care work. In fact, many stakeholders thought that the state's increase in the minimum wage among all workers was making direct care work a less attractive career because similar wages could now be earned in other (possibly less demanding) industries. Some provider group stakeholders reported that efforts to improve DCW wages in New York are complicated by the MLTSS system in which Medicaid pays MCOs who pay providers, who then pay workers. This system also requires providers to negotiate rates with MCOs. Most stakeholders said that Medicaid reimbursement needs to be increased so that workers can be paid more, and state representatives said that additional federal funding of Medicaid is needed. Others noted that money saved by moving care into the community should be passed along to DCWs. Stakeholders also suggested that direct care work could be improved by better valuing these workers, improving the pipeline of workers, and building career ladders.

South Dakota Case Study Summary

DCW Wage Policies in South Dakota

South Dakota has issued several short-term policies in recent years to improve DCW wages and job quality. In 2015 and 2018, South Dakota passed one-time appropriations to improve recruitment and retention of DCWs. They also approved a 10% increase in Medicaid reimbursement rates in 2019. During the COVID-19 pandemic, the state government has issued two rounds of grant funding for nursing facilities with monies from the federal CARES Act. Stakeholders noted that they planned to use increased FMAP funding to increase DCW wages in future years.

Worker and provider group stakeholders noted that the state passed the one-time appropriations in 2015 and 2018 because there was some additional funding available in the state budget, likely due to sales tax revenue. A provider group stakeholder said that the Medicaid reimbursement increase happened after several facility closures "got people's attention in the legislature." This stakeholder also noted that the latest increase happened as a result of money made available through the Federal Government. Worker and provider group stakeholders all noted that they attempt to advocate on behalf of their members to the legislature for these kinds of increases.

Stakeholders noted the following successful elements of these policies, as well as challenges with policies.

Successful Elements of Policies

- The state representative and a provider group stakeholder noted that increases in Medicaid reimbursement rates are the most successful kind of policy change because they are more sustainable than one-time measures.
- The worker group stakeholder said that over the past several years, the most impactful policies have been related to ballot initiatives rather than legislative priorities.
- One provider group stakeholder noted that CARES Act money has helped facilities stay afloat during the pandemic.

Challenges with Policies

- Stakeholders from both provider groups and the state noted that although providers may be happy to get the one-time appropriations, the monies are not a long-term solution. They report that the state is reluctant to spend money that comes from a one-time source on a program that requires continuous funding, like Medicaid reimbursement rates. In the state's view, "money that the state gets on a one-time basis should go to a one-time project."
- A worker group stakeholder noted that the policies often do not specifically require additional funding to go toward worker wages, so they do not feel an appropriate amount

of funds actually makes it to workers. They also noted that because workers are not unionized in South Dakota, they have no real ability to negotiate wages.

Effect of Wage Policies

Medicaid reimbursement increases are helpful, but one provider group stakeholder noted that a 10% increase does not equate to a 10% bump in wages because there is no requirement that a certain percentage go to wages. The residential provider group stakeholder noted that they prefer the Medicaid reimbursement increases remain flexible and allow administrators to spend money on what they think is most pressing in their buildings. He said that even with that flexibility, internal wage surveys over the past three years show the wages of CNAs in nursing homes have gone from about $10 per hour to $14 per hour. He said, "If you continue to increase our reimbursement, that money is going to find its way into those wages." However, he also noted that South Dakota is far behind the reimbursement rates of surrounding states, making it challenging to recruit and sustain workers. The two provider group stakeholders also noted that the one-time appropriations do help with staff retention, if only for six months, because they often go towards bonuses for DCWs.

Improving Wages, Job Quality, Worker Recruitment and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work, as well as what else could be done to improve wages and other aspects of direct care work.

Barriers to Improving Wages and Other Aspects of Direct Care Work

- All respondents noted that Medicaid reimbursement rates are the main barrier to improving wages and other aspects of direct care work in South Dakota. A worker group stakeholder noted that many people in South Dakota depend on Medicaid for their health care, so facilities are not getting reimbursed by private insurance as much. Because Medicaid reimbursement rates are so low, it is difficult for providers to keep their businesses afloat if they do not have a mix of private and state reimbursement for services.

- According to both provider group stakeholders, South Dakota has low unemployment rates, which means there are very few available workers from which to draw. Both of these stakeholders and state representatives also noted that the challenge of finding available workers is especially prevalent in rural parts of South Dakota, which "are slowly emptying out and makes it harder to draw people in."

- The residential provider group stakeholder and state representative noted the physical and emotional burden of the job, which is leading to burnout among DCWs. The provider group stakeholder said that this leads to a "vicious cycle" where employees leave their work at nursing facilities, putting more burden on the staff who stay and making it more difficult for administrators to recruit staff.

- Providers are also competing with other low-wage jobs. Both provider group stakeholders and the state representative agreed that $14 an hour is not an appropriate wage for DCWs,

and that these kinds of workers have other types of jobs to choose from that are much less demanding. One said, “It's hard for me to blame someone for thinking maybe I'd rather run the cashier somewhere than do this, especially if it pays the same.”

- A worker group stakeholder noted that state policies that limit or disincentivize unionization leave workers without the ability to negotiate for wage increases or advocate for policies aimed and recruiting or retaining the workforce.
- DCWs in South Dakota lack benefits like paid time off, sick leave, or guaranteed mileage pay, according to the worker group stakeholder. They also noted that they often lack set hours.

What Else Could be Done to Improve Wages and Other Aspects of Direct Care Work

- All respondents agreed that improving Medicaid reimbursement rates would improve DCW wages. However, the worker group stakeholder noted that it is important to ensure some percentage of that increase goes directly towards wages, and a provider group stakeholder advocated for flexibility for administrators to determine how to spend that money.
- The worker group stakeholder also noted that unionization could ensure that the state “couldn't make their own rules to hinder employee voices.”
- One provider group stakeholder talked about how important it was for the state to work on making direct care work feel more professionalized.
- Another noted the work they are doing with the state Department of Education to boost interest in the field among high school students.
- The state representative noted that there could be some technological innovations to help supplement direct care work or improve efficiency.

Conclusion

South Dakota has made attempts to improve DCW wages, but policies have most often been on a short-term basis. Although Medicaid reimbursement rates have increased in recent years, South Dakota’s reimbursement still lags significantly behind the rates of surrounding states and the country. Stakeholders agree that continuing to increase these rates is the most impactful policy the state could implement to improve DCW wages.

Tennessee Case Study Summary

DCW Wage Policies in Tennessee

Tennessee's QuILTSS value-based payment program rewards nursing facilities for outcomes and supports workforce development. DCWs in HCBS are excluded from the program.

Tennessee has used Medicaid FMAP funds associated with the ARP to institute a pilot program to increase DCW wages through training programs in hopes of increasing wages and decreasing workforce turnover. Tennessee also plans to use additional ARP funding to pass funds to providers with the condition that all funding be used to increase DCW wages. The Tennessee Medicaid department has verbally committed to seek recurring funding for those increases beyond the period funded by the ARP.

Stakeholders noted the following successful elements of these policies, as well as challenges with policies.

Successful Elements of Policies

- State representatives say the QuILTSS program incentivizes workers by tying wage increases to the completion of trainings designed to improve care quality.
- The state also expects the pilot program to reduce turnover and training costs by identifying staff committed to higher levels of training and quality care.

Challenges with Policies

- Provider group stakeholders universally report complaints about the QuILTSS program. Specifically, multiple provider group stakeholders expressed concern over the lack of recurring funding in the QuILTSS program. One stakeholder said "they're asking you to commit to this program and increase wages for individuals without any commitment of dollars on the back end."
- Provider group stakeholders explained many facilities are already doing trainings similar to those in the QuILTSS program, but the stringent standards in the QuILTSS program disqualify these pre-existing trainings from counting toward certifications. This means providers who have already been training their workers--but not in the QuILTSS approved trainings--may lose money because their QuILTSS quality score will go down, which in turn causes rates to decrease.
- Provider stakeholders criticized the one-size-fits-all approach of the QuILTSS program and generally felt their input has not been considered. Provider group stakeholders reported that the program is too complex, onerous for DCWs, and is not adaptable.
- One provider group stakeholder mentioned the inadequacy of the FMAP funding, saying a 9-10% increase in reimbursement will not cover the 25% increase in wages the state expects (i.e., the state has said they expect workers to be paid $12.50/hour).
- State representatives cited the "challenge and the difficulty in making sure that the dollars get to the people that it's supposed to get to," explaining rate enhancements paid to

providers from the QuILTSS program and rate increases sometimes do not get passed onto DCWs in the form of higher wages.

- A state representative further said, “most of what had been done pre-COVID was just increases into rates with an expectation that the increases in the rates was for the purpose of increasing the wages of frontline staff, but without real accountability mechanisms built in to make sure that that was actually happening.”

Effect of Wage Policies

Provider group stakeholders report the QuILTSS program has had minimal effect on DCW wages. One provider stakeholder expressed dismay over the low level of wage increases resulting from the program, noting that “at the incentive to participate, it's just not compelling enough. In some cases… it's like a 50 cent pay increase on a completion of a number of those modules.” State representatives mentioned that due to the COVID-19 pandemic, they have not yet been able to implement the incentives that would provide additional pay. A provider group stakeholder stated that the program may lead to more workforce turnover because of the complexity and demand of the training process. DCWs may choose to leave the industry and make equivalent or more money rather than complete these time-consuming trainings that potentially offer minimally higher wages.

One provider group stakeholder noted they have increased DCW wages by about 10% as a result of the FMAP funding.

Improving Wages, Job Quality, Worker Recruitment and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work. We also asked stakeholders what else could be done to improve wages and other aspects of direct care work.

Barriers to Improving Wages and Other Aspects of Direct Care Work

- All provider group stakeholders agreed that low Medicaid reimbursement levels are the main barrier to improving wages.

- All stakeholders noted that other industries, such as retail and fast food, offer wages competitive to those of DCWs, and the challenging nature of direct care work causes many workers to leave for jobs in other sectors.

- Several provider group stakeholders said Tennessee’s complicated EVV system, which includes three different EVV programs depending on the payer, creates unnecessary complexity and results in DCW dissatisfaction.

- Several provider stakeholders also mentioned the one-time nature of ARP funds as a barrier. These appropriations help “keep the boat afloat… but it doesn’t really address long-term wages where we’d like to get them to and where we’d like to sustain them.”

- One provider group stakeholder cited the lack of a pipeline into the workforce as a barrier, saying “if we don't make individuals available to be employed, it really doesn't matter what the wage is.”
- State representatives reported that providers have not bought into state initiatives like the QuILTSS program, which is a major barrier.

What Else Could be Done to Improve Wages and Other Aspects of Direct Care Work

- All provider group stakeholders said that improving provider incentives for enrolling DCWs in programs such as QuILTSS would increase wages and improve job quality, recruitment, and retention.
- Provider group stakeholders suggested more training opportunities or pathways, such as explicit wage increases for CNA certifications for HCBS workers.
- One provider group stakeholder said that reducing the administrative burden in direct care work in Tennessee, such as simplifying the EVV system, would improve these jobs.

Conclusion

Tennessee has increased DCW wages through the QuILTSS program and additional FMAP funds received from the ARP. The QuILTSS program has not been popular with providers due to its complexity, inflexibility, burdensome training requirements, and lack of significant wage increases. The FMAP funds have led to wage increases, but the one-time nature of the payments does not present a long-term solution to funding issues. Provider group stakeholders advocate for increased Medicaid reimbursement rates and additional training opportunities, and state representatives argue that provider rate increases are not always passed on to DCWs in the form of higher wages. All stakeholders agree that the difficult nature of direct care work and low pay results in recruitment and retention struggles, especially considering the increasingly competitive pay from other less demanding sectors. All stakeholders also suggested direct care work could be improved by better valuing DCWs and creating opportunities for career advancement.

Washington State Case Study Summary

DCW Wage Policies in Washington

Washington State has a parity statute, passed in 2006, mandating that wage increases gained through collective bargaining for DCWs in self-directed programs, also known as individual providers, also apply to DCWs employed by agencies. This parity policy creates a statewide standardized compensation rate for all Medicaid home care workers. Washington DCW unions worked together with private home care agencies to advocate for this legislation in an effort to eliminate the need to continually lobby the state legislature for wage increases and to minimize competition for workers between the self-directed programs and home care agencies. Relatedly, our environmental scan identified a wage pass-through law implemented from 2017 through 2019 that increased rates to home care agencies to be used exclusively for improving DCW wages and benefits. A provider group stakeholder clarified that the state agency is no longer be the employer of record for individual providers in self-directed programs. This removes the state from collective bargaining negotiations with DCW unions.

Washington has used funds received from the FFCRA for a COVID-19 related hazard pay wage enhancement, resulting in a wage increase of approximately $2.40 per hour for all DCWs who work for agencies serving Medicaid beneficiaries. This policy began in April 2020 and remains in effect today. Washington also passed a ballot initiative in 2011 requiring increased training, background checks, and home care aide certification.

Stakeholders noted the following successful elements of these policies as well as challenges with policies.

Successful Elements of Policies

- Stakeholders appreciate the standardization of the parity statute and that it is applied automatically. Once collectively bargained wages increase, or agencies raise pay for their workers, wages automatically rise for the opposite group of DCWs. This mitigates the need for continual lobbying to the state legislature for wage increases.
- Stakeholders also emphasized that the parity statute stabilizes the home care direct care workforce by guaranteeing equal pay between state-run and private agencies, meaning workers have less incentive to switch agencies due to compensation concerns.
- Multiple stakeholders mentioned how the COVID-19 hazard pay has helped stabilize the direct care workforce, and therefore the standard of care across the state. The wage increase means that Washington is among the states with the highest DCW wages, and this has led to lower rates of worker turnover than in some other states.
- Worker and provider group stakeholders also mentioned how the COVID-19 hazard pay has been administratively straightforward and less burdensome because the increased pay goes directly to workers.

- A provider group stakeholder said the training and credentialing ballot initiative passed in 2011 raised DCW wages by creating a more competent workforce.

Challenges with Policies

- All stakeholders expressed concern over the temporary nature of the COVID-19 hazard pay wage increases. The wage bumps have been extended on a three-month basis since April 2020.
- Stakeholders worry DCWs and providers have become accustomed to this temporary pay increase, and that the removal of this wage enhancement would disrupt the workforce and cause an exodus to jobs in other sectors that may pay similarly and be less demanding.
- A worker group stakeholder referenced the absence of nursing home workers from the parity statute as a challenge. Consequently, nursing home DCWs are subject to more sporadic, less standardized pay increases.
- The same worker group stakeholder also mentioned that the state's individual providers and private agencies have different tax structures that sometimes causes private agency workers to receive less after-tax pay.

Effect of Wage Policies

The parity statute does not inherently raise wages, but stakeholders report the standardization of wages across providers leads to improved job quality and retention. One worker group stakeholder felt that "there is a level of stability stemming from these policies in the home care workforce here that doesn't exist as much in other states."

Stakeholders universally asserted that the COVID-19 hazard pay has had a clear effect on wages. They explicitly raised hourly wages by about $2.40. These higher wages fostered higher recruitment and retention, especially in light of the rising wages in competitor industries like retail and fast food. However, the temporary nature of these wage enhancements worries stakeholders. One provider group stakeholder said, "I could just speculate how challenging it would have been had we not got[ten] this wage enhancement. We're also extremely concerned [about] what happens when this wage enhancement goes away, because as hard as it's been to hire someone at this wage, if it suddenly drops another $2 or $2.40, it's going to be extremely challenging to recruit people."

A worker group stakeholder cited the presence of collective bargaining for the state-paid DCWs in self-directed programs as a major source of higher wages--something both public and private DCWs benefit from as a result of the parity statute. Multiple stakeholders mentioned state minimum wage laws, and the higher Seattle minimum wage law, as having a positive effect on DCW wages, recruitment, and retention as well. However, these comments were made largely in reference to historical trends, with the minimum wage in Washington and Seattle perhaps not having as large of an impact on DCW wages, recruitment, and retention in the current labor market where DCW wages have risen above the minimum wage. A provider group stakeholder

credited the ballot initiative passed in 2011 requiring additional DCW training and credentialing with raising wages.

Improving Wages, Job Quality, Worker Recruitment and Retention

We asked stakeholders about barriers to improving wages and other aspects of direct care work. We also asked stakeholders what else could be done to improve wages and other aspects of direct care work.

Barriers to Improving Wages and Other Aspects of Direct Care Work

- Despite recent wage increases and the fact that Washington now has some of the highest DCW wages, stakeholders still report Medicaid funding as the primary barrier to improving wages. A provider group stakeholder said, "if Medicaid reimbursement is woefully inadequate, how do you offer a wage that's going to compete with hospitals and clinics and doctor's offices--you can't."

- All stakeholders pointed to the difficult nature of direct care work and nationwide staffing shortages as contributors to an overall challenging work environment. DCWs are being forced to work longer hours at pay that is often equal to or barely above retail or fast food rates. One provider group stakeholder cited staffing shortages and retention as "the number one issue" facing the long-term care industry.

- Stakeholders also unanimously noted that the COVID-19 pandemic has exacerbated the workforce shortage.

- A provider group stakeholder mentioned that although the training and credentialing ballot initiative from 2011 increased wages, it also created additional barriers to entry into the workforce.

What Else Could be Done to Improve Wages and Other Aspects of Direct Care Work

- Stakeholders mentioned making the temporary COVID-19 hazard pay wage enhancements permanent would drastically improve the long-term outlook of DCWs and providers.

- State representatives stressed the need for the department of labor to see DCW as a "viable and important industry." This stakeholder stated DCWs have for too long been seen as domestic workers, even though they perform skilled nursing, medication management, systems navigation, and interpersonal and behavioral health tasks. They emphasized DCWs should be seen as part of a larger care team for patients and should be respected and paid accordingly.

- State representatives also mentioned the need for increased federal funding of Medicaid.

- One provider group stakeholder noted that providing more consistent pay schedules, perhaps a 40-hour per week salary, would improve the stability of direct care work. Currently, hours for DCWs can fluctuate significantly based on patient health and

mortality. A weekly salary independent of exact workload would create stability and make direct care work more attractive.

- A provider group stakeholder posited that immigration reform may help provide a much needed increase to the DCW workforce.

Conclusion

Washington has instituted a parity statute and COVID-19 hazard pay wage enhancements funded by the FFCRA to raise DCW wages. The parity statute only applies to home care workers and does not on its own raise wages, but it does ensure equal pay between state-paid and agency-employed DCWs. Stakeholders agree this standardization of pay, resulting from collective bargaining, creates a more stable workforce. The hazard pay wage enhancements have clearly led to increased wages, resulting in a wage increase of approximately $2.40 per hour. Stakeholders praised the simplicity and effectiveness of these wage increases but expressed concern over the temporary nature of the enhancements--stakeholders worry that their removal could amplify existing staffing shortage issues considering the rising wages in competitor industries. All stakeholders agree Medicaid reimbursement should be increased to raise worker pay. State representatives also advocated for increased federal funding of Medicaid. Additionally, stakeholders posited direct care work could be improved by placing more value on the workers and treating them as part of an integrated health care team.