

#2006-18
October 2006

**Paying for Quality Care:
State and Local Strategies for Improving
Wages and Benefits for Personal Care Assistants
by**

**Dorie Seavey, Ph.D
Vera Salter, Ph.D.
*Paraprofessional Healthcare Institute***

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

© 2006, AARP.

Reprinting with permission only.

AARP, 601 E Street, NW., Washington, DC 20049

<http://www.aarp.org/ppi>

Foreword

The United States is experiencing a severe shortage of qualified direct-care workers to provide personal care services. This shortage only promises to grow as our country ages. Direct-care work is demanding, and working conditions are often difficult. Turnover is high because the job is strenuous and offers limited opportunities for advancement, inadequate training, lack of respect, and exclusion from care planning. These workers also are underpaid and often lack benefits. Nearly one in five home care aides live below the poverty line, with an income of roughly \$1,000 per month, and four in ten lack health insurance.

If policymakers want to ensure quality of care in peoples' own homes, where most people with disabilities prefer to live, they must address the pay and benefits that direct-care workers receive from Medicaid, the major payer for long-term care services.

To assist states in ensuring the quality of personal care services, the AARP Public Policy Institute commissioned two of the nation's top experts on the direct-care workforce to provide this in-depth analysis of state and local practices and initiatives to improve the wages and benefits received by direct-care workers. The authors address the pros and cons of different wage enhancement strategies as well as their practical implications. It is our hope that policymakers, providers, researchers, and advocates will draw upon the emerging state-level experience and lessons analyzed in this report as they seek to improve the wages and benefits paid to workers.

The AARP Public Policy Institute also commissioned a companion report, *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*, which examines the adequacy of backup service assurance systems when direct-care workers are unable to provide services or when emergencies arise. Together, these two papers highlight critical issues that need to be addressed to ensure the viability of home care services under Medicaid for people with disabilities.

Wendy Fox-Grage and Enid Kassner
Senior Policy Advisors
AARP Public Policy Institute

Table of Contents

<i>Executive Summary</i>	i
I. Introduction	1
II. Methodology	4
III. Findings	5
A. Survey Results on Wage Rates	5
B. Survey Results on Health Insurance Benefits	7
C. Strategies to Improve Direct-Care Wages and Benefits	7
<i>Strategy #1: Wage Pass-Through Legislation</i>	7
<i>Strategy #2: Rate Enhancements Linked to Provider Performance Goals</i>	9
<i>Strategy #3: Reform of Methods For Rebasing and Updating Reimbursement Rates</i>	11
<i>Strategy #4: Litigation Against State Medicaid Agencies</i>	14
<i>Strategy #5: Collective Bargaining by Direct-Care Workers</i>	17
<i>Strategy #6: Living Wage Ordinances and Minimum Wage Improvements</i>	19
<i>Strategy #7: Health Insurance Initiatives Targeting Direct-Care Workers</i>	21
IV. Summary and Conclusions	24
APPENDICES	
<i>APPENDIX A</i>	28
<i>APPENDIX B</i>	29
<i>APPENDIX C</i>	31

Executive Summary

Introduction

From the perspective of someone who is authorized to receive Medicaid personal care services (PCS), the most basic “quality” issue is straightforward: **Can I find a qualified worker to provide the services I need?** While many factors influence the adequacy and stability of the PCS workforce, empirical evidence from a growing number of research studies reveals that the wages and benefits paid to personal care workers play a fundamental role in determining the quality and quantity of workers.

Given the vital role that wages play in determining workforce adequacy and ultimately care quality, it is of serious concern that, in most states, personal care and home care workers earn wages that place them in the realm of low-wage work. In addition, these workers typically lack access to affordable benefits, receive minimal training, and are often employed on erratic, part-time schedules.

The consequences of chronic low job quality for direct-care work are by now well known: most states across the country report shortages of direct-care workers, high turnover rates, lack of qualified staff, and difficulty retaining workers. Low retention and high turnover also create strong disincentives for providers to invest in staff training as well as in retention-oriented supervisory practices and career advancement programs—practices which, in addition to higher wages and better benefits, can play an important role in improving job quality.

In light of the critical interconnections between the quality of jobs and the quality of care, this report examines state and local initiatives to improve wages and benefits for direct-care workers delivering Medicaid PCS. Seven strategies for improving direct-care wages and benefits are identified and effective practices for states are highlighted as well.

Methodology

In January 2005, a written survey was fielded to Medicaid officials and state units on aging in the 50 states and the District of Columbia asking questions relating to health insurance benefits for direct-care workers as well as supplementary questions designed to identify whether states set wage rates for publicly-funded personal care workers. Eleven states and the District of Columbia were selected for more in-depth investigation to gather information about either common or innovative practices. In addition to the 2005 survey and follow-up telephone interviews, relevant secondary sources such as federal and state government websites, and state-specific reports and regulations, were reviewed. Several of the follow-up states were selected because various state or national reports indicated interesting programs or policies in these states.

Findings

1. In most states, PCS wages for workers delivering Medicaid PCS are not set by the state but rather are determined by employers. In their responses to the 2005 state survey, the majority of states (22 of 38 responding states or 58 percent) said that they do not directly set any wage rates for Medicaid PCS, frequently adding that wage rates are determined by provider agencies. Although the wage rates received by agency PCS workers are generally agency-

determined, they are influenced by the reimbursement rates that provider agencies receive. The underlying reimbursement rates, in turn, either are set by the state and apply to all provider agencies or, alternatively, the rates are negotiated between the provider agencies and a regional intermediary such as an Area Agency on Aging. Another variation on the negotiation option is that the reimbursement rates may be the result of a regular bid process between provider agencies and a state purchase-of-services office. Larger states particularly tend to delegate ultimate rate-setting responsibility to regional or county agencies. However, in contrast to wage setting for agency-employed PCS workers, a number of states do set the wage rates paid to directly-hired PCS workers in Medicaid- or general fund-supported consumer-direction programs. In states where directly-hired PCS workers are represented by unions and have collective bargaining status, the wage rates and related benefits ultimately are legislatively approved and set by the state. However, they usually result from regular contract negotiations between the union and a public authority that serves as the employer-of-record for PCS workers.

2. The ability to provide access to affordable health insurance for direct-care workers is an issue of growing concern around the country with nearly a quarter of state survey respondents reporting strategies or plans to develop mechanisms to address the lack health insurance. Only 18 percent of state respondents (seven states) report that their states currently collect data on health insurance coverage by occupation or have the capacity to collect such data.

3. States, localities, and advocates have engaged in seven types of strategies to improve direct-care wages and benefits:

a. Wage pass-through legislation. Wage pass-throughs—that is, legislatively enacted appropriations earmarked for specific groups of direct-care workers—are a popular, although problematic, state policy tool for addressing inadequate direct-care wages. The evidence to date suggests that pass-throughs at best have been an imperfect substitute for what can be seen as a defect in most state reimbursement methods for Medicaid home and community-based services (HCBS)—namely, the failure to provide for a built-in cost-of-living adjustment.

b. Rate enhancements linked to provider performance goals or targets. A few states provide enhanced rates to PCS agency providers meeting certain programmatic, financial, or performance goals relating to improved workforce outcomes such as higher retention and better quality of care. These enhanced rates can be used to maintain higher wages and benefits.

c. Reform of methods for rebasing and updating reimbursement rates for HCBS so that they are based on actual costs and/or competitive market rates. The principal driver of the actual wage rates and benefits received by workers is the reimbursement rates that states pay to provider organizations for the delivery of PCS. States can improve direct-care compensation by reforming their methods for rebasing and/or updating HCBS reimbursement rates, although more systematic rate-setting methods do not necessarily guarantee wage and benefit improvements for workers because provider agencies typically make the final determination of worker wage rates.

d. Litigation against state Medicaid agencies. In the last six years, federal lawsuits, brought by groups of Medicaid-eligible individuals challenging state Medicaid HCBS payment policies and payment rates, have been pursued in a number of states. These lawsuits claim, among other things, that state Medicaid payments violate federal Medicaid law because direct-care wages allegedly are so low that the resulting workforce is insufficient to provide Medicaid beneficiaries with reliable services. Another litigation strategy has been to challenge state HCBS

reimbursement rate-setting through lawsuits in state courts brought by provider associations. Either through their resolution in the courts and/or the scrutiny they create along the way, litigation strategies have been effective in creating pressure on states to improve their reimbursement methods, increase payment rates, and support higher wages and benefits for direct-care workers. However, the legal system tends to move slowly, with full resolution often requiring many years of ongoing effort and legal costs.

e. Collective bargaining by direct-care workers. To date, the collective bargaining model which has had the greatest impact on personal care workers is the “public authority” model for personal care workers directly hired by consumers. Currently, four states—California, Washington, Oregon, and Michigan—have created these quasi-public intermediaries which typically serve as the “employer-of-record” for independent workers whose remuneration comes from public funds. When combined with worker representation, these arrangements have achieved significant wage and benefit increases through biannual contract negotiations.

f. Living wage ordinances and minimum wage improvements. Significant wage increases for many low-wage workers, including direct-care workers, have been achieved through city and county living wage ordinances and through action to increase state and city minimum wage standards. A municipal living wage ordinance typically applies only to private agencies and companies receiving significant contracts through city or county procurement processes while a minimum wage establishes a pay floor for *all* businesses in a given locality, and thus covers a greater number of workers.

g. Health insurance initiatives targeted at direct-care workers. While most of the above strategies focus primarily on wages, they do not preclude attention to benefits. In just the last few years, the problem of direct-care workers’ lack of access to affordable health care coverage has gained greater attention on its own merits. A variety of initiatives, ranging from small, local pilot demonstrations to statewide campaigns, have been launched to gain greater health care coverage for direct-care workers.

Summary and Conclusions

This review of state and local efforts to improve compensation for direct-care workers suggests several important issues and implications for advocates, policymakers, researchers, and providers.

1. Lack of Federal Oversight and Guidance. Federal oversight of and guidance to state Medicaid rate-determination methods and procedures have been minimal but should be strengthened to help improve workforce adequacy and the quality of services received by consumers. Few meaningful federal review requirements are in place regarding state rate-setting methods and procedures, and the U.S. Centers for Medicare and Medicaid Services (CMS) has not used its enforcement powers to assure adequate reimbursement payment. Furthermore, CMS has not developed guidance for states concerning desirable rate-setting principles and standards to inform rate setting across long-term care (LTC) settings. Useful guidance could include:

- Standards for assessing the adequacy and reasonableness of rates.
- Guidelines concerning the minimum frequency with which rates should be revised.
- Options regarding the economic and financial information to be considered when establishing and/or revising base rates as well as updating them.

- Options for creating rate enhancement incentives (e.g., “pay-for-performance” or “tiered reimbursement strategies”) which target specific policy and program goals to be achieved through performance standards related to quality-of-care and quality-of-job.

2. Existing Direction to States. Court decisions as well as federal statutes and regulations arguably provide the following direction to state Medicaid agencies:

- Payments for services must be consistent with efficiency, economy, and quality of care.
- The state Medicaid agency’s payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.
- The state Medicaid agency must provide methods and procedures to achieve the above two outcomes.
- The state Medicaid plan must describe the policy and methods to be used in setting payment rates for each type of service included in the state’s Medicaid program.
- The state Medicaid agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

3. *Ad Hoc* Reimbursement Rate-Setting Methods. Most states set reimbursement rates for Medicaid PCS in a relatively *ad hoc* manner:

- *Ad hoc* refers to situations where no requirements exist that rates be reviewed on a periodic basis in order to evaluate their adequacy over time, and where no systematic process is in place to update or rebase rates taking into account relevant economic and financial information, including provider costs. Rather, rates are largely determined on an as-needed basis in response to improvement or deterioration in a state’s financial condition, the emergence of pressing workforce issues, or in response to targeted provider or consumer advocacy efforts or lawsuits.
- Most states do not know what the provider agencies they contract with pay their workers or the extent to which workers in direct-care occupations have health insurance coverage — two key factors which research shows play critical roles in determining turnover and vacancy rates and, therefore, the overall adequacy and stability of the PCS workforce.
- While Medicaid reimbursement rates for nursing facilities typically are updated annually based on an inflation factor, these adjustments are extremely rare for HCBS. In the absence of regular rebasing, the lack of an automatic cost-of-living adjustment means that the real value of HCBS rates will fail to keep up with provider costs and inflation.

4. Problematic Rate Setting. Most current approaches to PCS rate setting and wage determination are problematic for several reasons:

- Rates tend to be determined primarily by the overall state budget-driven process which can be heavily influenced by political factors, including the relative advocacy strength of different LTC providers, consumer groups, and organized labor.
- Providers are subject to considerable uncertainty regarding their year-to-year funding.

- If the state neither knows the profile of worker wage rates and benefits paid by provider agencies nor sets a ceiling on the percentage of administrative expenses, there is a danger that rate increases will not reach workers.
- Lack of an integrated approach to rate setting across Medicaid HCBS can lead to unrelated and inconsistent rate setting across departments and programs. This lack of coordination can impede overall system-reform goals for LTC such as shifting the locus of care to home and community settings and away from nursing facilities (“rebalancing”). It also can result in different wages being paid to workers performing the same tasks, thus putting jobs in one LTC setting at a competitive disadvantage relative to other settings.

5. No Single State Solution. Exemplary approaches to improving wage rates and benefits for personal care workers usually are unique to particular state and local contexts. A one-size-fits-all solution across the states is difficult to imagine given the considerable variation in state circumstances. Instead, advocates, policymakers, worker associations, organized labor, and provider associations need to determine, within their own unique state context, where the most strategic leverage points lie for increasing direct-care wages and benefits. This review does suggest that establishing a foothold in at least one LTC setting providing for regular and consistent wage-setting review can be valuable for two reasons: It sets a precedent or standard for other settings or occupations to follow, and it can create upward pressure on direct-care wages in other sectors.

6. Effective Components of Wage and Benefit Improvement Strategies. While they are far from common practice, particular components of compensation improvement strategies deserve highlighting because they have the potential to have a noticeable impact on improving the adequacy of wages and benefits for direct-care workers. These components include:

- Providing an automatic update mechanism, such as an annual inflation adjustment using an index tied to health care labor costs, or at least to the Consumer Price Index (CPI) or the Medical Care CPI.
- Putting protocols and procedures in place which assure that the administrative portion of the payment rate received by agency providers is not excessive and that a substantial portion of any given rate increase is actually allocated to direct-care labor costs and, therefore, can reach workers.
- Tying the evaluation of the adequacy and reasonableness of wage rates and benefits to a “comparable wage” or “living wage” approach. The former assumes that direct-care staff should be paid hourly wages and fringe benefits comparable to what other employees receive in similar positions or which are otherwise competitive with local economic conditions. Local market surveys conducted on a regular basis can be an effective tool for determining comparable wages. The living wage approach assumes that direct-care workers are paid a living wage at least sufficient to make them ineligible for government assistance *and* able to afford basic living expenses. Still another alternative is to tie reimbursement rate setting to a cost-based approach that recognizes providers’ actual costs of doing business.

- Building in the capacity to evaluate the adequacy of the rates over time so that base rates stay competitive and keep up with changing relative costs.

The continuing movement in this country toward an LTC system that is primarily home and community-based raises the question of how to ensure the quality of care provided in hundreds of thousands of private and congregate homes. While provider licensure, regulatory standards, and quality management programs, including tracking and monitoring systems, clearly can play important roles, investing in and supporting the quality and stability of the direct-care workforce could not be more important to ensuring service quality and the well-being of consumers.

In sum, ensuring good quality care hinges on the ability of policymakers to address the adequacy of the wages and benefits typically paid to direct-care workers. Most states appear to be at the earliest stages of designing comprehensive and systematic approaches to setting payment rates for directly-hired and agency-employed PCS workers. Federal guidance and direction in this area appear to be remarkably minimal. At the same time, policymakers, providers, researchers, consumers, and advocates seeking to improve the wages and benefits paid to workers can draw upon the emerging state-level experience and lessons which this report begins to detail.

I. Introduction

From the perspective of someone who is authorized to receive Medicaid personal care services (PCS), the most basic “quality” issue is straightforward: **Can I find a qualified worker to provide the services I need?** While many factors influence the adequacy and stability of the PCS workforce, the wages and benefits paid to personal care workers play a fundamental role in determining the quantity and quality of workers. This report examines state and local initiatives to improve wages and benefits for direct-care workers delivering Medicaid PCS.

Empirical evidence from a growing number of research studies reveals that adequate wages and affordable and accessible health insurance play a critical role in recruiting and retaining a competent and stable direct-care workforce. Researchers consistently find a negative correlation between higher wages and job turnover¹ and a positive correlation between employer-provided health insurance benefits and average tenure (retention).² “Before and after” studies of actual interventions that have improved wages and benefits for direct-care workers have found that investments in better compensation have reduced turnover and increased retention.³ Some research also suggests that, for direct-care workers, health insurance is even more important than wages in reducing turnover,⁴ or in increasing the supply of direct-care workers and hours worked.⁵ Finally, while there are more studies for care received in nursing facilities than in home and community settings, research indicates that the size, stability, and training of the direct-care workforce all play a profound role in determining the quality of care and quality of life for people receiving long-term care (LTC) services in home and community-based settings.⁶

Given the vital role that wages play in determining workforce adequacy and ultimately care quality, it is of serious concern that, in most states, personal care and home care workers earn wages that place them in the bottom 20th percentile of the wage distribution—that is, in the realm of “low-wage work.” The median hourly wage for all direct-care workers in 2004 was \$9.45, according to data from the U.S. Bureau of Labor, but personal care aides typically earn only \$8.18, significantly less than hospital and nursing home workers (\$10.20) (see Chart 1).

Furthermore, most PCS workers lack access to affordable benefits. Surveys have shown that, in general, workers consider health insurance to be the most important fringe benefit they can receive from employers.⁷ Roughly 40 percent of PCS workers lack health insurance,⁸ and only about 30 percent of PCS workers are covered under their own employer-based health care coverage.⁹ PCS workers may find themselves uninsured for a number of reasons: they are not offered coverage by their employers, they are ineligible for health benefits because they are part time or new hires, they cannot afford to participate in their employer’s health insurance plan, or they are self-employed.

In addition to low compensation, most PCS workers receive minimal training, and often engage in erratic, part-time work. Supervision is often poor or non-existent, and career paths to higher-paying related work usually are unavailable. As a result of these factors, personal care employment is relatively unattractive because it does not offer the compensation and job quality that would make it competitive with other job opportunities that low-income workers now have.

The consequences of chronic low pay and inadequate benefits for direct-care workers are by now well known: most states across the country report shortages of direct-care workers, high turnover rates, lack of qualified staff, and difficulty retaining workers.¹⁰ These factors combine to create

an industry with worker shortages and high rates of “churn,” with turnover typically ranging from 40 to 50 percent annually for home health aides and personal care aides.¹¹ Workforce instability contributes to service delivery failure and disruptions, impeding the ability of some consumers to remain in their own homes.¹² Low retention and high turnover also create strong disincentives for providers to invest in staff training as well as in retention-oriented supervisory practices and career advancement programs—practices which, in addition to higher wages and better benefits, can play an important role in improving job quality.¹³

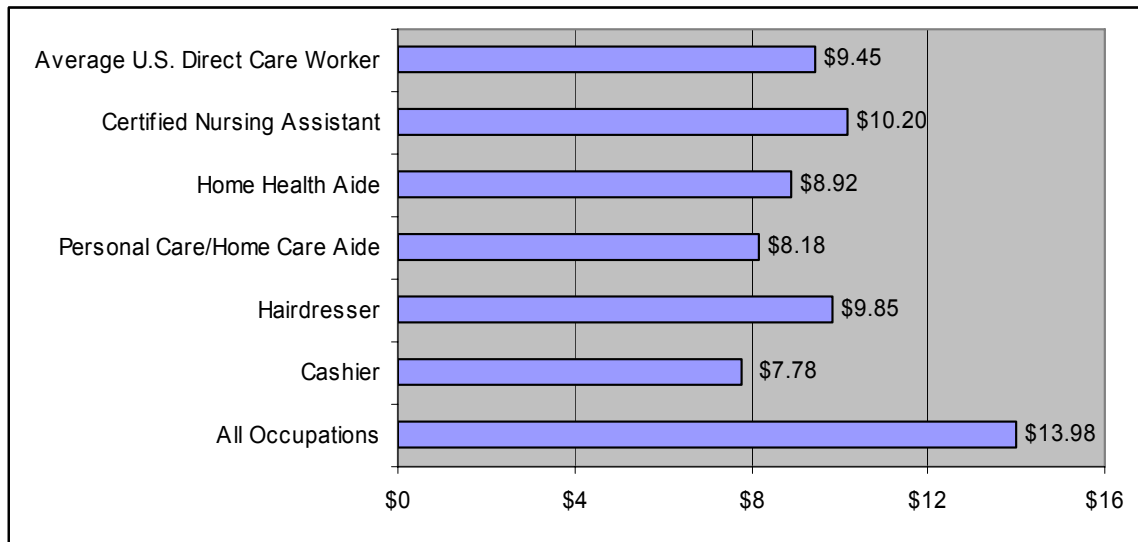
These concerns about the adequacy and instability of the direct-care workforce and the quality of PCS are occurring at a time when the demand for non-institutional LTC services across the country has been growing rapidly. A recent analysis finds that, from 1989 to 2004, Medicaid LTC spending on personal assistance services provided under state personal care plans, home and community-based services (HCBS) waivers, and the home health services benefit increased steadily from \$3.3 billion to \$14.7 billion (1989 dollars).¹⁴ The growth in the PCS and home care workforce has been commensurate: over the same time period, the size of this workforce tripled, growing from 264,000 to 894,000. These patterns of home and community-based spending and workforce growth stand in sharp contrast to institutional LTC, where spending increased only 19.7 percent over the same period and the workforce performing functions similar to personal care and home health care workers expanded by just over a third (35.6 percent).

The continuing movement in this country towards an LTC system that is primarily home and community-based raises the question of how to ensure the quality of care provided in hundreds of thousands of private and congregate homes. While provider licensure, regulatory standards, and quality management programs, including tracking and monitoring systems, clearly can play important roles, investing in and supporting the quality and stability of the direct-care workforce could not be more important to ensuring service quality and the well-being of consumers.

In light of the key role that direct-care worker wages and benefits play in determining the availability and quality of PCS, states and localities around the country as well as advocates and providers are working to improve wage rates and benefits for direct-care workers, often within the midst of difficult state fiscal pressures. This report examines these state and local initiatives in order to:

1. Identify the primary state and local practices and initiatives to improve wages and benefits for direct-care workers;
2. Provide detailed information about the more developed state and local approaches; and
3. Highlight effective practices for states to consider.

Chart 1
Median Hourly Wages, 2004



Source: U.S. Bureau of Labor Statistics, November 2004.

Personal Care Services

Personal care services (PCS) refer to hands-on or cueing assistance with the performance of activities of daily living (ADL) such as eating, bathing or dressing, or instrumental activities of daily living (IADL) such as meal preparation, using the telephone, and transportation.¹⁵ PCS help older people and people with disabilities maintain their independence in their own homes and communities.

Due to demographics and consumer preferences, PCS have been growing and now constitute a considerable portion of Medicaid HCBS. Medicaid PCS can reach a beneficiary through one of three channels: Through the PCS option of a state's Medicaid program, through state Medicaid waivers [1915(c) or 1115], or through the Medicaid home health benefit. Currently, 26 states plus the District of Columbia use the personal care option in their Medicaid state plans to provide at least one type of PCS program to adults.¹⁶ All states have waiver programs that provide these services to seniors and/or people with disabilities.

In addition to Medicaid, many states provide PCS using state or local funds and/or funds received under the federal Older Americans Act. These state programs frequently direct PCS to individuals who do not qualify for Medicaid services either because of income ineligibility or because they require lower levels of ADL support.

II. Methodology

Three main methods were used to collect the information presented in this report: a written survey fielded to state officials with responsibility for Medicaid LTC and aging programs, follow-up telephone interviews with state and local officials, and review of relevant secondary sources of state information. In many cases, the complexity of topics treated in this report resulted in survey respondents making referrals to other contacts within their states for more detail on specific issues and information about effective or innovative initiatives.

1. State Survey. At the request of the AARP Public Policy Institute, five supplementary questions were added to the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce.¹⁷ The questions were used to identify state wage-setting practices for publicly-funded PCS workers, and also to identify state practices in tracking the provision of authorized services and providing backup or emergency PCS.¹⁸ (See Appendices A and B for the supplemental survey questions and responses, respectively.) In addition, the main survey contained two questions related to health insurance for direct-care workers that also were analyzed for this report (see Appendix C). The full survey, including the supplementary questions, was fielded by e-mail in January 2005 by the Direct Care Workers Association of North Carolina and the National Clearinghouse on the Direct Care Workforce; follow-up was completed by August 2005.

Thirty-eight states responded to the main survey; two of these did not respond to the supplementary section. After additional follow-up, two more responses to the supplementary questions were received for a total of 38 overall responses or a 76 percent response rate.

2. Telephone Interviews. Eleven states—Arizona, Kansas, Massachusetts, Mississippi, New Hampshire, Oregon, Rhode Island, Texas, Vermont, Washington, and Wyoming—and the District of Columbia, were selected for more in-depth investigation of either common or innovative practices and policies pertaining to wages and benefits. In addition, several follow-up states were selected because various state or national reports indicated interesting programs or policies in these states. In most states, the authors conducted more than one interview with state officials and/or local service providers because of referrals to multiple state offices for more information; in other instances, “expert” organizations or individuals on particular topics were identified, and interviews were conducted with those agencies or individuals.

3. Secondary Research. To find additional information on state Medicaid reimbursement practices that have a determinative impact on the wage rates that direct-care workers receive, the authors searched a number of websites that compile state information on these topics. These included the website of the Center for Personal Assistance Services at the University of California San Francisco, the website of the National Association of State Medicaid Directors, the state Medicaid database of the Kaiser Family Foundation, the website of the National Governors Association, and the official CMS site.¹⁹ In addition, the authors accessed individual state government websites for specific reports and regulatory information. In some cases, the authors were referred to state-specific reports during follow-up interviews.

III. Findings

The authors report here on survey results concerning three topics: (i) The different ways that wage rates are determined for direct-care workers delivering Medicaid home and community-based PCS, (ii) the prevalence of state initiatives to address and quantify the lack of affordable health insurance for direct-care workers, and (iii) seven policy and reimbursement tools that state and local governments and other advocates have been using to improve the remuneration received by PCS workers.

A. Survey Results on Wage Rates

In most states, PCS wages for workers delivering Medicaid PCS are not set by the state but rather are determined by the agencies that hire them. In their responses to the state survey conducted for this report, the majority of states (22 of 38 or 58 percent) responded that they do not directly set any wage rates for Medicaid PCS. States set the payment rates to agencies, but they do not specify the wages that the agencies pay.

The provision of Medicaid PCS usually takes place in one of two ways. One is through sub-contracts with home care or attendant care agencies that hire, place, and supervise PCS workers, or through subcontracts with residential care and assisted living facilities which in turn employ direct-care workers to care for their residents. The other is through consumer-directed care arrangements wherein the LTC consumer (or his or her surrogate)²⁰ directly hires and supervises the workers. Nearly all states offer at least some consumers the option to direct their own PCS while also offering agency-directed services. A few states provide virtually all of their Medicaid PCS through a consumer-directed model (e.g., Oregon and California).

Mirroring this bifurcated service delivery system, most states now have a multi-track approach to determining payment rates for Medicaid PCS provided to seniors and individuals with physical disabilities, one approach for services provided by agencies and another for services provided by independent providers. Each of these approaches “produces” wages rates, but they emerge in different ways (see Exhibit 1).

Exhibit 1
Wage-Setting Approaches

	Agency Worker Wages (workers employed by agencies)	Independent Provider Wages (workers directly hired by consumers)
Set by provider agencies	Majority of states	
Set by state or county/ regional intermediaries, or by consumers together with case managers and payroll agents		Majority of states

1. Wage rates received by agency workers. The wages received by agency PCS workers are generally agency-determined but are influenced by the reimbursement rates which provider agencies receive from Medicaid. The underlying reimbursement rates, in turn, either are

set by the state and apply to all provider agencies, or, alternatively, the rates are negotiated between the provider agencies and a regional intermediary such as an Area Agency on Aging (AAA). Another variation is that the reimbursement rates may be the result of a bid process between provider agencies and a state purchase-of-services office, wherein the latter issues a notification of intent to contract as part of an annual bid procedure. The resulting payment rates typically are fee-for-service rates for either hours of services provided or time units (such as a quarter of an hour).

Larger states tend to delegate ultimate rate-setting responsibility to regional or county agencies. For example, under Michigan's Medicaid waiver program, MI Choice, the state largely contracts with AAAs to serve as "waiver agencies." These agencies in turn contract with provider agencies to provide services in a specific region. The state pays these regional and county intermediaries a total amount for their anticipated caseload, and the intermediaries are charged with setting the rate for home care services by negotiating rates with individual home care agencies or other vendors. The rates negotiated with one vendor may not be the same as those paid to another vendor for the same service.

States which delegate rate setting to regional and county intermediaries may receive little if any information about the rates actually paid to agencies and the resulting wage rates paid by agency providers to direct-care workers.

2. Wage rates received by independent providers. In contrast to wage setting for agency-employed PCS workers, a number of states do set the wage rates paid to directly-hired PCS workers in Medicaid- or general-fund supported consumer-directed programs. For example, in California, Michigan, Oregon, and Washington, where directly-hired PCS workers are represented by unions and have collective bargaining status, the wage rates and related benefits ultimately are legislatively approved and set by the state. However, they usually result from biannual contract negotiations between the union and a public authority that serves as the state-directed employer-of-record for PCS workers. Still another variation on wage-setting mechanisms for independent providers can be found in consumer-directed programs, such as Cash and Counseling.²¹ These programs may allow consumers to directly negotiate wage rates with their independent providers, using the state minimum wage as a "floor" wage; in some states, case managers and independent payroll agents assist with wage negotiation.

Again, large states may give counties complete or at least partial autonomy in setting consumer-directed wage rates. Michigan is an example of a large state which recently moved from "complete autonomy" to "partial autonomy" with the implementation of a wage floor for consumer-directed workers in its Home Help Program. The program serves about 50,000 people under the state's Medicaid personal care benefit, and county boards of the Michigan Department of Human Services set payment rates and approve services. As of early 2006, wage rates ranged from \$5.15 in Wayne County (the Detroit area which contains about 45 percent of the Medicaid consumer-directed workforce) to \$10.00 in Benzie and Grand Traverse Counties. These rates had been frozen by the state since 2003. In July 2006, the Michigan Legislature established a minimum \$7.00/hour wage floor for the Home Help Program and gave a 50 cent/hour raise for PCS workers already making more than the \$7.00/hour wage floor.

B. Survey Results on Health Insurance Benefits

In their responses to the state survey conducted for this report, nine states (24 percent) reported having (or having future plans to develop) strategies to address the problem of inadequate health care worker insurance (see Appendix C for complete state responses).²² A careful review of secondary sources showed that three of the non-responding states also had initiatives underway, bringing the total number of states with health insurance projects impacting direct-care workers to a dozen (see Exhibit 9 for details).

However, only 18 percent of state survey respondents (seven states) report that their states collect data on health insurance coverage by occupation or have the capacity to collect such data (see Appendix C).

C. Strategies to Improve Direct-Care Wages and Benefits

States, localities, and advocates have engaged in seven types of strategies to improve direct-care wages and benefits. They are as follows:

- **Strategy #1: Wage pass-through legislation**
- **Strategy #2: Rate enhancements linked to provider performance goals or targets**
- **Strategy #3: Reform of methods for rebasing and updating reimbursement rates for Medicaid HCBS**
- **Strategy #4: Litigation against state Medicaid agencies**
- **Strategy #5: Collective bargaining by direct-care workers**
- **Strategy #6: Living wage ordinances and minimum wage improvements**
- **Strategy #7: Health insurance initiatives targeting direct-care workers**

Strategy #1: Wage Pass-Through Legislation

a. Wage pass-throughs—that is, legislatively enacted appropriations earmarked to go directly to specific groups of direct-care workers—have become a popular state policy tool for addressing inadequate direct-care wages, but they can be problematic (see Exhibit 2).

Little research has been conducted on the efficacy of wage pass-throughs as a policy tool for improving direct-care worker wages and reducing turnover and vacancies. However, it is clear that their effectiveness is closely connected to: (i) the size of the wage increase, (ii) whether state legislatures require and ensure that pass-through funds are used to increase direct-care wages and benefits, and (iii) whether states insist that outcomes be monitored.²³

Exhibit 2

Wage Pass-Through Legislation

What Is It?	State Examples	Results
Legislatively enacted appropriations earmarked for specific groups of direct-care workers.	• About two dozen states in recent years have implemented wage pass-throughs for direct-care workers. • Over 40 percent have been for workers in skilled nursing facilities only.²⁴ • Examples of relatively successful pass-throughs include Wyoming and the District of Columbia.	• A popular state strategy, but actual trickle down to wages is often small, typically approximating change in cost-of-living. • Enforcement and accountability mechanisms often are lacking. • Annual legislative and advocacy effort required.

Wyoming offers an example of a wage pass-through that has been effective in increasing wages for a specific segment of its direct-care workforce, namely, direct support professionals providing PCS to individuals with intellectual and developmental disabilities (see Exhibit 3). Notably, the Wyoming Legislature has continued to maintain its considerable initial investment by providing two years of follow-up increases. It has also required that the expected outcomes of this investment—increased wages, and reduced turnover and vacancies—be tracked and reported.

Exhibit 3

Wyoming: Example of a Successful Wage Pass-Through

Spurred in part by the fact that Wyoming wages for direct service professionals ranked 50th in the nation, the Wyoming Legislature in 2000 commissioned a wide-ranging survey of wages and salaries of nonprofessional direct-care personnel. The goal of the study was to determine “the level of salary and benefits needed to attract, retain and build a skilled workforce of direct healthcare providers”.²⁵ The final report concluded that the average wages of direct-care staff were uncompetitive and that healthcare providers would continue to have difficulty recruiting and retaining direct-care staff until wages in this sector were increased. The report calculated the cost to state government of increasing the average wage paid to direct-care staff to \$10.23 (90 percent of the market rate as determined by the survey).

In response to this study that focused on *all* direct-care workers, in 2002 the Wyoming Legislature appropriated a 28 percent increase in funds for the adult developmental disability waiver with the goal of improving staff reimbursement and retention. This increase was followed by two further cost-of-living increases (3 percent each). Wages and retention for Wyoming direct support professionals working in programs for people with developmental disabilities have been transformed: The average wage level (after 12 months of work experience) increased from \$7.38 in Fall 2001 to \$10.74 in Fall 2004, and full-time staff turnover declined from 52 percent to 32 percent over the same time period.²⁶ New training and career development initiatives funded by the state have also played a positive role in reducing turnover.²⁷

Another strong and successful wage pass-through, directed at personal care and home health aides, was implemented recently by the District of Columbia. This appropriation raised the hourly reimbursement rate for services provided under the District’s own Medicaid plan as well

its two Medicaid waivers by \$2.80, effective January 2006, with instructions that \$2.00 of the increase be paid out in higher wages such that home care workers receive payment of a “living wage” at “a minimum of \$10.50 per hour.”²⁸ Providers failing to meet this “minimum wage requirement” become ineligible for receiving Medicaid funds, but the primary driver of compliance appears to be word-of-mouth and competition, particularly since surrounding jurisdictions, up until the recent wage increase, tended to pay higher wages than the District.

The wage improvements resulting from the Wyoming and District of Columbia policies appear unique when compared to most state wage pass-throughs implemented across the country. In general, wage pass-throughs have proven to have problematic features:

- **Too Small.** While the initial appropriations request may be significant relative to the payroll of providers, actual appropriated amounts are often too small to make much difference, even when these monies are fully received by the intended workers. At most, many of these appropriations typically approximate at best the annual change in the overall cost of living.²⁹
- **Unreliable.** Pass-throughs must be repeated every year because they depend on annual appropriations which are not automatic and, therefore, cannot be counted on. As a result, pass-throughs tend to be an unreliable source of additional funding.³⁰
- **Lack of Accountability or Enforcement.** The effectiveness of pass-throughs depends on their ability to successfully “trickle down” to worker wages and benefits, but many states fail to put in place strong accountability mechanisms or enforcement procedures. Even in instances where accountability and enforcement measures have been specified, providers have not always distributed the pass-through funds to workers.³¹
- **Selective Settings.** Pass-throughs rarely are directed at direct-care workers across all LTC settings but rather are targeted to specific settings. Many wage pass-throughs enacted to date have been directed at nursing home workers; far fewer have targeted PCS workers in aging programs or programs for individuals with physical disabilities.
- **Time-Consuming and Expensive.** Finally, pass-throughs require on-going, sustained advocacy, usually on an annual legislative cycle, on the part of providers, consumers, and workers. As a result, they can be time-consuming and expensive.

b. The evidence suggests that, to date, wage pass-throughs have been at best an imperfect or *ad hoc* substitute for what can be seen as a defect in most state HCBS reimbursement methods, namely, that these methods do not provide for a built-in cost-of-living adjustment. Pass-throughs generally are largely a symbolic way for state legislatures to acknowledge that direct-care workers are important and underpaid.

Strategy #2: Rate Enhancements Linked to Provider Performance Goals

- a. **Some states, for example, Rhode Island and Texas, provide enhanced rates to agency providers meeting certain programmatic, financial, or performance goals.** In the case of Rhode Island, although no formal evaluations have been conducted, the state official interviewed reports that these enhanced rates have encouraged higher direct-care wages and benefits as well as better quality of care (see Exhibit 4).

Exhibit 4

Rate Enhancements Tied to Performance

What Is It?	State Examples	Results
Enhanced reimbursement rates to agency providers that meet certain programmatic, financial, or performance goals.	Rhode Island, Texas	In Rhode Island, some evidence of higher wages and benefits, improved retention, and higher quality of care (no formal evaluations conducted).

In Rhode Island, the Department of Health Services has operated an Enhanced Home Health Agency Reimbursement Program since 2000. It provides additional reimbursement when agency providers meet standards or performance goals beyond those pertaining to minimal licensing requirements. The original goal of this program was not to raise direct-care workers wages *per se*, but rather to improve the quality of home care services and increase staff retention. About three-quarters of Rhode Island's 64 licensed home care agencies currently apply to receive at least one of seven possible rate enhancements for the following standards:

- **Shift differential:** For services provided on nights, weekends, and holidays.
- **Staff education and training:** For the provision of a comprehensive in-service training program at a frequency of 20 percent above Rhode Island Department of Health licensure requirements with 100 percent staff attendance.³²
- **Client acuity:** For services provided to a client assessed as being high acuity by the agency's Registered Nurse based on the minimum data set (MDS) for home care.
- **Accreditation:** For achievement of state accreditation and/or accreditation from the Joint Commission for Accreditation of Healthcare Facilities (JCAHO)/Community Health Accreditation Program (CHAP).
- **Client satisfaction:** For providers who maintain a log of client complaints and resolution procedures followed.
- **Continuity of care:** When no more than two aides per client provide services to at least 85 percent of individuals receiving between 10-20 hours of agency home care services each week.
- **Worker satisfaction:** For improved staff retention such that 75 percent of employees who work a minimum of two weeks are continuously employed for at least six months.

The enhancement attached to each of these standards ranges from \$0.50 to \$1.50 per hour of service provided. An agency meeting all of the standards would boost its reimbursement rate by as much as an additional \$6.00 per hour of PCS.³³

Texas initiated its Attendant Compensation Rate Enhancement Program in 2000 in response to concern from legislators about low reimbursement rates for both home care providers and nursing homes. The program provides enhanced rates to providers which agree to maintain a higher level of attendant compensation, including wages, payroll taxes, workers' compensation, benefits, and mileage reimbursement.³⁴ Participating agency providers are required to spend approximately 90 percent of their attendant revenues, including their enhancement, on attendant compensation. In 2005/06, under Texas's Medicaid Waiver Program called the Community Based Alternatives (CBA) Program, providers can choose to participate at one of twenty

different successive levels of enhancement, ranging in five-cent increments up to a dollar. The maximum enhanced rate for an hour of personal assistance services is \$10.93; the minimum is \$9.98. Providers choosing not to participate receive a rate of \$9.93.³⁵ The participation rate of CBA providers is 47 percent, and for other programs ranges from 25 percent to 64 percent, with an average participation rate of about 50 percent.³⁶

While no evaluation of the Texas enhancement program has been conducted to date, according to a recent report issued by the U.S. Department of Health and Human Services (DHHS), “[Texas] [s]tate staff reported that participating providers have additional monitoring and reporting requirements, but in return have less recruiting and training costs. In addition, by offering higher rates for attendants, the facility will be more competitive than those offering lower rates.”³⁷ For state fiscal year 2006, state budgetary constraints have caused open enrollment for the attendant compensation rate enhancement program to be cancelled. Agency providers that are already enrolled are automatically re-enrolled.

b. While rate enhancements can be effective in directing additional resources to LTC providers that are meeting important direct-care workforce goals and quality-of-care outcomes, they cannot make up for inadequate base rates. For example, when the rate-setting method does not provide for a cost-of-living adjustment (COLA), the real value of the rates fail to keep up with provider costs and inflation, and, therefore, decline over time. In this situation, a rate enhancement is likely to serve as a *de facto* one-time COLA for those providers meeting the required standards.

Strategy #3: Reform of Methods For Rebasing and Updating Reimbursement Rates

The principal driver of the actual wage rates received by workers is the reimbursement rates which states pay to provider organizations for the delivery of PCS. These reimbursement rates in turn are determined by whatever methods are in place for rebasing and updating them.³⁸ Federal regulatory and statutory authorities give little guidance to states concerning rate setting for Medicaid PCS.³⁹

a. Across the country, *ad hoc* approaches to rate setting for Medicaid HCBS are the norm, not the exception. *Ad hoc* refers to approaches where there is no state commitment to or explicit systematic method for setting, rebasing, or updating the rates. As a result, rates are largely established in response to improvement or deterioration in a state’s fiscal condition and often in response to targeted provider, worker, or consumer advocacy efforts.

b. Some states, however, have improved direct-care compensation by reforming their methods for rebasing and/or updating their reimbursement rates for Medicaid HCBS in such a way that they are based on actual costs and competitive market rates. Arizona and Texas are examples of states which have systematic methods for determining HCBS base rates and for rebasing (see Exhibit 5).

Exhibit 5
Reform of Methods for Rebasing and Updating Reimbursement Rates
for Personal Care Services

What Is It?	State Examples	Results
Establishment of a systematic, on-going method for determining payment rates for PCS based on providers' actual costs and competitive market rates, and allowing for evaluation of adequacy of rates over time.	Arizona, Texas Also consider examples from other human service areas such as childcare.	• Reduces reliance of rate setting on the political process and links it to actual costs of providing services. • Reduces provider uncertainty about year-to-year funding. • Promotes consistency and coordination of rate setting across programs and departments. • Does not guarantee wage improvements for direct-care workers.

As a result of an ongoing court case (*Ball v. Biedess*; see Strategy #4 below), Arizona has instituted important revisions to its rate determination process. Arizona delivers Medicaid LTC services through a managed care program that serves about 40,000 Medicaid beneficiaries. Selected by a competitive bid process, the state currently contracts with seven Program Contractors (PCs) to administer services, and these PCs in turn subcontract with local agencies and facilities to provide actual care services. The PCs are paid a bundled rate prospectively on a capitated per member per month basis,⁴⁰ and then they negotiate payment rates with individual providers.

In 2001, Arizona rebased its fee-for-service (FFS) rates for Medicaid HCBS. These rates, along with utilization rates, are the two key inputs into the calculation of the system's capitated rates. According to the consultants who assisted in the development of the new approach, this rate-setting method has two important features: "a structure for evaluating the adequacy of the rates over time" and a method for evaluating "the adequacy of the individual assumptions and components used to set the rates" (e.g., the level of wages or benefits).⁴¹ The new model was used to build rates based on what the program was purchasing for each service in terms of:

- Hourly and annual wages (estimated using Arizona data from the Occupational Economic Statistics data from the U.S. Bureau of Labor Statistics (BLS)).
- Employee-related expenses (EREs) such as Federal Insurance Contributions Act (FICA) taxes, workers' compensation, unemployment compensation, and health/dental insurance (EREs assumed at 30 percent of wage bill).
- Adjustment factor for non-direct-care service hours (total hours adjusted for time spent traveling and completing notes/records, and "down time").
- Average mileage.
- Administrative overhead (at 10 percent of non-travel cost).

Initial baseline cost data for these components were derived from the results of a cost survey sent to a sample of providers.

In two of the three years after 2001, the state Medicaid agency trended the FFS HCBS rates by an inflationary factor of 3.4 percent. Then in 2004-05, it began a rebasing process designed to update the components of the above model. Additional sources of information were considered: A survey was conducted of Arizona home and community-based LTC providers in order to gather information about wages, benefits, travel time, mileage and supervision; and information was obtained about rates paid by other agencies for similar services in Arizona as well as rates paid in other states. Among other changes, rate models were modified to reflect the highest wage data available, either from the BLS or from a provider survey.

In 2003, Texas centralized all of its rate setting in one department, the Rate Analysis Department (RAD) of the Texas Health and Human Services Commission (HHSC). This change was part of a major restructuring that eliminated twelve Health and Human Services agencies by consolidating functions within five newly-defined agencies.

RAD develops reimbursement methodology rules for determining payment rates or rate ceilings for recommendation to HHSC for Medicaid payment rates and non-Medicaid payment rates for programs operated by the Department of Aging and Disability Services (DADS) and the Department of Family and Protective Services (DFPS). The Texas Legislature directed that rates for nursing facilities and home and community-based settings be set in a similar manner and that both have enhancement payments for increased staffing.⁴² All contracted providers, whether nursing facilities or providers serving home and community settings, are required to submit financial and statistical information via an electronic cost report. Rates are reviewed every two years, and rate components are based on the weighted median of adjusted costs of all facilities. Allowable cost categories include: attendant care costs, other direct-care costs, facility costs, dietary costs, and administration and transportation costs. Final rates are subject to appropriated funding.

c. While Medicaid reimbursement rates for nursing facilities typically are updated annually based on an inflation factor, these adjustments are extremely rare for HCBS.

In addition to having a systematic and regular method for rebasing reimbursement rates, another critical component of ongoing and consistent rate setting is a reliable method for updating rates in non-rebasing years. It is extremely rare for Medicaid HCBS rates to be subject to regular cost of living adjustments. Texas and Arizona again are examples of states which have built in an inflation adjustment factor to their HCBS rate setting. Recently, Texas has been using an inflation adjustment factor of 4.4 percent and Arizona a 3.4 percent rate of increase. However, these increases are subject to appropriated funding and do not necessarily occur annually.

d. While more systematic reimbursement rate-setting methods are desirable for many reasons, they do not necessarily guarantee wage and benefit improvements for workers. In the case of Arizona, for example, while wage rates for attendant care workers have improved, they have increased far less than the FFS reimbursement rate received by provider agencies.⁴³ The latter has increased approximately 41 percent from October 2000 to October 2005—from \$11.00 per hour to \$15.52. Attendant care wages, in contrast, have only increased by 11 percent, from \$8.46 to \$9.39, according to Arizona wage data from the BLS for 2001 and 2005. Survey data from Arizona's state Medicaid agency suggest an even more modest wage increase of only nine percent to \$8.95. These observed wage increases suggest that the wage rates of attendant care workers in Arizona at best have kept up with inflation. In sum, while it contains desirable

features and appears to have resulted in substantial reimbursement rate increases to provider agencies, the available evidence indicates that Arizona's new reimbursement methodology has yet to result in a significant upgrade in the wages paid to attendant care workers.

In Texas, while reimbursement rates for PCS are revised using a systematic provider cost-report approach, and while there are incentives for providers to direct more funding toward increased wages, in fact only about half of providers avail themselves of this rate enhancement, with the balance choosing to remunerate personal care workers at just above the minimum wage of \$5.15 (Texas relies on the federal minimum wage). PCS workers in Texas are among the lowest paid in the nation. From 1999 to 2004, BLS wages data indicate that wages have only increased 3.7 percent, from \$6.20 to \$6.43, a negative increase in real terms taking into account inflation.⁴⁴

Both the Arizona and Texas approaches to HCBS reimbursement rate setting are examples of cost-based approaches. Other methods are possible. For example, the effort by Wyoming's legislature to reform reimbursement rates for PCS provided to individuals with developmental disabilities evidences the beginnings of what might be called a "comparable position approach." While it has not been formalized into a regular rebasing method in Wyoming (and, therefore, the authors of this report have categorized it as a wage pass-through), it represents an important effort to peg wages for at least one group of direct-care workers to competitive wages as determined through a market rate survey process.

e. Reimbursement rate determination methods from other human service areas may inform efforts to improve rate setting for Medicaid PCS. Together, the U.S. Congress and the DHHS have encouraged a market-based approach to state rate setting for publicly reimbursed childcare services. Authorization for the 1998 act establishing the Child Care and Development Fund, the main fund providing matching federal dollars to support state childcare services for low-income families, requires states to "provide a summary of the facts relied on to determine that its payment rates ensure equal access," including "[h]ow payment rates are adequate based on a local market rate survey conducted no earlier than two years prior to the effective date of the currently approved Plan."⁴⁵ Thus, states are required to conduct market rate surveys every two years and to consider these market rates in setting the public rates, although they are not compelled to use them. In addition, the Child Care Bureau of DHHS encourages states to set their maximum reimbursement rates for public childcare providers at or above the 75th percentile of current market-based fees.⁴⁶

Strategy #4: Litigation Against State Medicaid Agencies

- a. In the last six years, lawsuits have been filed in a number of states either in federal or state courts challenging state Medicaid HCBS payment policies and payment rates (see Exhibit 6).** The federal lawsuits were brought by groups of Medicaid-eligible individuals who claim lack of access to HCBS, service failure, or denial of care in the most integrated care settings. State lawsuits were brought by provider associations. The lawsuits claim, among other things, that state Medicaid payments violate federal Medicaid law because they are insufficient to enlist adequate numbers of providers. In practical terms, what this means is that direct-care wages allegedly are so low that the resulting workforce is insufficient to provide Medicaid beneficiaries with reliable services.

Exhibit 6

Litigation Against State Medicaid Agencies Based on Claims of Inadequate Payment Rates

What Is It?	State Examples	Results
Plaintiffs: Federal lawsuits brought by groups of Medicaid-eligible individuals who claim lack of access to HCBS, service failure, or denial of care in the most integrated care settings. State lawsuits brought by provider associations. Defendants: State Medicaid agencies; sometimes state human service agencies.	Federal Lawsuits Arizona, California, Colorado, Mississippi, Wisconsin State Lawsuits Kansas, New Hampshire	• Results vary across states and by lawsuit and need to be evaluated on a case-by-case basis. • Existence of lawsuit can create pressure for state policy changes, including higher payment rates. • Litigation can involve a lengthy process and be very expensive.

The statute upon which inadequate payment claims rest is known as the “equal access” provision of Title XIX of the Social Security Act (§1902(a)(30)(A)). It provides that:

A state plan for medical assistance...[must] provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan...as may be necessary to...assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

According to the latest litigation status report of the Human Services Research Institute,⁴⁷ since 2000, lawsuits have been filed in federal court in at least five states alleging inadequate payment, among other claims: Arizona (*Ball et al. v. Biedess et al.* in 2000), Colorado (*Mandy R. et al. v. Owens et al.* in 2000), California (*Sanchez et al. v. Johnson et al.* in 2000), Mississippi (*Billy A. and Mississippi Coalition for Citizens with Disabilities v. Jones et al.* in 2002), and Wisconsin (*Nelson et al. v. Milwaukee County et al.* in 2004). Of these five cases, only the Mississippi and California cases have been fully resolved.

- In Mississippi, a settlement was reached in March 2005 in which the state agreed to increase payments to personal care attendants by \$0.50 per hour effective July 1, 2005, and request funds from the legislature for additional pay increases totaling \$1.50 over three years.⁴⁸
- In California, a District Court judge dismissed the Sanchez case in January 2004 agreeing with the state that the federal Medicaid Act’s provision dealing with payment rates does not confer individually enforceable rights for which Medicaid recipients and providers can seek federal court intervention. The Ninth Circuit Court of Appeals upheld the lower court’s decision in 2005. This decision represents a worrisome setback to advocates for Medicaid beneficiaries seeking to base claims on the Medicaid Act’s equal access provision. This provision, however, still is considered individually enforceable in other parts of the country. CMS also can enforce the provision, but CMS has thus far shown little inclination to do so.

While it has been appealed to a higher court, the U.S. District Court's August 2004 and June 2005 decisions in Arizona's *Ball v. Biedess* case have attracted considerable attention. In this case, the court found that Medicaid recipients went without critical home care services for substantial amounts of time. The court found that, at the root of the service delivery problems, were direct-care wages too low to elicit a sufficient supply of personal care attendants. Arizona was ordered to make sweeping changes in its home and community-based LTC programs, including providing a rate of pay to direct-care workers sufficient to attract enough workers. Specifically, the court ordered Arizona to:⁴⁹

- Provide a rate of pay to direct-care workers sufficient to attract enough workers;
- In cases of a "gap" in service, provide "critical services" within a two-hour period using on-call backup staffing; and
- Develop and employ methods and procedures both to calculate payment rates and monitor provider performance in the delivery of services.

During the six years which the case has been under litigation, Arizona has taken demonstrable steps both to increase the FFS reimbursement rates it pays for attendant care services, and to revamp the methods which it uses to rebase and adjust capitated payment rates. However, the available evidence indicates that these changes have yet to have a meaningful impact on wages for attendant care workers (see Strategy #3 above).

Another litigation strategy is to pursue lawsuits in state courts challenging state reimbursement rate setting for Medicaid HCBS. New Hampshire and Kansas offer two examples of this strategy.

In April 2004, the Home Care Association of New Hampshire (HCANH) filed a complaint in New Hampshire Superior Court asking that the state be compelled to comply with an existing state statute governing the establishment and updating of home health reimbursement rates (including rates for homemaker services provided by personal care workers). That statute directs the Commissioner of DHHS to establish a rate-setting methodology that builds rates to "reflect the average cost to deliver services" in consideration of factors such as "economy, efficiency, quality of care, and access to care". It also directs that these rates be reviewed annually so that they may "better reflect the average cost to deliver services".⁵⁰ In July 2005, HCANH and the state reached a settlement which provides that DHHS will work cooperatively with HCANH and its member agencies to establish a new rate-setting methodology based on the average costs of providers and that cooperative and best efforts will be made to seek rate increases for provider payments.

In Kansas, five community service providers and Interhab (an association of Kansas community service providers) filed a class action suit in a county district court against the Kansas Department of Social and Rehabilitation Services (SRS). The 2002 lawsuit (*Interhab, Inc. et al. v. Schallansky et al.*) claims that state payments are insufficient to meet the needs of people with developmental disabilities and, thereby, violate Kansas and federal law. The lawsuit alleges that the state has violated its own act, the Developmental Disabilities Reform Act of 1996 (DDRA), which plaintiffs argue mandates that the state provide "adequate and reasonable" funding for community services and conduct regular rate reviews. Plaintiffs hold that the wage rate upon which SRS bases payments is inadequate and that, therefore, provider agencies are unable to

recruit and retain qualified staff. According to Gary Smith of the Human Services Research Institute:⁵¹

The plaintiffs are asking the court to: (a) review all payment rates for the period 1996 – 2003; (b) order the state to pay for all “underfunding” during that period; (c) enjoin the state to pay “adequate and reasonable reimbursement rates”; (d) enjoin the state to establish a rate setting methodology that complies with federal and state law; and (e) enter a judgment directing SRS to reimburse all costs incurred by the plaintiffs in delivering services, including hourly wages and benefits that reflect the amounts paid to other workers in each locality.

b. Litigation strategies can be effective in creating pressure on states to improve their reimbursement methods, increase payment rates, and support higher wages and benefits for direct-care workers, either through their resolution in the court system and/or through the scrutiny they create along the way. However, the legal system tends to move very slowly, with full resolution (including appeals of lower court decisions) often requiring many years of ongoing effort and legal costs.

It should also be noted that the recent Sanchez decision (see above) poses a significant challenge to outstanding and future individual claims of inadequate payment under the federal equal access provision because it lends an appeals court’s support to the interpretation that Medicaid beneficiaries do not have a private right of action in federal court with respect to this provision. While it is clear that the federal government could enforce the equal access requirement against any state Medicaid program, it will depend on which state the individual resides in as to whether that individual can bring such a challenge. For example, under the 2006 decision of the Eighth Circuit Court of Appeal in *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, people living in the states of North and South Dakota, Nebraska, Minnesota, Iowa, Missouri, and Arkansas have been found to have the right to individually enforce the equal access law. With the federal Courts of Appeal now in conflict, the status of the law is unclear over what had appeared to be a settled right of Medicaid beneficiaries.

Strategy #5: Collective Bargaining by Direct-Care Workers

Economist and LTC researcher, Candace Howes notes, “Unlike the private employers in manufacturing, retail, and services, which also pay very low wages, state and federal governments are subject to direct political pressure from unions and consumer groups, often working in coalition.”⁵² Within the public LTC sector, this pressure has resulted in collective bargaining outcomes which in some cases have resulted in significant improvements in direct-care wages and/or benefits.

The collective bargaining model which to date has had the greatest impact on PCS workers is the “public authority” model for PCS workers who are directly hired by consumers and not by agencies (see Exhibit 7). Currently, four states—California, Washington, Oregon, and Michigan—have created public authorities which assume responsibility, under agreements with the state or under state laws, for the payment process and serve as the “employer-of-record” for workers whose remuneration comes from public funds. They also provide a support system such as training for both beneficiaries and providers, and often create and maintain registries of individual home care provider candidates in order to improve beneficiary access to individual

providers. (In Massachusetts, a Personal Care Attendant Quality Workforce Council was approved by the state legislature in July 2006, overriding the governor's veto, and is under implementation. It is estimated that the new public authority will cover about 20,000 PCS workers.)

Exhibit 7 Public Authorities

What Are They?	State Examples	Results
Independent governmental agencies ("public authorities") which serve as the employer-of-record for personal care workers directly hired by consumers.	California (county-based; first one in 1992) Oregon (2000) Washington (2002) Michigan (2004) Massachusetts (approved July 2006; under implementation)	• When combined with worker representation, public authorities offer the potential for significant wage and benefit increases through regular contract negotiations. • Authorities can vary in the degree to which they serve a full set of interests of both consumers and workers. • State officials can be reluctant to rely on an entity which represents the interests of consumers and workers to conduct union negotiations on their behalf.

In each of the four states with fully implemented authorities, independent providers elected to join the Service Employees International Union (SEIU) or the American Federation of State, County and Municipal Employees (AFSCME). The union then elects a bargaining committee to negotiate contracts for the independent workers concerning wages and benefits with the public authority (two years is the typical contract period). Once the legislature sets the overall reimbursement rate for PCS, then these negotiations determine the amounts for wages and benefits that get incorporated into the payment rates.

California, the first state to develop the public authority model, operates a county-based public authority system that provides Medicaid-funded PCS to approximately 380,000 consumers of In-Home Supportive Services (IHSS). Counties began establishing these authorities in 1992, and there are now 52 of them. As of March 2005, there were 317,709 IHSS providers,⁵³ and the vast majority of these workers have chosen to organize with SEIU locals or with AFSCME. The unions have been able to negotiate significant wage and benefit increases, although progress has been slower in some counties (e.g., Los Angeles) than others. In general, according to SEIU, "all IHSS workers in counties with a collective bargaining agreement now earn above the state minimum wage of \$6.45, with several counties achieving wages above \$10 per hour."⁵⁴ Benefits (including health, vision, and dental insurance; pension; transportation subsidy; and limited sick and vacation leave) have been added in several counties, although Howes reports that most IHSS workers do not work enough hours to be eligible.⁵⁵

The Oregon Quality Home Care Commission was formed in 2000, and its 13,000 home and community-based workers elected to join SEIU in 2001. The workers' first contract, ratified in 2003, provided for a wage increase of 40 cents an hour, health insurance, workers' compensation coverage, health and safety training, and paid vacation days. According to SEIU, "negotiations over health benefits were extensive and led to an innovative solution where the local is administering the benefit".⁵⁶ The 2005-07 contract provides for vision and dental coverage as well as a 25-cent increase in hourly wages.

The Washington Home Care Quality Authority (HCQA) was established in 2002 as the employer of 26,000 personal care workers who elected to join SEIU. (Recently, employer-of-record responsibility was moved from the HCQA to the Governor's office.) In 2003, a two-year contract was successfully negotiated which brought wage improvements, health benefits, and workers' compensation insurance. However, the negotiated \$2.00 hourly wage increase was rejected by the governor who instead approved a 75 cents per hour increase. The negotiated contract for the period 2005 to 2007 provides vision and dental health coverage and establishes a wage scale based on cumulative career experience, effective July 1, 2006. Wages will be adjusted upward for each employee based on accumulation of hours.⁵⁷

Michigan's public authority, the Quality Community Care Council, was formed in December 2004. It covers about 41,000 independent, individual providers providing services under the state's Home Help Program, a program funded by the state's Medicaid personal care benefit. The unionization vote occurred in April 2005. Contract negotiations between the public authority and SEIU were underway as of early 2006, and the Governor's fiscal year 2007 budget proposal set aside \$20 million for wages increases for workers covered by the authority. Frozen since 2003 at an average hourly wage of \$6.69, in July 2006 the Michigan Legislature established a minimum \$7.00/hour wage floor for the Home Help Program and gave a 50 cent/hour raise for PCS workers already making more than the \$7.00/hour wage floor.

When combined with worker representation, the public authority model offers the potential for significant wage and benefit increases through contract negotiations. However, state officials can be reluctant to rely on an entity which represents the interests of consumers and workers to conduct union negotiations on their behalf. In addition, the effectiveness of public authorities in successfully representing and serving the interests of both workers and consumers requires a delicate balancing of mutual interests and power.

Strategy #6: Living Wage Ordinances and Minimum Wage Improvements

Significant wage increases for many low-wage workers, including direct-care workers, have been achieved through city and county living wage ordinances and through action to increase state and city minimum wage standards (see Exhibit 8). A municipal living wage ordinance typically applies *only* to private agencies and companies receiving significant contracts resulting from the city or county's procurement process, while a minimum wage establishes a pay floor for *all* businesses in a given locality, and is thus more comprehensive since it applies to a greater number of employers.⁵⁸

Exhibit 8

Living Wage Ordinances and Minimum Wage Improvements

What Are They?	State Examples	Results
Living Wage Ordinances: Local laws requiring private businesses which receive significant city or county service contracts to pay their workers a higher minimum wage, nearer the wage which would enable workers to meet their basic needs or sustain a family. ⁵⁹	Living Wage Ordinances: • 140 in the U.S. as of the end of 2005 with about 70 campaigns underway.⁶⁰ • Examples of ordinances impacting significant numbers of PCS workers include New York City, Westchester and Suffolk Counties in New York, and San Francisco.	• Often significant wage increases for covered workers. • Covered workers whose employers do not offer health insurance typically are compensated at higher rate (e.g., \$1.00 more per hour). • Wage discrepancies can be created between covered and not-covered workers.
State/City Minimum Wage Laws: Laws which set the minimum wage above the federal level, or in the case of a city law, above the state minimum wage.	State/City Minimum Wage Laws: • 17 states plus the District of Columbia. • Two cities: San Francisco and Santa Fe.	• Wage floor is established for the low-wage labor market. • When indexed to inflation, this floor increases annually, creating upward pressure on all low-income wages.

City and County Living Wage Ordinances. According to the Living Wage Resource Center, “[m]any campaigns have defined the living wage as equivalent to the poverty line for a family of four, (currently \$9.06 an hour), though ordinances that have passed range from \$6.25 to \$13.00 an hour, with some newer campaigns pushing for even higher wages”.⁶¹ The ordinances often require that roughly a dollar more an hour be paid to workers whose employers do not offer health benefits. Some of the ordinances are designed to target specific groups of low-wage employees at companies which perform tasks that municipalities have outsourced such as garbage collection, security services, home healthcare, and personal care. Low-wage workers in the private sector (e.g., in restaurants, hotels, and retail stores) are not directly affected.

Several recent living wage ordinances have targeted home care workers and together have affected tens of thousands of direct-care workers. Examples include ordinances in New York City, Westchester and Suffolk Counties in New York, and San Francisco. The New York City ordinance, which was signed into law in November 2002, applies to about 50,000 PCS workers who previously earned \$7.69 per hour working for home care agencies operating under contract with the city through the state’s Medicaid program.⁶² The current living wage is set at \$9.60 assuming the employer provides health benefits or \$11.20 if health benefits are not provided. In July 2006, the wage rate increased to \$10.00 an hour (\$11.50 if no health benefits are provided).

State and City Minimum Wage Laws. The federal hourly minimum wage of \$5.15 has remained unchanged since 1997. According to the Center on Budget and Policy Priorities, over the past eight years the purchasing power of the minimum wage has deteriorated by 17 percent and, after adjusting for inflation, the value of the minimum wage currently is at its second lowest level since 1955.⁶³ Seventeen states and the District of Columbia have raised their minimum wages above the federal level.⁶⁴ The higher wages (2006 levels) range from \$6.15 in Delaware

and Minnesota to \$7.63 in Washington. Furthermore, four states—Washington, Oregon, Florida, and Vermont—have chosen to index their minimum wage so that they automatically increase each year with inflation.⁶⁵ Indexation is an important policy tool for addressing the problem of declining real wages for the lowest paid workers, and it also avoids the political battle of an annual legislative fight to protect workers' living standards.

In addition to efforts to increase and/or index state minimum wages, over the past four years seven cities have decided to enact their own minimum wage laws. Five of these laws have been blocked either by state legislatures or the courts; the two still standing are in San Francisco and Santa Fe, both enacted in 2003. The San Francisco minimum wage, approved in November 2003, is indexed to the inflation rate and applies to all businesses with at least ten employees and has a phase-in for non-profits and small businesses. In 2005, the business wage was set at \$8.62, with \$7.75 for non-profits and small businesses. The Santa Fe minimum wage applies to all large businesses. Santa Fe's wage began at \$8.50 and is scheduled to increase to \$9.50 in 2006 and \$10.50 in 2008.

State and city minimum wages have direct effects on the workers who receive them, but they also have indirect effects on other low-wage workers because they essentially establish a floor under the low-wage labor market and exert upward pressure on the general wage scale for low-income workers. Just how much that floor helps support higher wages for workers who are still low-income but receiving wages above the minimum wage is an issue that has not been well researched. The related policy tool of indexing minimum wages is also likely to strengthen pressure on state government to keep its reimbursement rates for LTC services more current.

Strategy #7: Health Insurance Initiatives Targeting Direct-Care Workers

While most of the strategies previously described in this report focus primarily on wages, they do not preclude attention to benefits. In just the last few years, the problem of direct-care workers' lack of access to affordable health care coverage has gained greater attention on its own merits. Policymakers and employers are realizing the importance of health benefits as a key component of a good job. As William Ebenstein, a senior researcher in the developmental disabilities field, writes, "[o]ver the last 20 years, much of the debate around the direct support workforce has focused on wages. The growing health care crisis requires that this debate be broadened to include the cost of benefits for both employers and workers".⁶⁶

Ranging from small, local pilot demonstrations to statewide campaigns, several initiatives across the country are drawing attention to the problem of health insurance coverage for direct-care workers, and are involving providers and policymakers, and in some cases workers and consumer organizations, in devising solutions. The importance of these efforts is underscored by recent research studies that suggest that the provision of health insurance benefits for this workforce may play a stronger role in reducing turnover and increasing retention than increasing wages alone.⁶⁷ To date, most of these initiatives are in the start-up phase and, therefore, do not yet have concrete results to report.

Exhibit 9
Health Insurance Initiatives Targeting Direct-Care Workers

Types of Initiatives	State Examples	Results
Subsidizing employer-sponsored insurance	Indiana, North Carolina, New York (agency-based pilots); Maine (statewide); Pennsylvania (regional pilots)	• New York evaluation of its Home Care Workers Health Insurance Demonstration Project showed improved retention and decreased turnover. • Indiana, Maine, and North Carolina evaluations due in 2007.
Innovative employer-based health insurance package	New Mexico (agency-based pilots)	Evaluation due in 2007.
Outreach for pre-established plans	Maine, Washington	Evaluations due in 2007.
Recommendations by Governor's Long-Term Care Workforce Commissions or other public/private initiatives or workgroups	Arizona, Michigan, Pennsylvania, Wisconsin	Various initiatives underway to address recommendations (from studies to broader expansion efforts).
Submission of state legislative bills to directly address the problem of lack of health insurance coverage for direct-care workers	Massachusetts, New Hampshire	• In Massachusetts, S. 705 was subsumed by H4850 (enacted in April 2006) which provides for near-universal health coverage and is expected to cover an additional 500,000 uninsured individuals. • In New Hampshire, SB 279-FN was killed in committee in February 2006.

As shown in Exhibit 9, the mechanisms for achieving broader health care coverage for direct-care workers typically rely one or more of the following mechanisms:⁶⁸ Subsidizing employer-based coverage, outreach to enroll direct-service workers in plans offered through public-private partnerships, pooling together small employers to form employer purchasing pools, and increasing eligibility for publicly-funded plans. These mechanisms are not mutually exclusive. Many states are experimenting with reforms that combine public support for private insurance (e.g., premium assistance programs).

As of mid-2006, initiatives targeting expanded health care coverage for direct-care workers had been undertaken in twelve states (see Exhibit 9). These initiatives vary widely in their strategy, design, and scope. Under CMS's Demonstration to Improve the Direct Service Community Workforce (DSW), ten states received grants in 2003 and 2004, and six of these focused on expanding health care coverage to direct-care workers in order to improve retention and recruitment. According to a recent overview report prepared for CMS:⁶⁹

- Grantees in four states—Indiana, North Carolina, Virginia, and New Mexico—are spending demonstration funds directly on benefits for a small target group of direct-service workers. While the first three states in this category are approaching this by

subsidizing employer-based coverage, New Mexico is offering an arrangement that combines basic insurance and personal accounts.

- Grantees in two states, Maine and Washington, are spreading grant funds more broadly to benefit larger groups of workers; both states are using outreach campaigns to increase the number of direct-service workers enrolled in already established plans.⁷⁰

In Maine, efforts are underway to expand DirigoChoice, Maine's new statewide subsidized health insurance program, by targeting home care agencies and a direct-care worker coalition. In Washington, the expansion effort is part of a public-authority collective bargaining agreement for consumer-employed direct-care workers whose services are reimbursed under a Medicaid waiver. The Maine intervention focuses on convincing employers to offer coverage whereas the Washington program is focused on improving the take-up rate of already eligible individuals.

Two other states, Michigan and Pennsylvania, have start-up initiatives sponsored by Health Care for Health Care Workers (HCHCW), a new national campaign of the Paraprofessional Healthcare Institute which seeks to bring public attention to the health insurance situation facing direct-care workers.⁷¹ These efforts aim to combine public education with pilots to expand employer-based coverage while at the same time linking with statewide campaigns to bring more universal state-based coverage.

- In Spring 2006, HCHCW in Michigan conducted the 2006 Michigan Long-Term Care Employer Survey on Health Insurance. This survey marked the first effort of its kind in Michigan to gather information across all sectors of LTC on the availability of health insurance coverage for direct-care workers and the problems facing employers in the provision of insurance.⁷² HCHCW also is developing recommendations and providing input into the design of the Michigan First Healthcare Plan, a coverage expansion proposed by the governor to provide health insurance coverage to 550,000 of the state's uninsured who have incomes below 200 percent of Federal Poverty Levels. In addition, HCHCW is developing a pilot to target outreach and enrollment to direct-care workers; identifying options for linking direct-care workers and small LTC employers with already established locally- or regionally-based subsidized health plans; and providing consultation and outreach to employers that currently provide health insurance but have low take-up rates.
- In Pennsylvania, building on recommendations made by the Pennsylvania Center for Health Careers (a public/private initiative created by the governor), HCHCW is currently engaged in two key efforts: 1) pooling small LTC providers in one tri-county area in order to establish a health insurance purchasing pool, and 2) creating a targeted health insurance pilot project that would either be regionally or occupationally based. For the tri-county project, in conjunction with the Wisconsin Regional Training Partnership, HCHCW is conducting a needs assessment of home and community-based providers' health insurance coverage for a newly formed Regional Workforce Center, including developing an employer survey to be used to prepare a feasibility study for a Professional Employer Organization (PEO).⁷³ The targeted pilot project would offer both public- and employer-sponsored options for insurance coverage for direct-care workers. As a first step, HCHCW is working with the Pennsylvania Department of Labor and Industry's Center for Workforce Information and Analysis to survey direct-care workers regarding their health insurance coverage, utilization patterns, and health status. The pilot will

explore a range of financing options and models of public and private health insurance vehicles, and could expand state-supported pools for covering direct-care workers.

In some states (for example, Arizona, Michigan, Pennsylvania, and Wisconsin), LTC workforce commissions or workgroups appointed by governors or other public/private initiatives have made recommendations regarding expanding health insurance coverage for direct-care workers. Such recommendations often become the springboard for further proposals and action.

Finally, a few states have introduced legislation that specifically calls for the establishment of direct-care worker health insurance coverage, as was the case this year in Massachusetts and New Hampshire.

- In Massachusetts, S. 705 would have established an insurance assistance program for the direct-care human service and health care workforce that would have eliminated the employee share of premiums for eligible direct-care workers who are currently offered employer based insurance. In addition, the program would have covered the full cost of premiums for eligible workers who are not currently offered employer-based insurance. S. 705 was subsumed by the passage of near-universal health insurance coverage in Spring 2006.
- In New Hampshire, SB 279-FN would have allowed employees of area agencies and mental health clinics to be treated as state employees for the purposes of health insurance. The bill was killed in committee in February 2006.

IV. Summary and Conclusions

This survey of state and local efforts to improve compensation for direct-care workers suggests several important issues and implications that advocates, policymakers, researchers, and providers may find useful to consider.

1. Lack of Federal Oversight and Guidance. Federal oversight of and guidance to state Medicaid rate-determination methods and procedures have been minimal but should be strengthened to help improve workforce adequacy and the quality of services received by consumers. To date, little attention has been paid to the impact of low payment rates (including low wages and benefits paid to direct-care workers) on the quality of services received by Medicaid recipients, and, therefore, to the need for states to monitor the wage rates and benefits paid to direct-care workers as part of their quality assurance approaches. Few meaningful federal review requirements are in place regarding state rate-setting methods and procedures, and CMS has not used its enforcement powers to assure adequate reimbursement payment. Furthermore, CMS has not developed guidance for states concerning desirable rate-setting principles and standards to inform rate setting across LTC settings. Useful guidance could include:

- Standards for assessing the adequacy and reasonableness of rates.
- Guidelines concerning the minimum frequency with which rates should be revised.
- Options regarding the economic and financial information to be considered when establishing and/or revising base rates as well as updating them.
- Options for creating rate enhancement incentives (e.g., "pay-for-performance" or "tiered reimbursement strategies") which target specific policy and program goals to be achieved through performance standards related to quality-of-care and quality-of-job.

2. Existing Direction to States. Court decisions as well as federal statutes and regulations arguably provide the following guidance to state Medicaid agencies:⁷⁴

- Payments for services must be consistent with efficiency, economy, and quality of care.
- The state Medicaid agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.
- The state Medicaid agency must provide methods and procedures to achieve the above two outcomes.
- The state Medicaid plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the state's Medicaid program.
- The state Medicaid agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

3. *Ad Hoc* Reimbursement Rate-Setting Methods. Most states set reimbursement rates for Medicaid PCS in a relatively *ad hoc* manner, and many do not know what the provider agencies they contract with pay their workers.

- *Ad hoc* refers to situations where no requirements exist that rates be reviewed on a periodic basis in order to evaluate their adequacy over time, and where no systematic process is in place to update or rebase rates taking into account relevant economic and financial information, including provider costs. Rather, rates are largely determined on an as-needed basis in response to improvement or deterioration in a state's financial condition, the emergence of pressing workforce issues, or in response to targeted provider or consumer advocacy efforts or lawsuits.
- Most states do not know what the provider agencies they contract with pay their workers or the extent to which workers in direct-care occupations have health insurance coverage — two key factors which research shows play critical roles in determining turnover and vacancy rates and, therefore, the overall adequacy and stability of the PCS workforce.
- While Medicaid reimbursement rates for nursing facilities typically are updated annually based on an inflation factor, these adjustments are extremely rare for HCBS. In the absence of regular rebasing, the lack of an automatic cost-of-living adjustment means that the real value of HCBS rates necessarily will decline and fail to keep up with provider costs and inflation.

4. Problematic Rate Setting. Most current approaches to PCS rate setting and wage determination are problematic for several reasons:

- Rates tend to be determined primarily by the overall state budget-driven process which can be heavily influenced by political factors, including the relative advocacy strength of different LTC providers, consumer groups, and organized labor.
- Providers are subject to considerable uncertainty regarding their year-to-year funding.
- If a state neither knows the profile of worker wage rates and benefits paid by provider agencies nor sets a percentage ceiling on administrative expenses, there is a danger that rate increases will not reach workers.

- Lack of an integrated approach to rate setting across Medicaid HCBS can lead to unrelated and inconsistent rate setting across departments and across programs. When financing incentives and reimbursement methods are not aligned with systems-change goals, this lack of coordinated rate setting can impede overall reform goals for LTC such as shifting the locus of care to home and community-based settings and away from nursing facilities (“rebalancing”).
- Lack of an integrated approach to rate setting across Medicaid HCBS also can result in different wages being paid to workers performing the same tasks, thus putting jobs in one LTC setting at a competitive disadvantage relative to other settings.

5. No Single State Solution. Exemplary approaches to improving wage rates and benefits for personal care workers typically are unique to particular state and local contexts. A one-size-fits-all solution across the states is difficult to imagine given the considerable variation in state circumstances. Instead, advocates, policymakers, worker associations, organized labor, and provider associations need to determine, within their own unique state context, where the most strategic leverage points lie for increasing direct-care wages and benefits. This review does suggest that establishing a foothold in at least one LTC setting providing for regular and consistent wage setting review can be valuable for two reasons. First, it sets an “example” (a benchmark or floor) for other settings or occupations to follow; and second, because all direct-care wages are ultimately connected, it can create a “vacuum effect” which puts upward pressure on direct-care wages in other sectors. This foothold, for example, could be an indexed living wage ordinance in an important city or county with sizable contracts with home care workers; it could be an indexed state minimum wage; it could be a unionized group of directly-hired workers whose employer-of-record is a public authority; and it could be state legislation or regulatory agency action which provides for a cost-based reimbursement rate-setting approach with biannual rate adjustments such that a certain minimum percentage of the costs of providing particular HCBS are guaranteed funding.

6. Effective Components of Wage and Benefit Improvement Strategies. While they are far from common practice, particular components of compensation improvement strategies deserve highlighting because they have the potential to have a noticeable impact on improving the adequacy of wages and benefits for direct-care workers. These components include:

- Providing an automatic update mechanism, such as an annual inflation adjustment using an index tied to health care labor costs, or at least to the Consumer Price Index (CPI) or the Medical Care CPI.
- Putting protocols and procedures in place which assure that the administrative portion of the payment rate received by agency providers is not excessive and that a substantial portion of any given rate increase is actually allocated to direct-care labor costs and, therefore, can reach workers.
- Tying the evaluation of the adequacy and reasonableness of wage rates to a “comparable wage” or “living wage” approach. The former assumes that direct-care staff should be paid hourly wages and fringe benefits comparable to what other employees receive in similar positions or which are otherwise competitive with local economic conditions. Local market surveys conducted on a regular basis can be an effective tool for determining comparable wages. The living wage approach assumes that direct-care

workers are paid a living wage at least sufficient to make them ineligible for government assistance *and* able to afford basic living expenses such as health insurance. Still another alternative is to tie reimbursement rate setting to a cost-based approach that recognizes providers' actual costs of doing business.

- Building in the capacity to evaluate the adequacy of the rates over time so that the base rates stay competitive and keep up with changing relative costs.

Ensuring good quality care hinges on the ability of state and local policy makers to address the adequacy of the wages and benefits paid to direct-care workers. As states move forward with efforts to reform their LTC systems so that they are increasingly home and community-based, this issue will only grow in importance. Most states appear to be at the earliest stages of designing comprehensive and systematic approaches to setting payment rates for directly-hired and agency-employed PCS workers. It is noteworthy that federal guidance and direction in this area appear to be remarkably minimal, suggesting that there is room for the federal government to take steps to assist states in their efforts to promote a quality direct-care workforce with sufficient capacity. At the same time, policymakers, providers, researchers, consumers, and advocates seeking to improve the wages and benefits paid to workers can draw upon the emerging state-level experience and lessons which this report begins to detail.

APPENDIX A
**SUPPLEMENTAL QUESTIONS TO THE 2005 NATIONAL SURVEY OF STATE
INITIATIVES ON THE LONG-TERM CARE DIRECT-CARE WORKFORCE**

The following five questions are asked in order to identify models that may be helpful to states in administering their Medicaid personal care services. They are part of a study commissioned from the Paraprofessional Healthcare Institute by the AARP Public Policy Institute (PPI,) with the findings to be published in a PPI report in 2006.*

1. Does your state (or do counties within your state) set direct-care worker wage rates for any of your Medicaid personal care services or aged and disabled waiver programs?
(Please do not include the setting of a service reimbursement rate.)

☐ Yes

☐ No

- a) **If yes**, please briefly explain how those wage rates are determined (e.g., by market survey, specification of minimum wage rate/salary, COLA adjustment, self-sufficiency wage analysis) and describe those rates.
- b) **If no**, do you have any information on how wage rates are determined (e.g., collective bargaining, agency determined, consumer determined) and describe those rates:
- c) Provide contact information for the person most knowledgeable about this issue (telephone number or email address):

2. Does your state have a system(s) to track and/or monitor whether Medicaid *personal care services** authorized in individual care-recipient care plans are delivered?

☐ Yes

☐ No

- a) **If yes**, please describe this system so that it may be shared with others for quality improvement purposes.

3. What state grievance procedures are available for Medicaid consumers who are dissatisfied with the delivery of their personal care services?

4. Are personal-care agencies required to provide back-up aide or attendant services when they contract with the state?

☐ Yes

☐ No

- a) **If no**, how does the state provide for back-up aide or attendant services?

5. Do you know of any highly successful or “best systems” at the state, county, agency, or program level to:

Provide back-up aide or attendant services:

☐ Yes

☐ No

Track authorized and delivered services:

☐ Yes

☐ No

Receive, resolve, and track consumer grievances:

☐ Yes

☐ No

- a) **If yes**, please briefly describe and provide a contact person (e-mail address or phone number) for additional information:

** Note: Personal care services include those provided in aged and disabled waivers, the Personal Care Option, and through consumer-directed or cash and counseling programs.*

APPENDIX B RESPONSES TO SUPPLEMENTAL QUESTIONS TO THE 2005 NATIONAL SURVEY OF STATE INITIATIVES ON THE LONG-TERM CARE DIRECT-CARE WORKFORCE					
State	Survey response <i>38 responses or 76% response rate</i>	AARP section response <i>38 responses or 76% response rate</i>	State directly sets any PCS worker wages?	State monitors whether Medicaid PCS are received?	State requires agency backup services?
Alabama	Yes	Yes	Yes	No	Yes
Alaska					
Arizona	Yes	Yes	No	Yes	Yes
Arkansas	Yes	Yes	No	Yes	No
California	Yes	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	No	Yes	No
Connecticut	Yes	No			
Delaware	Yes	Yes	Yes	No response	No response
Florida	Yes	Yes	No	Yes	Yes
Georgia	Yes	Yes	No	Yes	No
Hawaii	Yes	No			
Idaho	Yes	Yes	Yes	Yes	Yes
Illinois					
Indiana					
Iowa	Yes	Yes	No	Yes	No
Kansas	Yes	Yes	No	Yes	Yes
Kentucky	Yes	Yes	No	No	Yes
Louisiana	Yes	Yes	No	Yes	Yes
Maine	Yes	Yes	Yes	Yes	No
Maryland	Yes	Yes	Yes	Yes	Yes
Massachusetts					
Michigan	Yes	Yes	Yes	Yes	Yes
Minnesota	Yes	Yes	No response	Yes	No
Mississippi	Yes	Yes	No	Yes	No
Missouri		Yes	Yes	Yes	Yes
Montana	Yes	Yes	No	Yes	Yes
Nebraska					
Nevada	Yes	Yes	No	Yes	Yes
New Hampshire					
New Jersey	Yes	Yes	Yes	Yes	No response
New Mexico		Yes	Yes	No	Yes
New York	Yes	Yes	Yes	No	No response
North Carolina	Yes	Yes	No	Yes	No
North Dakota					
Ohio	Yes	Yes	No	Yes	Yes
Oklahoma	Yes	Yes	No	Yes	Yes
Oregon		Yes	Yes	Yes	Yes
Pennsylvania	Yes	Yes	No	Yes	Yes
Rhode Island					

APPENDIX B RESPONSES TO SUPPLEMENTAL QUESTIONS TO THE 2005 NATIONAL SURVEY OF STATE INITIATIVES ON THE LONG-TERM CARE DIRECT-CARE WORKFORCE					
South Carolina	Yes	Yes	No	Yes	Yes
South Dakota	Yes	Yes	No	Yes	Yes
Tennessee					
Texas	Yes	Yes	No	Yes	Yes
Utah	Yes	Yes	No	No	No
Vermont	Yes	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	No	Yes	No
Washington	Yes	Yes	Yes	Yes	Yes
West Virginia					
Wisconsin	Yes	Yes	No	Yes	No
Wyoming	Yes	Yes	Yes	Yes	Yes

APPENDIX C RESPONSES TO HEALTH INSURANCE QUESTIONS TO THE 2005 NATIONAL SURVEY OF STATE INITIATIVES ON THE LONG-TERM CARE DIRECT-CARE WORKFORCE*		
State	Question 6 Has your state developed (or has plans to develop) strategies to address the lack of affordable health insurance for health care workers?	Question 7 Does your state collect data or have the capacity to collect data on health insurance coverage by occupation (e.g., HRSA grant or Medicaid)?
Alabama	No	No
Alaska		
Arizona	Yes. The state Long Term Care Workforce Taskforce is expected to recommend approaches to making health insurance more affordable for direct-care workers.	No
Arkansas	No	No
California	No response	No response
Colorado	No	No response
Connecticut	No response	No response
Delaware	No response	No
Florida	No	Yes
Georgia	No	No
Hawaii	No response	No response
Idaho	No	No
Illinois		
Indiana		
Iowa	Yes. Iowa conducted a wage and benefit survey of direct-care workers and its BJBC Coalition is currently reviewing options to ensure that direct-care workers are covered.	No
Kansas	Yes	No response
Kentucky	No	No
Louisiana	No	No
Maine	Yes. Dirigo Health program makes health insurance coverage available to small businesses and individuals. A workforce demonstration project in Maine is evaluating direct-care worker recruitment, which includes an effort to enroll workers in Dirigo Health.	No
Maryland	No	Yes
Massachusetts		
Michigan	Yes. A planning project in Michigan is seeking to extend health insurance to all citizens in the state.	Yes
Minnesota	No	Yes
Mississippi	No	No
Missouri	No response	No response

APPENDIX C RESPONSES TO HEALTH INSURANCE QUESTIONS TO THE 2005 NATIONAL SURVEY OF STATE INITIATIVES ON THE LONG-TERM CARE DIRECT-CARE WORKFORCE*		
Montana	No	No
Nebraska		
Nevada	No	No
New Hampshire		
New Jersey	No response	No response
New Mexico		
New York	Yes. New York currently has a small Home Care Worker Rate Demonstration Project.	No
North Carolina¹	No response	No responses
North Dakota		
Ohio	No	No
Oklahoma	No	No
Oregon		
Pennsylvania	Yes	Yes
Rhode Island		
South Carolina	No	No
South Dakota	No	No
Tennessee		
Texas	No	No
Utah	No	No
Vermont	No	No
Virginia	Yes. Small pilot demonstration through a Direct Service Worker grant offers insurance through the child health program.	No
Washington	Yes	Yes
West Virginia		
Wisconsin	No	No response
Wyoming	No	Yes

* Susan Harmuth and Susan Dyson (September 2005) *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce*, National Clearinghouse on the Direct Care Workforce and Direct Care Workers Association of North Carolina, p. 17. Available at: http://www.directcareclearinghouse.org/download/2005_Nat_Survey_State_Initiatives.pdf.

¹ Added by survey report authors (see p. 8): “The Direct-Care Workers Association of North Carolina will conduct an analysis of potential health insurance / mini medical plans that might be considered for inclusion as an optional benefit of association membership.”

ENDNOTES

¹ See, for example, K.C. Lakin and R. H. Bruinninks (1981) "Personnel Management and Quality of Residential Services for Developmentally Disabled People." In: T. C. Muzzio, J. J. Koshel, and V. Bradley, eds., *Alternative Community Living Arrangement and Non-Vocational Social Services for Developmentally Disabled People*. Washington, DC: The Urban Institute; D. Braddock and D. Mitchell (1992) *Residential Services for Persons with Developmental Disabilities in the United States: A National Study of Staff Compensation, Turnover, and Related Issues*. Washington, DC: American Association on Mental Retardation; and S. Larson and C. Lakin (1999) *Longitudinal Study of Recruitment and Retention in Small Community Homes Supporting Persons with Developmental Disabilities*. *Mental Retardation* 37(4): 267–280; L. Dresser, D. Lange, and A. Sirkus (March 1999) *Improving retention of frontline caregivers in Dane County*, Madison, WI: Center for Wisconsin Strategy, University of Wisconsin; E. Hatton and L. Dresser (2003) *Caring About Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin*, Center for Wisconsin Strategy, University of Wisconsin-Madison [available at: <http://www.cows.org/pdf/rp-jwf-cna.pdf>].

² See, for example, Niev Duffy (September 2004) *Job Tenure of Frontline Healthcare Workers: Do Health Benefits Reduce Turnover? Working Paper 102*, New York, NY: City University of New York, JFK Jr. Institute for Worker Education; Niev Duffy (October 2004) *Keeping Workers Covered: Employer-Provided Health Insurance Benefits in the Developmental Disabilities Field*, New York, NY: City University of New York, JFK Jr. Institute for Worker Education; L. Dresser, D. Lange, and A. Sirkus (March 1999) *Improving retention of frontline caregivers in Dane County*, Madison, WI: Center for Wisconsin Strategy, University of Wisconsin.

³ See Candace Howes (2006) *Wages, Benefits and Flexibility Matter: Building A High Quality Home Care Workforce*, Washington, DC: IFAS/AAHSA, Better Jobs Better Care Research Study; Candace Howes (January 2005) *Living Wages and Retention of Homecare Workers in San Francisco*, *Industrial Relations* 44 (1): 139-163; Robert T. Clabby (November 2002) Report to the Joint Appropriations Committee on the Impact of Funding for Direct Staff Salary Increases in Adult Developmental Disabilities Community-Based Programs, Cheyenne, Wyoming: Wyoming Department of Health, Developmental Disabilities Division [available at: <http://ddd.state.wy.us/Documents/JAC1102.htm>]; Robert M. Lynch, Jon Fortune, Clifford E. Mikesell, and Terry L. Walling (October 2005) "Wyoming Demonstrates Major Improvements in Retention by Enhancing Wages and Training," *Links*, Volume 35, No. 9, pp. 9-10; H. S. Berliner (June 2004) *Home Care Workers Health Insurance Demonstration Project: Final Evaluation*, New York, NY: Milano Graduate School, New School University [available at: http://www.hchcw.org/docs/HomeCareDemo_Year3.pdf]; B. Wheeler, D. Kurtz, and T. Smith (January 2002) *Evaluation of the Impact of WIC Section 4681.4 (Rate Increase) on Staff Turnover for Direct Support Workers in Licensed Community Care Facilities for People with Developmental Disabilities, 1998-2000*, Submitted to California Department of Developmental Services by University of Southern California University Affiliated Program.

⁴ See RTZ Associates, Inc (2004) *The Impact of Health Benefits on Retention of Homecare Workers: A Two-Year Study of the IHSS Health Benefits Program in Los Angeles Count*, Prepared for the Los Angeles County Personal Assistance Services Council (PASC) [available at: http://www.rtzassociates.com/publications/benefits_retention_la2004.pdf].

⁵ Holly Akselrod Rodin (2006) *Increasing the supply of certified nursing assistants*, PhD Dissertation, Minneapolis, MN: School of Public Health, University of Minnesota.

⁶ See, for example, Sheryl A. Larson, Amy S. Hewitt, and K. Charlie Lakin (November 2004) "Multiperspective Analysis of Workforce Challenges and Their Effects on Consumer and Family Quality of Life," *American Journal of Mental Retardation* Vol. 109, No. 6, pp. 481-500 as well as sources cited in: US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy (January 2006) *The Supply of Direct Support Professionals Serving Individuals with Intellectual Disabilities and Other Developmental Disabilities: Report To Congress* [available at: <http://aspe.hhs.gov/daltcp/reports/2006/DSPsupply.pdf>]; Direct Care Workforce Issues Committee (June 2005) *Strengthening Wisconsin's Long-Term Care Workforce*: WI Council on Long Term Care Reform [available at: <http://www.wcltc.state.wi.us/PDF/cdrpt.pdf>]; and Holly Akselrod Rodin (2006) *Increasing the supply of certified nursing assistants*, PhD Dissertation, Minneapolis, MN: School of Public Health, University of Minnesota.

⁷ Ellen O'Brien (2003) "Employers' Benefits from Workers' Health Insurance". *Milbank Quarterly* Vol. 81, No.1, pp. 5-43.

⁸ See: Health Care for Health Care Workers (January 2006) *The Facts about a Critical Gap in Long-Term Care, Policy Brief*. No. 1, Bronx, NY: Paraprofessional Healthcare Institute [available at: <http://www.directcareclearinghouse.org/download/PHI-191%20PolicyBriefFinal.1.pdf>]; and Debra Lipson and Carol Regan (March 2004) *Health Insurance Coverage for Direct Care Workers: Riding Out the Storm*. Issue Brief

No. 3, Better Jobs Better Care, Washington, DC: Institute for the Future of Aging Services [available at: <http://www.directcareclearinghouse.org/download/BJBCIssueBriefNo3.pdf>].

⁹ H. Stephen Kaye, Susan Chapman, Robert Newcomer and Charlene Harrington (July/August 2006) “The Personal Assistance Workforce: Trends In Supply and Demand,” *Health Affairs*, Vol. 25, No. 4, pp. 1113-1120.

¹⁰ For five years now, the National Survey of State Initiatives on the Long-Term Care Direct Care Workforce has found that the vast majority of states consider the direct-care vacancies to be a serious issue. The percentage of states has varied from 88% in 1999 to 76% in 2004. For the latest survey, conducted in 2004/2005, see: National Clearinghouse on the Direct Care Workforce and Direct Care Workers Association of North Carolina (September 2005) *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce*. Available at: http://www.directcareclearinghouse.org/download/2005_Nat_Survey_State_Initiatives.pdf. Prior year’s surveys can be found at <http://www.directcareclearinghouse.org>.

¹¹ Steven Dawson and Rick Surpin (February 2001) *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care*, Aspen, CO: Domestic Strategy Group, Aspen Institute; Dorie Seavey, Steven Dawson, and Carol Rodat (forthcoming 2006) *Addressing New York City’s Care Gap: Aligning Workforce Policy to Support Home and community-based Care*, Bronx, NY: Paraprofessional Healthcare Institute; Dorie Seavey (October 2004) *The Cost of Frontline Turnover in Long-Term Care*, Washington, DC: IFAS/AAHSA, Better Jobs Better Care Practice and Policy Report.

¹² See evidence cited in Dorie Seavey and Vera Salter (October 2006) *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*. Washington, DC: AARP Public Policy Institute.

¹³ Dorie Seavey (October 2004) *The Cost of Frontline Turnover in Long-Term Care*, Better Jobs Better Care Practice & Policy Report, Washington, DC: Institute for the Future of Aging Services. Available at: <http://www.bjbc.org/content/docs/TOCostReport.pdf>.

¹⁴ H. Stephen Kaye, Susan Chapman, Robert J. Newcomer, and Charlene Harrington (July/August 2006) “The Personal Assistance Workforce: Trends In Supply and Demand,” *Health Affairs* Vol. 25, No. 4, pp. 1113-1120.

¹⁵ Personal care services are also known as personal assistance services, personal attendant services, attendant care services, and other titles. See US Department of Health and Human Services (October 2000) *Understanding Medicaid Home and Community Services: A Primer*. Washington, DC: The Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services.

¹⁶ For background, see: Laura L. Summer and Emily S. Ihara (August 2005) *The Medicaid Personal Care Services Benefit: Practices in States that Offer the Optional State Plan Benefit*, Research Report, Washington, DC: AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/health/2005_11_medicaid.pdf; and Laura L. Summer and Emily S. Ihara (October 2004) *State-Funded Home and Community-Based Service Programs for Older People*, Research Report, Washington, DC: AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/post-import/2004_11_hcbs.pdf.

¹⁷ Susan Harmuth and Susan Dyson (September 2005) *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce*. National Clearinghouse on the Direct Care Workforce (an initiative of the Paraprofessional Healthcare Institute) and Direct Care Workers Association of North Carolina. Available at: http://www.directcareclearinghouse.org/l_art_det.jsp?res_id=184110 (This is the fifth such survey of Directors of State Medicaid Agencies and State Units on Aging conducted from 1999 to 2005.)

¹⁸ The latter two issues are analyzed in another AARP Public Policy Institute Report: see Dorie Seavey and Vera Salter (October 2006) *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*. Washington, DC: AARP Public Policy Institute.

¹⁹ See <http://www.pascenter.org/home/index.php>; <http://www.nasmd.org>; <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>; <http://www.nga.org/portal/site/nga>; <http://www.cms.hhs.gov/default.asp?>

²⁰ A surrogate refers to a family member or other designated individual who assumes responsibility for directing the care of the Medicaid beneficiary.

²¹ Cash and Counseling programs “cash out” particular Medicaid waivers creating individualized budgets which consumers use arrange for their services and supports, including purchasing care services, labor saving devices, or home modifications that promote independent living. See <http://www.cashandcounseling.org>. Also see: Stacy Dale, Randall Brown, Barbara Phillips, and Barbara Carlson (August 2005) *Experiences of Workers Hired Under Cash and Counseling: Findings from Arkansas, Florida, and New Jersey*. Princeton, NJ: Mathematica Policy Research, Inc.

²² The complete results can be found on p. 8 of Susan Harmuth and Susan Dyson (September 2005) *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce*. National Clearinghouse on the Direct Care Workforce (an initiative of the Paraprofessional Healthcare Institute) and Direct Care Workers

Association of North Carolina. Available at:

http://www.directcareclearinghouse.org/download/2005_Nat_Survey_State_Initiatives.pdf.

²³ Paraprofessional Healthcare Institute (April 2003) *State Wage Pass-Through Legislation: An Analysis*. Workforce Strategies Occasional Paper No. 1, Bronx, NY: PHI, and Washington, DC: Institute for the Future of Aging Services.

²⁴ Paraprofessional Healthcare Institute (April 2003) *State Wage Pass-Through Legislation: An Analysis*. Workforce Strategies Occasional Paper No. 1, Bronx, NY: PHI, and Washington, DC: Institute for the Future of Aging Services.

²⁵ Wyoming Department of Health (December 2001) *Report to the Joint Appropriations Committee on Study of Nonprofessional Direct Care Staff Recruitment, Retention, and Wages*. Cheyenne, WY: Developmental Disabilities Divisions, WY Department of Health.

²⁶ Wyoming Department of Health, Developmental Disabilities Division (April 2005) "Direct Service Professionals Wages and Retention," Cheyenne, WY.

²⁷ Robert M. Lynch, Jon Fortune, Clifford E. Mikesell, and Terry L. Walling (October 2005) "Wyoming Demonstrates Major Improvements in Retention by Enhancing Wages and Training," *Links*, Volume 35, No. 9, pp. 9-10.

²⁸ One waiver is for persons with mental retardation and developmental disabilities, and the other is for seniors and people with physical disabilities. See the District of Columbia Council's Fiscal Year 2006 Budget Support Act of 2005, Title V, Sec. 5259. Available at: <http://www.dccouncil.washington.dc.us/images/00001/20050726173839.pdf>.

²⁹ For example, for FY 2006 the Massachusetts Legislature appropriated \$20 million towards a "Salary Reserve" for personnel employed by private human service providers that deliver human and social services under contracts with departments within the Executive Office of Health and Human Services and the Executive Office of Elder Affairs, including home health care workers. The initial request had been for \$35.8 million and the Legislature had to override the Governor's veto of the Salary Reserve. The actual amounts to be received by workers will result in a 3.04% salary increase for employees earning less than \$25,000 per year and a 1.81% increase for those earning more than \$25,001 and less than \$40,000 per year. However, the actual salary increases are likely to be less because organizations may use up to 15% of both allocations to cover the employer portion of payroll and fringe benefit obligations directly associated with this increase in salaries.

³⁰ Again in Massachusetts, the FY 2001 Salary Reserve was funded at \$15 million; this was slashed to \$5 million in FY 2002, and then was eliminated entirely in the next two fiscal years. A \$20 million Salary Reserve was appropriated in FY 2005 and then was sustained in the current fiscal year.

³¹ Some nursing homes in Wisconsin and California reportedly failed to pay out wage pass-through funds to their workers. If not properly distributed, these funds are supposed to be returned to the state. See Eric Carlson (March 2003) *Payment Due: California's leaky system to improve the wages of nursing home employees*. National Senior Citizens Law Center; and Phil Trewyn (Feb. 5, 2001) "Audit says nursing homes didn't pass through wage increases," *The Business Journal*, Milwaukee, WI.

³² Nine specific training topics are required (e.g., Alzheimer's Diseases, fire and home safety, cultural sensitivity) and the agency must pay CNAs to attend the required in-services.

³³ Rhode Island's enhancement program resembles what are known as "tiered reimbursement" strategies in publicly reimbursed childcare services for low-income children. In childcare, the goal of these differential reimbursement strategies is to create system-wide improvements in childcare quality by providing higher rates to childcare centers and family child care homes that achieve one or more levels of quality beyond basic licensing requirements. While tiered rate enhancement programs are rare in the realm of publicly financed home and community-based services, they are fairly common in childcare: As of June 2005, 29 states had established tiered reimbursement programs relating to publicly reimbursed childcare services. See: National Child Care Information Center (November 2002) *Overview of Tiered Strategies: Quality Rating, Reimbursement, Licensing*. Washington, DC: NCCIC, Administration for Children and Families, US Department of Health and Human Services, available at: <http://www.nccic.org/poptopics/tieredstrategies.html>. See also: <http://www.naeyc.org/ece/critical/chart1.asp>.

³⁴ In Texas, an attendant is an unlicensed caregiver providing direct assistance to clients with limitations in their ADLs or IADLs. In some home and community-based programs in Texas, an attendant may perform non-attendant functions, such as serving as a driver or medication aide, in which case the attendant must perform attendant functions at least 80 percent of his or her total time worked to be counted toward the Enhancement Program.

³⁵ See information available at <http://hhsc.state.tx.us/Medicaid/programs/rad/cba/cba.html>

³⁶ Information from interviews with RAD officials conducted in November 2005.

³⁷ Janet O'Keeffe, Christine O'Keeffe, and Shulamit Bernard (December 2003) *Using Medicaid to Cover Services for Elderly Persons in Residential Care Settings: State Policy Maker and Stakeholder Views in Six States* (Appendix

F: Texas). Washington, DC: US Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (DALTCP), p. 22.

³⁸ **Rebasing** refers to a recalculation, based on more current information, of the cost components that make up the basic reimbursement rate or base rate. **Updating** refers to an automatic adjustment of the base rate in non-rebase years in order to keep the rate current with overall price changes in the economy at large or the industry at issue.

³⁹ Confirming this, in its Medicaid HCBS “Primer” the US Department of Health and Human Services notes that “[i]t is frequently, but mistakenly, believed that Federal policy prescribes precise methods states must follow in purchasing Medicaid services”. US Department of Health and Human Services (October 2000) *Understanding Medicaid Home and Community Services: A Primer*. Washington, DC: The Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, p. 158.

⁴⁰ The capitated rates are blended to include nursing facility care, HCBS, acute medical care, behavioral health, and case management.

⁴¹ EP&P Consulting, Inc. (August 2005) *Factors Considered During the 2004-2005 Rebasing of Fee-for-Service (FFS) Rates*, Report prepared for the State of Arizona Health Care Cost Containment System (AHCCCS). Available at: <http://www.ahcccs.state.us/PublicNotices/RebasingWages.pdf>.

⁴² Texas Senate Committee on Human Services (September 2000) *Interim Report*. Austin, TX: Texas Senate. http://www.senate.state.tx.us/75r/Senate/commit/archive/c610/pdf/Human_report.pdf.

⁴³ In Arizona, most Medicaid-financed attendant care is delivered through a managed care system administered by seven regional Program Contractor agencies. However, some attendant care is delivered through fee-for-service (FFS) arrangements, for example on reservations in remote areas. The FFS rates are set by the state whereas the rates received under non-FFS arrangements are determined by contracts between Program Contractors and provider agencies. The observed FFS rates thus are assumed to be rough approximations of the unobserved managed-care rates.

⁴⁴ Calculated by the authors from data available at <http://www.bls.gov/oes/home.htm>.

⁴⁵ See: US Social Security Act, 45 CFR 98.43, available at:

<http://www.washingtonwatchdog.org/documents/cfr/title45/part98.html#98.43> The Equal Access provision reads: “The Lead Agency shall certify that the payment rates for the provision of child care services under this part are sufficient to ensure equal access, for eligible families in the area served by the Lead Agency, to child care services comparable to those provided to families not eligible to receive CCDF assistance or child care assistance under any other Federal, State, or tribal programs.”

⁴⁶ For information on conducting market rate surveys, see: Lisa Schock and Jane Daugherty (March 2001) *Rate Setting Policies: Ensuring Access and Improving Quality*. Proceedings of the Child Care Bureau Issue Meeting. Child Care Bureau, Administration for Children and Families, Administration on Children, Youth, and Families; Eric Karolak, Ray Collins and Louise Stoney (July 2001) *Conducting Market Rate Surveys and Establishing Rate Policies*, Paper prepared for Child Care Bureau, Administration on Children, Youth and Families, US Department of Health and Human Services, available at: <http://www.nccic.org/pubs/conductmrs-erp.html>. For additional sources on childcare reimbursement rate setting, see: US General Accounting Office (September 2002) *Child Care: States Exercise Flexibility in Setting Reimbursement Rates and Providing Access for Low-Income Children*, Washington, DC: GAO, available at: <http://www.gao.gov/newitems/d02894.pdf>; and <http://www.nccic.org/pubs/stateplan/exsum.html>.

⁴⁷ Gary A. Smith (December 2005) *Status Report: Litigation Concerning Home and Community Services for People with Disabilities*. Washington, DC and Portland, OR: Human Services Research Institute. Available at: <http://www.hsri.org/docs/litigation120605.PDF>.

⁴⁸ Gary A. Smith (December 2005) *Status Report: Litigation Concerning Home and Community Services for People with Disabilities*. Washington, DC and Portland, OR: Human Services Research Institute, p. 30. See: <http://www.hsri.org/docs/litigation120605.PDF>; and “Notice of Proposed Class Action Settlement and Hearing,” United State District Court Southern District of Mississippi. Available at: http://www.mdrs.state.ms.us/about/Proposed_Settlement_Agreement.pdf.

⁴⁹ For court filings in *Ball v. Biedess*, see <http://www.azdisabilitylaw.org/legalpolicynews.html#HealthCare>.

⁵⁰ NH General Court, Rate Setting for Home Health Services. Section 126-A:18-a, Title X. Available at: <http://www.gencourt.state.nh.us/rsa/html/X/126-A/126-A-18-a.htm>.

⁵¹ Gary A. Smith (December 2005) *Status Report: Litigation Concerning Home and Community Services for People with Disabilities*. Washington, DC and Portland, OR: Human Services Research Institute, p. 49. Available at: <http://www.hsri.org/docs/litigation120605.PDF>.

⁵² Candace Howes (November 2004) “Upgrading California’s Home Care Workforce: The Impact of Political Action and Unionization.” *State of California Labor*, Vol. 2004, No. 1, p. 101.

⁵³ See RTZ Associates, Inc. (May 2005) *The State of IHSS Health Benefits in California: A Survey of Counties*, p. 4. Available at: http://www.rtzassociates.com/publications/issue_brief2005.pdf.

⁵⁴ Service Employees International Union (February 2005) *Working Together for Quality Personal Care: How SEIU Has Worked in Coalition with Consumers and Advocates to Win Workforce Improvements for Consumer-Directed Personal Care Through Workforce Councils*. Available at: <http://www.pcaqualityworkforce.org>.

⁵⁵ Candace Howes (November 2004) "Upgrading California's Home Care Workforce: The Impact of Political Action and Unionization," *State of California Labor*, Vol. 2004, No. 1, pp. 71-105. From 1997, when the first union contract was negotiated, until August 2002, wages for San Francisco IHSS workers nearly doubled, from \$5.29 to \$10.10. Howes analyzes the impacts of this large wage increase and the provision of benefits which accompanied it on turnover, recruitment, and retention. See also: Candace Howes (January 2005) "Living Wages and Retention of Homecare Workers in San Francisco," *Industrial Relations* Vol. 44, No. 1, pp. 139-163.

⁵⁶ Service Employees International Union (February 2005) *Working Together for Quality Personal Care: How SEIU Has Worked in Coalition with Consumers and Advocates to Win Workforce Improvements for Consumer-Directed Personal Care Through Workforce Councils*. Available at: <http://www.pcaqualityworkforce.org>.

⁵⁷ The wage rate ranges from \$9.43 for 0 to 2000 cumulative career hours up to \$10.31 for 12,001 plus hours. See the collective bargaining agreement at <http://www.hcqa.wa.gov/documents/2005-2007ratifiedagreement.pdf>.

⁵⁸ Paul K. Sonn (June 2005) *City Minimum Wage Laws: A New Policy Tool for Local Governments*. Economic Policy Brief No. 1. New York, NY: Brennan Center for Justice. Available at: <http://www.brennancenter.org/programs/downloads/minimumwage-policybrief.pdf>.

⁵⁹ Tax breaks can include financial assistance from the city in the form of grants, loans, bond financing, tax abatements, or other economic development subsidies.

⁶⁰ See statistics on living wage campaigns available at the Living Wage Resource Center (Brooklyn, NY) at <http://www.livingwagecampaign.org/index.php?id=1958>.

⁶¹ See <http://www.livingwagecampaign.org>.

⁶² The programs covered are the Medicaid-funded Home Care Services Program (formerly the Home Attendant and Housekeeping Programs), and a very small non-Medicaid EISEP Program (Expanded In-Home Services for the Elderly Program). It also covers workers in day care, food services, and disability services. See analyses available at the Brennan Center for Justice's Fiscal Policy Institute, available at: http://www.brennancenter.org/programs/living_wage/index.html.

⁶³ Jared Bernstein and Isaac Shapiro (September 2005) *Unhappy Anniversary: Federal Minimum Wage Remains Unchanged For Eighth Straight Year, Falls To 56-Year Low Relative To The Average Wage*, Washington, DC: Center on Budget and Policy Priorities. Available at: <http://www.cbpp.org/9-1-05mw.htm>.

⁶⁴ See: <http://www.epi.org/issueguides/minwage/table6.gif>.

⁶⁵ Several other states are considering indexing their minimum wage. See: http://www.epi.org/content.cfm/webfeatures_snapshots_20051221. In November 2004, voters in Nevada approved a constitutional amendment to raise the state minimum wage and index it to inflation; this measure must be voted on a second time in 2006 before it becomes law.

⁶⁶ William Ebenstein (April 2006) "Health Insurance Coverage of Direct Support Workers in the Developmental Disabilities Field," *Mental Retardation* Vol. 44, No. 2, p. 133.

⁶⁷ See endnote 3 in the Introduction to this report.

⁶⁸ Health Care for Health Care Workers (January 2006) *The Facts about a Critical Gap in Long-Term Care, Policy Brief*. No. 1, Bronx, NY: Paraprofessional Healthcare Institute. Available at:

<http://www.directcareclearinghouse.org/download/PHI-191%20PolicyBriefFinal.1.pdf>; and Paraprofessional Healthcare Institute (April 2006) *CMS Direct Service Workforce Demonstration Grants: Overview and Discussion of Health Coverage Interventions*, Prepared for CMS. Available at:

http://www.hchcw.org/docs/CMS.DSW.Grant.Health.Coverage.Analysis.final_4.5.06.pdf.

⁶⁹ Paraprofessional Healthcare Institute (April 2006) *CMS Direct Service Workforce Demonstration Grants: Overview and Discussion of Health Coverage Interventions*, Prepared for CMS. Available at: http://www.hchcw.org/docs/CMS.DSW.Grant.Health.Coverage.Analysis.final_4.5.06.pdf.

⁷⁰ In Virginia, the original proposal to insure 75 workers across four agencies was suspended and the state is examining alternative interventions. See Paraprofessional Healthcare Institute (April 2006) *CMS Direct Service Workforce Demonstration Grants: Overview and Discussion of Health Coverage Interventions*, Prepared for CMS. Available at: http://www.hchcw.org/docs/CMS.DSW.Grant.Health.Coverage.Analysis.final_4.5.06.pdf.

⁷¹ For more information, see <http://www.coverageiscritical.org>.

⁷² A final report is expected in late 2006.

⁷³ A PEO is an off-site or out-sourced human resources department which enters into a co-employer relationship with its clients in order to share and manage many employer-related liabilities and responsibilities. Clients outsource their human resources to the PEO and maintain control of their companies, while the PEO provides human resources services, employee benefits, payroll administration and workers' compensation.

⁷⁴ For relevant statutes and regulations, see US Civil Code, 42 U.S.C. 1396a(a)(30)(A) and Code of Federal Regulations, 42CFR447.201 and 42CFR447.204. The former is commonly known as the Equal Access Provision of the Social Security Act; the latter are from Title 42 and concern federal prescriptions for state plan requirements for setting payment rates ("Payment Methods" Provisions).