



# Long-Term POLICY GUIDE | Care



The Council  
of State  
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# Abstract

- ISSUE** ..... The pandemic brought a renewed focus to long-term care in nursing homes. The American Rescue Plan Act provided states essential funding to expand eligibility and increase access to Medicaid home- and community-based services. One of the thorniest issues states are facing is the direct care workforce. Difficult work, low-level compensation and a lack of career advancement opportunities are exacerbating workforce recruitment challenges.
- GOAL** ..... Examine strategies states are deploying to regulate long-term services and supports, invest in home- and community-based services and meet the needs of the direct care workforce.
- METHODS** ..... Review of challenges, state strategies, investments and opportunities.
- KEY FINDINGS** ..... States are strengthening long-term care ombudsman programs, working to address staffing shortages and improving data collection. States are using ARPA funding to invest in quality improvement initiatives, housing programs and supports for family caregivers. States are taking steps to increase direct care worker wages, enhance training and education, and expand the pipeline of potential employees.
- CONCLUSIONS** ..... Data collection is an area ripe for improvement in states — whether it is data on the needs of the direct care workforce, on quality of nursing home care or on the care provided in home and community-based settings.

# Introduction

In 2022, The Council of State Governments assembled an interbranch task force of policymakers representing eight states (**Arizona, Georgia, Hawaii, Indiana, Minnesota, New York, Pennsylvania** and **Virginia**). During the course of eight virtual meetings of the full task force and one state-curated conversation for each of the eight participating states, task force members examined three focus areas in long-term care that are highlighted in this policy guide:

## State Regulation of Long-Term Services and Supports Facilities

Nursing homes and other congregate care facilities in the U.S. and around the globe saw high concentrations of COVID-19 fatalities. Residents have experienced neglect, social isolation and loneliness due to staffing challenges and restricted visitation policies. That has renewed calls for reimagining these facilities and moving to invest more in community-based alternatives. States are strengthening long-term care ombudsman programs to provide oversight of facilities, working to address staffing shortages and improving data collection on the quality of care. Illinois approved legislation in 2022 to overhaul how the state assesses and reimburses nursing facilities and link future funding to staffing levels and quality of care.

## Optimizing American Rescue Plan Act Spending on Home- and Community-Based Services

In 1999, the U.S. Supreme Court declared that the unjustified institutionalization of people with disabilities violates the Americans with Disabilities Act. Since then, there has been a shift toward serving more people in home and community-based settings, reflecting state obligations and evolving public preferences. The American Rescue Plan Act of 2021 provided states an increase in the federal government's share of total Medicaid costs to strengthen Medicaid home- and community-based services. States have until March 31, 2025, to spend \$12.7 billion on initiatives to expand eligibility and increase access to these services. States are investing in provider and workforce supports, quality improvement initiatives, housing programs and supports for family caregivers. They are also working to ensure that many of these initiatives will be sustainable over time. One ambitious ARPA spending plan is found in **Minnesota**, where policymakers agreed to spread \$680 million across more than 50 initiatives in five categories.

## Revitalizing the Direct Care Workforce and Supporting Family Caregivers

The direct care workforce — those individuals who care for older Americans and people with disabilities across a variety of long-term care settings — is facing significant challenges. Difficult work, low-level compensation and a lack of career advancement opportunities are exacerbating workforce recruitment challenges and making it difficult to keep facilities adequately staffed. But some states are taking steps to increase wages, enhance training and education and expand the pipeline of potential employees for the industry. In **New York**, lawmakers in 2022 passed a \$20 billion, multi-year health care investment that included a \$7.7 billion component to increase the hourly minimum wage for home health care workers over two years.

This policy guide highlights challenges facing the long-term care industry, state strategies already enacted to address them and state case studies. Inclusion of state strategies in this guide does not constitute endorsement by The Council of State Governments, the CSG National Interbranch Task Force on Effective and Sustainable Care or The Commonwealth Fund, which provided funding for this project. It is intended as a roadmap of potential policy opportunities in a variety of areas that may require additional discussion on a state-by-state basis. The strategies profiled in this guide may also be ripe for further assessment and study as to their efficacy in the years ahead.





# Addressing State Regulation of Long-Term Services and Supports Facilities

## Background and Introduction

Everything ranging from nursing facility care to assistance provided by a family caregiver fall under the umbrella term long-term services and supports (LTSS). People often turn to some form of paid or unpaid medical and personal care assistance when they experience difficulty completing self-care tasks as a result of aging, chronic illness or disability. Millions of Americans require these supports and services, including elderly and non-elderly people and those with intellectual, developmental or physical disabilities; dementia, spinal cord or traumatic brain injuries and disabling chronic conditions.<sup>1</sup>

Long-term services and supports are delivered in institutional settings such as nursing homes and in home and community-based settings including group homes and apartments.<sup>2</sup>

The U.S. Supreme Court's Olmstead decision in 1999 declared that the unjustified institutionalization of people with disabilities violates the Americans with Disabilities Act.<sup>3</sup> Studies about consumer preferences consistently show that more than 75% of older adults and people with disabilities would prefer to live at home.<sup>4</sup> As a consequence, there has been a shift toward serving more people in home and community-based settings, reflecting state legal requirements and evolving public preferences.<sup>5</sup>

Congregate care facilities in the U.S. and around the globe saw high concentrations of COVID-19 fatalities from the earliest days of the pandemic. There has also been an epidemic of neglect,<sup>6</sup> social isolation and loneliness among residents due to staffing challenges and restricted visitation policies.<sup>7</sup> The number of nursing facility residents has dramatically declined in the last two years, falling under 1.2 million total residents in 2022.<sup>8</sup> This trend away from residential facilities has prompted calls for reimagining these facilities and investing more in community-based alternatives. Experts say evidence suggests the need for both strategies to meet the growing demand for long-term care services in the years ahead.<sup>9</sup>

The CSG National Interbranch Task Force on Effective and Sustainable Long-Term Care discussed five key issues for addressing the future of long-term services and supports:

- Learning lessons from the pandemic.
- Shoring up the oversight, transparency and accountability of nursing facilities.
- Adjusting payment models to incentivize quality.
- Enhancing the collection of data that can inform efforts toward improvement.
- Addressing the future of the direct care workforce.

## Key Findings

Among the challenges facing long-term services and supports facilities are historically under-resourced state long-term care ombudsman offices, inadequate staffing and training of employees, Medicaid-reliant nursing home care financing, a patchwork of state regulation, increasing consolidation and ownership changes in the nursing home industry, and flawed data collection. But some states have begun to enact initiatives to strengthen ombudsman programs, address staffing shortages in a variety of ways, toughen oversight and improve data collection to examine the quality of care in these facilities.

## Challenges Facing Long-Term Services and Supports Facilities

### Under-Resourced Oversight

First authorized by the Older Americans Act passed in 1965 in response to concerns about a lack of community social services for older persons,<sup>10</sup> the State Long-Term Care Ombudsman program began in 1972 as a demonstration project and now operates in all 50 states, Washington, D.C., Puerto Rico and Guam to support residents living in LTSS facilities and their families.<sup>11</sup> State ombudsman programs are required to:

- Identify, investigate and resolve complaints made by or on behalf of residents of LTSS facilities.
- Provide information to residents about long-term services and supports.
- Ensure that residents have regular and timely access to ombudsman services.
- Represent the interests of residents before governmental agencies.
- Analyze, comment on and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents.<sup>12</sup>

But ombudsman programs in many states have long been under-resourced, which has limited their effectiveness. In addition, the pandemic reduced ombudsman and family member access to nursing homes to maintain oversight.

- **Hawaii** established a state ombudsman program in 1979 but faces unique challenges due to its island geography. The Honolulu-based ombudsman is expected to monitor facilities on Oahu and all the neighboring islands. A 1995 report by the Institute of Medicine calculated that states need a minimum of one full-time equivalent ombudsman staff person per 2,000 long-term care beds.<sup>13</sup> Hawaii should therefore have a minimum of six ombuds for its nearly 13,000 long-term care residents.<sup>14</sup> The need for ombuds stationed on neighboring islands became especially apparent during the earliest days of the COVID-19 pandemic, when the state's only ombud was not able to fly between islands.<sup>15</sup>
- The **Iowa** ombudsman office is charged with advocating on behalf of 29,000 Iowans in 435 care facilities. Each local ombudsman serves a region of at least a dozen Iowa counties. In 2020, the **Iowa** Long-Term Care Ombudsman's Office reported that staff had scaled back visits to care facilities, with responses to complaints dropping from 636 annually to 163. The office also cut its participation in nursing home inspections in half, decreased training sessions for nursing home workers, curtailed legislative lobbying efforts and was considering plans to outsource some basic functions.<sup>16</sup>





Ombudsman offices around the country have been under-resourced even as their responsibilities have expanded. When the provisions of the Older Americans Act were expanded to add investigative and advocacy responsibilities for assisted living communities,<sup>17</sup> no additional federal funding was appropriated, said **Virginia** Long-Term Care Ombudsman Joani Latimer.<sup>18</sup> **Virginia** is among a group of states that have chosen to expand the program's jurisdiction to include home and community-based care.<sup>19</sup> But these programs have no guarantee of additional funding for these additional responsibilities. In addition, the cases and issues ombud offices are called on to address have become more complex, making the resource gap even more pronounced.

## Inadequate Staffing and Training

Insufficient staffing in long-term care facilities has been well established as contributing to poor outcomes for residents. The Centers for Medicare & Medicaid Services have not set minimum staffing requirements for nursing homes, leaving it to facilities to determine whether they have sufficient personnel to provide “the highest practicable physical, mental and psychosocial well-being of each resident”<sup>20</sup> required under federal law.<sup>21</sup> Staffing shortages in nursing homes became even more acute during the pandemic. The nursing home industry has lost 235,000 jobs since March 2020, roughly 15% of its workforce.<sup>22</sup> Researchers say most nursing homes do not provide sufficient staffing to ensure basic quality.<sup>23</sup> Some examples from states include:

- **Minnesota's** nursing home staffing crisis became so dire in late 2021 that members of the National Guard were called in to take shifts feeding and caring for residents. The state reported 23,000 job openings in long-term care, 20% of the industry's workforce.<sup>24</sup>
- Already low staffing levels in **New York** decreased to “dangerous levels” in some nursing homes, according to a 2021 report by the state Attorney General's Office.<sup>25</sup>
- One fifth of **Virginia's** nursing homes were not meeting expected staff levels in 2021, disproportionately impacting low-income residents, according to the Joint Commission on Health Care. The same number were not providing enough hours of direct care. More than 60% of facilities with low staffing received poor health inspection ratings based on criteria such as medication management and resident quality of life.<sup>26</sup>
- **Alaska, Kansas, Maine, Oregon, Washington, Wisconsin** and **Wyoming** were among the other states that experienced dire staff shortages, with more than 60% of facilities reporting a lack of sufficient staff.<sup>27</sup>

In February 2022, the President Joe Biden administration proposed changes to how nursing homes are regulated and run, including a promise to adopt federal minimum staffing requirements, step up enforcement of regulations and discourage overcrowding. A White House fact sheet suggested the reforms will ensure that “every nursing home provides a sufficient number of staff who are adequately trained to provide high-quality care.”<sup>28</sup> CMS is expected to conduct a study to determine the level and type of staffing needed and propose a new federal standard early in 2023.<sup>29</sup>

While some have praised the proposed reforms,<sup>30</sup> not everyone supports mandatory staffing minimums. Nursing home operators have argued against them, saying there simply are not enough qualified workers available.<sup>31</sup> One recent analysis suggested operators would have to spend an additional \$10 billion more per year and hire more than 187,000 new workers to meet the requirements of one possible federal minimum staffing approach.<sup>32</sup> AMDA, the Society for Post-Acute and Long-Term Care Medicine, which represents nursing home medical directors and others, suggests that decisions about staffing levels need to consider such issues as the complexity and acuity of a facility's population, the functional level of the residents and services they require, and shortages of some particular types of staff in some geographic locations.<sup>33</sup>

## Nursing Home Care Financing

Medicare provides health coverage to most older Americans and many people with disabilities, but it pays only for episodes of short-term use of nursing home and home health services. Medicaid is the single largest

source of funding for long-term services and supports but starts only after people deplete their personal resources. Analysts suggest that the models under which providers are reimbursed do not incentivize increases in the quality of care. Thirty states have transitioned to some form of Medicaid risk-adjustment-based nursing home payment. The remaining states use capitated managed care and managed fee-for-service models and still rely on cost-based reimbursement that is not risk-adjusted or value-based.<sup>34</sup>

## Patchwork of State Regulation

States have the primary responsibility for licensing long-term care providers and imposing minimum standards. Some states maintain certificate of need requirements to regulate expansion in the health care market to constrain spending. These policies employ a need-based evaluation of applications to increase the number of facility beds. Further, nursing home facilities and assisted living communities differ considerably in cost and regulation.<sup>35</sup> What Medicaid will pay for differs across states. **Alabama, Kentucky, Maine, Pennsylvania** and **Virginia** have Medicaid programs that either do not pay anything for assisted living or their programs are so limited as to disqualify the majority of low-income seniors.<sup>36</sup> The National Center for Assisted Living's 2022 Assisted Living State Regulatory Review summarizes the requirements assisted living communities in each state must meet to gain or maintain licensure and certification. States are graded on their standards for transparency, licensing and certification.<sup>37</sup>

## Nursing Home Consolidation and Ownership Issues

Some analysts suggest that the increasingly complex corporate ownership of many nursing homes has prompted a heavy focus on profitability for investors. Sixty-nine percent of nursing homes are operated by for-profit corporations (including the 58% operated by corporate chains), 24% are owned by not-for-profit organizations and 7% are government owned.<sup>38</sup> A 2022 analysis of ownership changes by CMS found that:

- Such changes have been more common in nursing homes than hospitals over the past six years.
- Sixty-two percent of skilled nursing facilities that were purchased have a single organization owner, 6.9% have multiple organization owners, 18.2% have individual owners and 12.7% have both types of owners.<sup>39</sup>





CMS plans to release updated ownership data quarterly to increase transparency and accountability and boost industry competition. But CMS has received criticism for not establishing standards or an approval process for changes in nursing home ownership. That lack of standards, critics contend, leaves residents “at risk of new ownership that does not have the motivation, expertise, acumen or financial wherewithal to adequately protect health and safety and promote positive outcomes.”<sup>40</sup>

The Biden administration has pointed to a number of concerning trends:

- Private equity firm investment in nursing homes rose from \$5 billion in 2000 to more than \$100 billion in 2018 with about 5% of nursing homes owned by private equity firms.<sup>41</sup>
- Residents of nursing homes acquired by private equity firms were 11.1% more likely to have a preventable emergency department visit and 8.7% more likely to experience a preventable hospitalization, compared to those in homes with other types of ownership.<sup>42</sup>
- Private equity ownership increased excess mortality by 10%, increased prescription of antipsychotic drugs by 50%, decreased hours of frontline nursing staffing by 3% and increased taxpayer spending per resident by 11%.<sup>43</sup>

## Flawed Data Collection

Policy experts have pointed to the need to increase the completeness and accessibility of data on quality and cost.<sup>44</sup> Under Medicare, participating providers are required to submit a minimum data set and select quality measures along with annual cost reports. Providers that participate in Medicare and Medicaid are also required to disclose ownership and controlling financial interests. But that information is largely limited to the tax status of facility owners and does not detail complex ownership structures or cost information.<sup>45</sup>

Federally mandated public reporting on nursing homes began in the late 1990s with Nursing Home Compare (renamed Care Compare), a web-based report card for certified nursing homes. In 2008, the website began publishing a five-star composite rating based on three domains: inspections, staffing and quality measures.<sup>46</sup>

Data on nursing home quality informs the work of policymakers and allows consumers and their families to make informed decisions. Unfortunately, as revealed in a January 2022 report by the U.S. Department of Health and Human Services Office of Inspector General, a majority of states faced significant challenges in conducting nursing home surveys. Just over half the states failed to meet one or more performance measures — most commonly because of a failure to conduct surveys in a timely manner. States often blamed staffing shortages. CMS regularly tasked these states with submitting corrective action plans, but 10% of these plans were missing from agency files and many others lacked substantive details.<sup>47</sup> The Office of Inspector General recommended that CMS adjust how they deal with states’ poor performance in conducting the surveys.<sup>48</sup>

A 2021 analysis by The New York Times found substantial flaws in the self-reported nursing home survey data from more than 15,000 nursing homes, examinations by state health inspectors and the national star rating system. The newspaper found:

- Much of the information submitted is wrong, making the homes seem cleaner and safer than they are.
- Some nursing homes inflate staffing levels by including employees who are on vacation.
- Nursing homes that earn five stars are nearly as likely to flunk in-person inspections as to do well.
- Underlying data was rarely audited for accuracy.
- At least some nursing homes learned in advance about what are supposed to be surprise inspections.<sup>49</sup>

# State Strategies for Long-Term Services and Supports in Nursing Homes

## Strengthening Long-Term Care Ombudsman Programs

State long-term care ombudsman staff say federal regulations for the program passed in 2016<sup>50</sup> also provide a template for state policy and best practices to strengthen it. Those regulations outline the functions and responsibilities of the ombud (identifying, investigating and resolving complaints, etc.) and state agencies related to the program. Those include ensuring that the program has sufficient authority and access to facilities, residents and information needed to fully perform all the responsibilities of the office. State agencies are also expected to:

- Provide training opportunities for ombudsman staff.
- Ensure that the office has mechanisms to investigate allegations of interference, retaliation and reprisals and prohibit these practices.
- Require the office to develop and provide final approval of an annual report.<sup>51</sup>

**Virginia** State Long-Term Care Ombudsman Joani Latimer believes state policies should ideally ensure that the program is statutorily enabled and empowered to fulfill its mandate. She said a pivotal component is the structure and location of a program that fully enables its independence as a voice for long-term care consumers. At the federal and state levels, she said, supplemental funding is needed to support the expansion of the program's responsibilities. State policymakers should also examine strategies to strengthen the role of the ombudsman program in promoting increased transparency and improved data collection, she said.<sup>52</sup>

**Georgia** State Long-Term Care Ombudsman Melanie McNeil agreed that strengthening the ombudsman role will require more funding (particularly to fulfill the federal mandate to serve residents in assisted living and residential care communities), more staff, a more robust regulatory system and a stronger commitment to facility access. She said many states do not meet the recommended ratio of one ombudsman for every 2,000 long-term care residents.<sup>53</sup> She said ombudsmen also need more support from federal and state agencies when they find deficiencies at nursing homes.<sup>54</sup>

Among the states working to reform long-term care ombudsman programs:

- **Hawaii** lawmakers moved forward with legislation in 2022 to create five new permanent, full-time ombudsman positions to have a local ombudsman in each county of the state.<sup>55</sup>
- **Michigan** lawmakers passed legislation in 2021 to exempt long-term care ombudsmen from any future visitation restrictions in long-term care communities.<sup>56</sup>





- Lawmakers in **New York** passed legislation in 2021 that:
  - Directs the office to advertise and promote the program.
  - Directs the commissioner of health, in consultation with the ombudsman and the commissioners responsible for the licensure or certification of long-term care facilities, to establish policies and procedures for staff and volunteer reporting of issues concerning the health, safety and welfare of residents.
  - Includes access to staff and volunteers within the pandemic emergency plan prepared by residential health care facilities.<sup>57</sup>

Another measure considered in 2022 would require additional information in state ombudsman annual reports to the governor and state legislature. It would also require an additional annual report to be submitted to the attorney general on instances of abuse, neglect and exploitation, for review and possible enforcement action.<sup>58</sup>

## Addressing Staffing Shortages

### *Nursing Home Reimbursement and Pay Increases*

- **Illinois** legislation enacted in 2022 ties new funding for nursing homes to improving quality measures, including hiring staff. The act also adopts a new pay scale for certified nursing assistants that increases wages based on years of experience in the field rather than in a particular facility.<sup>59</sup>
- This year the **Nebraska** legislature provided \$26 million in increased pay for private aging services providers, a 15% increase. That will allow the state to leverage additional federal Medicaid matching funds for a total of more than \$60 million. The head of the Nebraska Health Care Association said it was the most significant increase nursing facilities have received in at least a decade and will help them raise wages.<sup>60</sup>
- The 2022-23 budget for the **Pennsylvania** Department of Human Services committed \$250 million in American Rescue Plan Act funding for long-term care facilities and programs. Nursing homes received a 17.5% increase in the daily payment toward people covered by Medicaid — the first increase in a decade. The department had reported that the previous payment of about \$200 per patient per day was about \$50 short of actual costs, causing facilities to lose more than \$800 million annually. Industry leaders were predicting significant financial losses in 2022 for nearly 60% of nursing homes in the state. Officials believe the nursing home funding, when combined with federal matching funds, will mean the state will have \$600 million annually to help meet staffing ratios advanced by Gov. Tom Wolf.<sup>61</sup>

### *Licensure Changes*

While not specific to long-term care, some states have enacted emergency licensure changes to deal with staffing shortages. Among them:

- **Hawaii** Gov. David Ige approved emergency rules to grant temporary authority for out-of-state nurses to practice in the state without applying for and obtaining a license, under certain conditions. This came in response to hospitals facing acute staffing shortages in 2022, delays in processing professional licenses required to work in the state and an inability to transfer patients to long-term care facilities which were also short-staffed.<sup>62</sup>
- **California, New York** and **Texas** are among other states with emergency proclamations in place that waive state licensing requirements.<sup>63</sup> New York Gov. Kathy Hochul has issued executive orders to extend the declaration of a statewide disaster emergency due to health care staffing shortages in the state.<sup>64</sup>

### *Staffing Requirements*

- **Virginia** is one of 16 states without workforce requirements for nursing facilities. Policymakers have been trying to establish standards for several years,<sup>65</sup> but legislative efforts have failed,<sup>66</sup> largely due to the anticipated cost. The latest legislative efforts, while also unsuccessful,<sup>67</sup> have left some hopeful that change may be on the way.<sup>68</sup>



- States like **Arkansas, Connecticut, Massachusetts** and **Rhode Island** have moved forward with permanent increases to requirements despite a challenging job market.<sup>69</sup>
- **Rhode Island's** 2021 Nursing Home Staffing and Quality Care Act requires facilities to provide 3.58 hours of direct nursing care and 2.44 hours of direct certified nursing assistant care per resident, per day.<sup>70</sup> This initiative was delayed by an executive order from Gov. Dan McKee,<sup>71</sup> out of concern that there is “no workforce available.”<sup>72</sup>
- A **New York** law requiring that facilities meet minimum staffing levels also went into effect this year following a three-month pause due to the industry’s staffing challenges. The state’s 600 nursing homes are now required to provide 3.5 hours of care per resident per day, including 2.2 hours provided by a certified nursing assistant or nurse aide. At least 1.1 hours of care must be provided by a registered nurse or licensed practical nurse. But before the law went into effect, 63% of the state’s nursing homes were considered below the 3.5 hours per resident threshold and it is estimated that New York facilities will need an additional 5,610 staff to meet the new staffing requirements. Fines for noncompliance could cost facilities up to \$2,000 a day.<sup>73</sup>

Other states have chosen to loosen staffing standards.<sup>74</sup>

- **Florida** lawmakers passed legislation in April cutting the minimum hours of care by a certified nursing assistant requirement from 2.5 hours per resident per day to two hours and broadening the types of care that can be counted toward the mandated minimum.<sup>75</sup> The measure was supported by the nursing home industry but opposed by the AARP Florida.<sup>76</sup>
- **Georgia** permanently decreased its minimum staffing requirement.<sup>77</sup>
- **Oregon**<sup>78</sup> and **South Carolina**<sup>79</sup> did so temporarily. In Oregon’s case, it was for six months.<sup>80</sup>
- **Arkansas** changed its staffing standard from a per shift ratio to hours per resident day. The state has also defined direct care staff/direct caregiver to include non-nursing staff such as licensed physical or occupational therapists, and licensed speech-language pathologists but also physicians, physician assistants, and “other licensed or certified healthcare professionals.”<sup>81</sup>



A 2022 report from the Economic Policy Institute pointed to a variety of strategies to address staffing shortages in nursing homes:

- Raising the minimum wage for direct care workers.
- Strengthening protections for workers seeking to organize a union.
- Establishing industry-specific worker standards boards to recommend changes to industry minimum wages and working conditions.<sup>82</sup> For example, **Michigan's** Nursing Home Workforce Stabilization Council, created by a 2021 executive order from Gov. Gretchen Whitmer, brings together nursing home workers, employers, residents and policymakers to review existing policy and offer recommendations for increasing staffing, improving career development and raising standards.<sup>83</sup>

### Training Requirements

As workforce shortages have become apparent during the pandemic, at least three states (**Kentucky, Missouri and Wisconsin**) have adopted permanent changes to staff training requirements. At least eight states (**Alaska, Connecticut, Delaware, Iowa, Indiana, Kansas, Missouri and Wisconsin**) have adopted temporary changes. Typically, those changes have meant lowering training hour requirements. **Wisconsin**, for example, lowered its requirement for nurse aides from 120 hours to the federal minimum of 75 hours. **Kentucky** now allows personal care attendants who finished training during the public health emergency to become state registered nurse aides without completing additional training.<sup>84</sup>

There have also been examples of state initiatives to enhance training of direct care workers.

- **Indiana** lawmakers in 2021 updated the state's Alzheimer's plan to emphasize identifying strategies to enhance the state's dementia care workforce, analyzing dementia-specific training requirements for paid professionals engaged in the care of individuals with dementia in institutions and home and community-based settings.<sup>85</sup>

### Toughening Oversight and Regulation

- **California** lawmakers in 2022 approved legislation that prohibits a person or an applicant for licensure from acquiring, operating, establishing, managing, conducting or maintaining a freestanding skilled nursing facility without first obtaining a license from the state Department of Public Health. The bill also applies the licensure requirement to a change of facility ownership or management.<sup>86</sup> It was part of an effort to fix aspects of a licensing process an investigation found to be marred by indecision and lengthy delays and that allowed a Los Angeles businessman to unofficially operate subpar nursing homes with license applications in "pending" status.<sup>87</sup>
- **Minnesota** legislators approved legislation in 2019 that requires assisted living facilities that market themselves as providing dementia care to be licensed accordingly.<sup>88</sup>
- **Texas** requires long-term care facilities which advertise themselves as providing memory care services to disclose whether they are certified to provide dementia care.<sup>89</sup>
- **Virginia** policymakers approved legislation in 2022 that directs the secretary of Health and Human Resources to study the effectiveness of the oversight and regulation of nursing homes, assisted living facilities and other congregate living settings by a single state agency. Goals of the study include improving efficiency and effectiveness of regulation and oversight, providing better transparency for members of the public navigating the process of receiving services from such facilities and better protecting the health and safety of the public. The measure required the secretary to report findings and recommendations to the governor and legislative leaders by Oct. 1, 2022.<sup>90</sup>



Human Rights Watch has made recommendations for states including:

- Repeal laws or executive orders shielding nursing homes from liability during the pandemic.
- Open investigations by state attorneys general, health departments and other relevant agencies into allegations of neglect and other harms during the pandemic, including any longer-term and systemic concerns.<sup>91</sup>

### Improving Data Collection on Nursing Home Quality

Analysts suggest that data collection is hindered by a variety of factors, including that it is inaccurate, it is collected but not acted on, and it is not in an easy-to-understand format. For example, the federal nursing home report card Care Compare, some contend, could be a more useful tool for consumers making long-term care decisions if the data it contains were easier to understand and more accurate about the facilities it surveys. AMDA, the Society for Post-Acute and Long-Term Care Medicine, recommends a number of other principles to improve the nursing home survey process, including making surveys more “resident centered,” based on realistic regulatory expectations, and less about compliance versus non-compliance and more about how well care processes are applied to resident needs.<sup>92</sup>

A couple of state initiatives on nursing home surveys and transparency to note:

- On its website, the **Massachusetts** Division of Health Care Facility Licensure and Certification offers nursing home survey information for consumers about the quality of care. Consumers can use the survey data to evaluate and compare facilities in five categories: administration, nursing, resident rights, kitchen/food services and environment. The survey evaluates 132 items from the last three surveys and reports on overall performance and the categories where facilities are in compliance. Nursing homes that participate in Medicare and Medicaid are inspected at least every 9-15 months to assess compliance with federal standards of care, including adequacy of staffing, quality of care and cleanliness of facilities. Complaints and serious incidents occurring within nursing homes are also investigated. All surveys are unannounced. If standards are not met, the nursing home must submit a plan of correction.<sup>93</sup>
- **New York** lawmakers passed legislation in 2021 that requires each residential health care facility to provide clients and their families with information on how to review complaints, citations, inspections, enforcement actions and penalties taken against the facility. It also is to provide nursing home quality information provided by the state and federal governments.<sup>94</sup> Another New York bill requires adult care facilities to include infection control in their biannual plans regarding quality assurance activities.<sup>95</sup>



# State Case Study: Illinois' Nursing Home Rate Reform

## What Did They Address?

There have long been concerns about the quality of care received by nursing home residents in Illinois. Officials at the Illinois Department of Healthcare and Family Services have pointed to data showing the state has more understaffed nursing homes than many other states, largely due to high turnover and low wages.<sup>96</sup> Illinois accounted for 47 of the 100 most understaffed facilities in the nation last year.<sup>97</sup>

According to the Long-Term Care Community Coalition, Illinois ranks last among the states in its ability to provide adequate daily direct care to nursing home residents. Illinois facilities provide on average only 2.98 hours of staff care per resident per day. The top five states were **Alaska** (5.61), **Oregon** (4.72), **Hawaii** (4.48), **North Dakota** (4.45) and **Maine** (4.3). The national staffing average for the third quarter of 2021 was 3.63, which falls short of what the coalition determines is the amount of time needed to ensure that residents receive quality clinical care, 4.10 hours.<sup>98</sup>

Staffing problems became particularly acute during the earliest days of the pandemic when nursing homes experienced multiple outbreaks and accounted for a disproportionate number of COVID-related deaths. But data showed a chronically bad situation that the pandemic only exacerbated. Illinois legislators also pointed to data showing long-term care facilities in predominantly Black and Latino communities had among the lowest staffing levels.<sup>99</sup>

## What Did Illinois Do?

Illinois lawmakers in 2022 passed and Gov. J.B. Pritzker signed House Bill 246, which overhauls how the state assesses and reimburses nursing facilities and links future funding to staffing levels and quality of care.<sup>100</sup>

The legislation will provide \$700 million annually for Medicaid-funded nursing homes, provided they use the money to increase staff and wages in their facilities. The funding is split evenly between state and federal funds, with the state's portion coming through an increase in the state's nursing home bed tax. Those funds are used to draw down additional federal dollars.<sup>101</sup>

Nursing homes will now be able to qualify for higher payment rates as they hire additional staff to reach certain target levels of staffing. The measure establishes new reimbursement rates for services provided by certified nursing assistants based on years of experience in the profession, rather than tenure at a specific facility. It also requires more disclosure about the ownership of nursing homes. Lawmakers and advocates had expressed concern about facilities putting profits over patients.<sup>102</sup>

It authorizes the state's transition to a Patient Driven Payment Model. This is a case-mix classification system already implemented at the federal level for Medicare. The model groups skilled nursing facility patients according to specific, data driven characteristics, including anticipated resource needs, rather than the volume of therapy services provided to them as the basis for payment classification.<sup>103</sup>

The model is an effort by the Centers for Medicare and Medicaid Services to move away from the Resource Utilization Group, Version IV patient classification system the federal government has used to determine reimbursement levels for skilled nursing facilities. The new model is designed to eliminate an incentive for skilled nursing facility providers to furnish therapy to patients regardless of the patient's unique needs and improve the overall accuracy and appropriateness of payments. The Centers for Medicare & Medicaid Services suggest it can also reduce administrative burdens on providers.<sup>104</sup>



The Illinois legislation also creates a direct tie between funding and quality measures, including the hiring of staff. Facilities are required to meet at least 70% of the staffing levels outlined in a federal study to be eligible for additional funding.<sup>105</sup>

The \$700 million in funding includes:

- \$290-\$350 million toward staffing incentives.
- \$170 million to boost base Medicaid reimbursement.
- \$83 million for certified nursing assistant compensation and support for workforce retention, tenure, promotion and training.
- \$52 million to transition from the Resource Utilization Group, Version IV to the Patient Driven Payment Model.
- \$70 million toward a new quality program.
- \$34 million to end rural reimbursement rate disparities.<sup>106</sup>

In signing the measure, Gov. Pritzker said “Illinois will no longer tolerate an emphasis on profits over people, especially at the expense of our most vulnerable Illinoisans. When it comes to taking care of our seniors, Illinois is setting a new standard — the highest in the nation. This is what accountability looks like.”

Lt. Gov. Juliana Stratton suggested that with the legislation, the state was “carving the path for well-funded, well-staffed nursing homes with workers who have the training to provide quality care.”

One of the bill’s co-sponsors, Sen. Jacqueline Collins said, “I am so pleased that this legislation has such a strong focus on the need for equity in health care, and it will make a significant difference in the lives of Illinois nursing home residents, no matter the location of the facility where they reside.”

Rep. Camille Lilly said, “Nursing home payment reform will be the first step and will create a more equitable long-term care system in the state, while putting in place a wage scale for CNAs that recognizes the value of their experience in their vital role of caring for our seniors.”<sup>107</sup>

## History of the Measure

The payment reform bill was ultimately passed unanimously out of both chambers of the legislature. But this was only after nearly two years of protracted negotiations between the Pritzker administration and the nursing home industry that appeared to reach an impasse several times.<sup>108</sup> The Health Care Council of Illinois, which represents nursing homes in the state, introduced a competing bill at one point in the negotiations. Council officials suggested the payment reform effort’s emphasis on rectifying over-coding of therapy services, willful under-staffing of facilities and profit-seeking painted the nursing homes in too negative a light. The organization identified 130 facilities that would see a decline in revenues as a result of proposed changes, along with 50 facilities they said would be at risk of closure. The Department of Healthcare and Family Services called the claims of closure a “red herring.”<sup>109</sup>

## What Else is Illinois Working On?

Pritzker and DHFS officials in August 2022 announced the launch of the state’s Program of All-Inclusive Care for the Elderly (PACE), which seeks to expand options for community-based care, allowing eligible seniors to continue to live at home. The program provides customized and coordinated medical care and social services for adults ages 55 and older who qualify for nursing home care but are able to safely continue living in the community. The program combines all the services covered under Medicare and Medicaid, including holistic care planning and coordination, long-term services and supports, therapies, medications, mental health care and hospital care. If an enrollee requires nursing facility care, the program will fund that and continue to coordinate the patient’s care. Program providers are expected to begin delivering services in FY 2024. Thirty-one other states have operational statewide programs serving an estimated 60,000 people.<sup>110</sup>



# Optimizing American Rescue Plan Act Funding for Home- and Community-Based Services Under Medicaid

## Background and Introduction

The American Rescue Plan Act was enacted in March 2021 as an effort by the federal government to offset many of the impacts of the COVID-19 pandemic. In particular, the legislation provided states a unique opportunity to undertake a series of transformative changes to the U.S. health care system. This included resources made available to improve long-term care services in the United States by strengthening Medicaid home- and community-based services.

The legislation included a 10-percentage point increase in the federal government's share of total Medicaid costs — the federal medical assistance percentage — for certain HCBS expenditures beginning April 1, 2021, and ending March 31, 2022. States have until March 31, 2025, to spend the estimated \$12.7 billion of additional funding. Each state and Washington, D.C., is required to submit a spending plan for these dollars.<sup>111</sup>

The Centers for Medicare & Medicaid Services recommended that states use the funds to implement structural changes to:

- Expand eligibility and increase access to HCBS for all Medicaid beneficiaries.
- Offer a broader range of community-based services.
- Make long-term investments in HCBS infrastructure.
- Support compliance with HCBS regulatory criteria and promote community integration.
- Strengthen the direct care workforce, which could include increasing pay and benefits.
- Address social determinants of health and improve equity.<sup>112</sup>

Following the submission of these spending plans, all 50 states and Washington, D.C., were approved to claim the increased funding and begin implementing the identified activities. The Centers for Medicare & Medicaid Services found a number of “innovative and exciting activities” in the submitted state plans, including:

- Providing recruitment and retention bonuses, pay increases and student loan forgiveness for direct support professionals.
- Expanding coverage to Medicaid beneficiaries on waiting lists for HCBS services.
- Expanding access to assistive technologies to promote independence and community integration.
- Implementing new behavioral health crisis response services for people with intellectual and developmental disabilities.
- Building partnerships to increase access to affordable housing and housing assistance for people with disabilities and older adults.
- Providing housing-related services and supports, such as home accessibility modifications and case management and other supportive services, to help people obtain and maintain housing.
- Developing new initiatives to increase access to competitive integrated employment for people with disabilities.<sup>113</sup>

An analysis of the plans for 49 states<sup>114</sup> and Washington, D.C., by ADvancing States, which represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors, found that the most popular funding activities proposed by the states included:

- Provider training and certification (38 states).
- Recruitment and retention bonuses (29 states).
- Provider pay rate increases (28 states).
- Provider pay rate studies (25 states).
- Caregiver supports (24 states).
- Provider bonuses (15 states).
- Housing supports (12 states).<sup>115</sup>

## Key Findings

In consideration of those commonalities in the state spending plans, this report highlights six categories of action they have explored:

1. Provider and workforce supports.
2. Quality improvement initiatives.
3. Housing initiatives.
4. Community transition.
5. Service expansions.
6. Caregiver supports.

The state examples in the sections that follow have been chosen to highlight the diversity of program offerings and descriptions.







## Categories of Investment

### 1. Provider and Workforce Supports

Many state spending plans included activities to improve provider and workforce support systems. Provider rate increases, recruitment or retention activities, training and expanding behavioral health capacity were among the planned actions in the states, including:

- **Alabama** will focus on all of these provider and workforce supports.<sup>116</sup> The state's proposed activities include increasing the reimbursement rate for direct service providers, investing in a per-service increase and offering incentives or salary increases for workers.<sup>117</sup>
- **Delaware's** spending plan adds special recruitment bonuses and retention payments for all direct support professionals across the entire network of HCBS services to promote equity and reduce competition among providers.<sup>118</sup>
- **Maine's** plan calls for 60% of provider rate increases to directly filter to wages for direct support professionals (those individuals who work directly with people who have intellectual or developmental disabilities). **North Carolina's** plan has an 80% requirement.<sup>119</sup>
- The **Minnesota** plan includes all of the provider and workforce supports except for recruitment and retention activities.<sup>120</sup>
- The spending plans from **New Jersey** and **New York** also include special payments.

In addition to those shared provider and workforce supports, the **New York** plan also includes initiatives to:

- Expand training and implementation support for evidence-based practices.
- Expand recruitment and retention of diverse and culturally competent and responsive personnel.
- Expand certified and credentialed peer capacity.
- Extend short-term support for the behavioral health care collaboratives of licensed providers.<sup>121</sup>

## 2. Quality Improvement Initiatives

Quality improvement investments were included in 38 state plans, which included proposals to conduct research on the home- and community-based services workforce, to implement initiatives to make HCBS more culturally informed and responsive, and to reform delivery systems.<sup>122</sup> State examples of these proposals include:

- **Arizona**'s Medicaid agency proposes the development of a public-facing dashboard to assist members and families as they make decisions and choose providers for their HCBS care. The data transparency initiative is part of a broader effort to implement the recommendations of an abuse and neglect prevention task force and is expected to incorporate utilization cost data, licensing/monitoring data and quality metrics.<sup>123</sup>
- **Indiana** highlights a number of initiatives to integrate HCBS data systems in order to improve quality and reduce inequities. Officials hope these activities will lead to an improved understanding of the differences in health outcomes and increased efficiency.<sup>124</sup>
- **Maine** proposes to enhance quality assurance under an HCBS waiver program for people with intellectual and developmental disabilities, brain injury and other related conditions by adding contracted positions in Maine Department of Health and Human Services district offices.<sup>125</sup>
- **Mississippi** proposes awarding innovation subgrants to communities to allow direct spending on community-proposed, short-term or one-time projects to enhance HCBS services, improve overall quality, encourage interagency partnerships to address social determinants of health, and build a stronger HCBS workforce.<sup>126</sup>
- **New York** is using ARPA funds to lay the groundwork for a future value-based payment arrangement that will incentivize more independent residential options for individuals with intellectual and developmental disabilities. The state's Office for People with Developmental Disabilities is establishing two grant-funded opportunities to support a wider range of more independent residential supports to foster independence and greater opportunity for community integration.<sup>127</sup>

While there is significant data about the quality of care in nursing homes available due to reporting requirements from the Centers for Medicare & Medicaid Services, better data collection and reporting about home and community-based services will be key to understanding issues like whether discrimination and access inequities exist across these services. A 2021 report from the California Health Care Foundation noted that despite the wide array of HCBS in **California** and the significant funding through the state's Medi-Cal program for these services, little public data exists to demonstrate whether HCBS is equitably available and used by those who qualify for services. The California Department of Health Care Services in 2022 launched a gap analysis to assess the gaps in HCBS data with the primary goal of reducing inequities in access to and availability of services, starting with identifying disparities in who is receiving services and where.<sup>128</sup> Other states may want to consider similar gap analyses and work to identify the needs in data collection and reporting as they seek to assess the quality of these services and the return on these investments.





### 3. Housing Initiatives

Supportive services to help people obtain and maintain housing are the focus of initiatives outlined in numerous state plans.

- **California** includes a program under which care plans managed by the state's Medicaid health care program, Medi-Cal, could earn incentive funds for addressing homelessness and housing insecurity. Officials hope the program can help the state address issues with social determinants of health and health disparities.<sup>129</sup>
- **Massachusetts** plans to embed options counselors and eligibility specialists in hospitals to provide people experiencing homelessness or housing instability with discharge planning, establish their HCBS service package upon discharge and connect them with community-based organizations.<sup>130</sup>
- **Minnesota, New Hampshire, Rhode Island** and **Washington** are among other states that initiated or enhanced homelessness reduction and/or prevention activities.<sup>131</sup> New Hampshire, for example, provided funding for whole-person and integrated care in the community to those experiencing homelessness.<sup>132</sup> Rhode Island's spending plan provides support to intensive outreach case management teams in designated areas of the state who have strong histories in engaging individuals and families experiencing homelessness.<sup>133</sup>
- **Washington** also highlights enhancing a state-funded rental subsidies housing program to help clients transition from nursing homes to their own homes in the community.<sup>134</sup>

### 4. Community Transition

More than 20 states proposed initiatives to improve the transition of individuals from institution-based care to community-based settings. These community transition programs include both traditional transition supports like home modifications and moving assistance as well as activities to increase access to affordable housing.<sup>135</sup>

- The **Colorado** spending plan provides short-term grant funding for behavioral health crises and transition services provided by the state's Department of Health Care Policy and Financing to support members moving from an institution, hospital or corrections facility to the community. The initiative specifically focuses on increasing capacity for community-based care. Under this plan, providers, non-governmental organizations and counties may request funding for projects that improve service delivery options or create pathways that improve care transitions. Potential grants would prioritize transition services that serve those who are disabled as a result of a mental health diagnosis.<sup>136</sup>





- **Michigan**'s plan suggests that its investments focus on areas such as "diverting long-term care facility placements or inpatient hospitalizations to HCBS settings, supporting long-term housing placements for individuals with intellectual or developmental disabilities, and programs that support individuals at risk of unstable housing."<sup>137</sup>
- **Oregon** lists a variety of supports in its spending plan that the state's Health Systems Division can offer to individuals who need assistance to find and maintain housing. These potential supports include:
  - Conducting a housing assessment identifying an individual's preferences.
  - Budgeting for housing/living expenses.
  - Assisting individuals in viewing and acquiring housing.
  - Developing an individualized housing support plan.
  - Communicating the individual's disability/condition and accommodations needed.<sup>138</sup>
- **Pennsylvania** intends to enhance community transitions by incentivizing managed care organizations to meet nursing home transition goals under the commonwealth's Nursing Home Transition program. This initiative allows nursing facility residents and their families to receive information about home- and community-based services. Under the state plan, one-time grants for housing adaptations will be made available to individuals transitioning from public or private intermediate facilities, children transitioning from congregate care and medically complex adults when cost effective. The grants also are intended to avoid placing individuals in a nursing facility and would support adults to age in place or transition to supported living.<sup>139</sup>
- **South Carolina** notes in its plan that community transition services are currently made available through its program, Home Again, which assists eligible individuals — Medicaid recipients who are older adults or have a physical disability — who live in a skilled nursing facility or a hospital to move back into their homes and communities. The program provides transition coordination, home delivered meals, personal care assistance, companion care and other services.<sup>140</sup> Home Again receives funding from a Money Follows the Person grant from the Centers for Medicare & Medicaid Services. South Carolina's 1915(c) HCBS waiver program is another source of services.<sup>141</sup>

## 5. Service Expansions

Many states plan to use federal funds to add home- and community-based services or increase benefit levels for existing services. According to the submitted spending plans, states plan to expand behavioral health benefits for certain populations, increase caps for home modifications, fund more home-delivered meals and enhance transportation services.

- **Illinois** is committing \$25 million to one-time grants to expand home- and community-based services in underserved areas and to promote underutilized existing services. For example, grants in the Illinois spending plan would be targeted toward opening community mental health centers or behavioral health clinics in the state's underserved areas.<sup>142</sup>
- **Nevada**'s plan includes four service expansions for senior citizens and people with disabilities:
  1. Establishment of a Program for All-Inclusive Care for the Elderly. Currently, 31 states operate 146 PACE programs around the country, which serve 60,000 participants. Nevada lawmakers passed legislation in 2009 to authorize the establishment of a program, however, as a result of the Great Recession, no funds were appropriated for the initiative. State officials plan to address the ongoing costs of a PACE program as part of the next biennial budget.
  2. Vehicle and home modifications including medical monitoring technologies.
  3. Increased hours beyond current limits for adult day care and adult day health care.
  4. Expanded individualized services to reduce congregate settings.<sup>143</sup>



- **New Hampshire** seeks to provide funding for pilot programs to establish a PACE program or Dual Eligible Special Needs Plan. Through the proposed state spending plan, New Hampshire seeks to learn how the integration of Medicare and Medicaid coverage can help meet the overall needs of dual eligible beneficiaries. With the goal of reducing costs within the state’s managed care program, the plan also weighs how to meet those needs in the community compared to how to meet those needs in institutional settings.<sup>144</sup>
- **Texas** proposes to fund additional slots in Medicaid HCBS waiver programs such as Texas Home Living, Community Living Assistance and Support Services and the Medically Dependent Children Program. Individuals served by these programs are required to reside in the community and not an institution.<sup>145</sup>

## 6. Caregiver Supports

In addition to providing support for the professional direct care workforce and other care providers, states have used federal funds to assist unpaid family caregivers by offering direct payments and culturally competent training in areas such as care for people with specific disabilities. States have also invested in caregiver resource centers and adult day services.<sup>146</sup>

- **Colorado** proposes a grant program in its state plan to increase access to respite services, which provide temporary relief for primary caregivers. State officials plan to identify the landscape of respite availability across Colorado and, noting gaps, create a report to develop a framework for the program. Grant recipients could include parents, grandparents or child caregivers of aging family members and could be expanded to include other members of a household that are not usually afforded respite but that could benefit.<sup>147</sup>
- **Connecticut** plans to provide access to caregiver assessment (evaluating caregivers to identify and prevent burn-out), dementia supports, care coordination and respite services and training. The state notes that “informal caregivers are the foundation for all HCBS in the state” and that support system has been even more important during the pandemic “when many people provided services to family members at home in lieu of placing the family member in a nursing home.” The state further emphasizes that “stabilizing and sustaining this informal system supports Medicaid HCBS members and also addresses the supply shortages in the paid workforce.” Connecticut plans to implement an evidence-based model program called Care of Persons with Dementia in their Environments as part of this initiative.<sup>148</sup>

- **Indiana** proposes a Caregiver Support Program that would help facilitate human connection and reduce loneliness for caregivers and loved ones as the isolating impact of the pandemic continues. It would provide access to technology such as tablet devices, image-sharing applications and animatronic pets. Another proposed program will allow family caregivers to receive support from a professional caregiver coach who is experienced in working with lay caregivers and navigating the home- and community-based services landscape. The state plans to commit resources to providing critical mental health supports for caregivers. State agencies will conduct research and connect with peer states and stakeholders to determine effective mental health support strategies, including increasing the state's capacity to assess the needs of family caregivers.<sup>149</sup>
- The **Massachusetts** Executive Office of Health and Human Services plans to develop a grant program to award community-based organizations and higher education programs funding to test innovative solutions and tools for caregivers. The agency hopes the grant-funded projects will provide a proof of concept for innovative solutions that might be sustainable within agencies or programs and provide immediate support to caregivers to reduce caregiver burnout.<sup>150</sup>
- **New Mexico** proposes using the additional funding to build on the existing Caregiver Cooperative with a program to support caregivers forming their own businesses that provide care in home and community settings.<sup>151</sup>

## Coronavirus State and Local Fiscal Recovery Funds

In addition to the Federal Medical Assistance Percentage increase, the American Rescue Plan Act also included the \$350 billion Coronavirus State and Local Fiscal Recovery Funds program through which state, local and tribal governments could access funding for purposes including:

- Responding to the adverse public health and economic impacts of the pandemic by supporting the health of communities and helping households, small businesses, impacted industries, nonprofit organizations and the public sector recover.
- Providing premium pay for essential workers, offering additional support to those who have and will bear the greatest health risks because of their service in critical sectors.<sup>152</sup>

Several states were able to push forward a variety of uses of these fiscal recovery funds that relate to long-term care:

- **Hawaii** appropriated \$18 million for one-time payments to help mitigate the effects of the pandemic for nursing facilities, community care family foster homes and expanded adult residential care homes, which allowed them to tap \$28 million in federal matching funds. The funds provided an estimated 15% increase of the total payments to these long-term care settings.<sup>153</sup>
- **Maryland** lawmakers approved a supplemental budget that included a Medicaid nursing home reimbursement rate increase.<sup>154</sup>
- **Michigan's** supplemental appropriations bill included \$100 million to increase the Medicaid match to nursing facilities that have experienced a 5% or greater decline in the average daily census.<sup>155</sup>
- **Montana's** appropriations bill authorized \$15 million for nursing home facilities and facilities with hospital-based swing beds. Lawmakers also allocated \$2.75 million for a Medicaid rate study.<sup>156</sup>
- **Virginia's** supplemental appropriations bill authorized \$31.15 million for the Department of Medical Assistance Services to make payments to Medicaid-eligible nursing homes and specialized care providers.<sup>157</sup>



## Sustainability of American Rescue Plan Act Investments in Long-term Care

In June 2022, the Centers for Medicare & Medicaid Services notified states that they would have an additional year — through March 31, 2025 — to use American Rescue Plan Act funds to enhance, expand and strengthen home- and community-based care services.<sup>158</sup> Previous guidance from the Centers for Medicare & Medicaid Services directed states to submit quarterly updates on their HCBS spending plans and include updates on how activities will be sustained beyond March 31, 2024.

While the state spending plans include a variety of one-time expenditures, they also include numerous service enhancements and new programs that seem likely to have ongoing costs. States will need to determine how to sustain the costs of these programs over time once federal funding expires. Even as states work to get new initiatives up and running, long-term care advocacy organizations are concerned about their sustainability, and many have called on Congress to ensure that long-term care remains a policy consideration for future investment.<sup>159</sup>

The states are considering how to fund and support these long-term programs. Many state spending plans and quarterly updates address the issue of sustainability:

- **California** includes funding for grants to acute care hospitals to support hiring trained behavioral health navigators in emergency departments to screen patients and offer interventions or referrals. The plan suggests the funded hospitals are expected to continue to support these hired navigators after the conclusion of the initial initiative.<sup>160</sup>
- **Connecticut** includes an initiative to integrate smart home technology into subsidized housing, tracking “return on investment to be measured by costs offset by decreasing need for paid caregivers, decreasing number of people with housing who ultimately are institutionalized, and increasing independence.” Of a variety of other initiatives, the plan suggests, “the state will sustain this initiative through General Fund dollars.”<sup>161</sup>
- **Colorado** policymakers have established a \$15 per hour minimum wage for direct care workers. The state’s plan notes that “understanding that the ARPA funds have an end date and the increased compensation for these workers cannot, we are committed to identifying funds to ensure long-term sustainability of this effort.” Elsewhere, the state plan speaks to building a sustainability model for housing supports “by identifying which services are billable as wraparound Medicaid benefits and which are fundable through (the Colorado Department of Human Services).”<sup>162</sup>
- **Hawaii** is adding a new residential service waiver for individuals with co-occurring mental illness and complex challenging behaviors. The state’s plan suggests federal funds “will be used to support the establishment and initial implementation of this service. Over time the costs will be incorporated in the (Intellectual/Developmental Disability) Waiver base budget, funded in part through this group’s reduced usage of other services.” An initiative to increase provider payment rates notes that maintaining the increases “will require additional legislative appropriations.” State officials plan to collect data while the increases are in effect to study the impacts on the number of providers, the availability of services across the state and turnover rates. The analysis is expected to inform decisions on the continuation of the rate increases.<sup>163</sup>
- In its plan, **New Jersey** suggests that “for those initiatives that do require ongoing funding and that the state determines should be continued, we will look to other state resources for ongoing support.”<sup>164</sup>
- **Rhode Island** mentions developing “sustainability strategies through the state’s budget process.” The plan also notes that with enhancements to its No Wrong Door program that “the State expects that savings derived from rebalancing, improving efficiency and performances, and promoting better access and outcomes will offset most of the costs associated with this initiative.” Additionally, regarding home- and community-based workforce development initiatives, the plan acknowledges “that Rhode Island requires ongoing investments ... to ensure that the state has the capacity required to support an aging population



in addition to our (intellectual and developmental disability) community and children and adults with behavioral health needs. We intend to use the lessons learned from each HCBS work force initiative to inform our ongoing policy work, including our annual budget development.”<sup>165</sup>

- **South Carolina** describes a carefully designed effort to “balance time-limited and one-time funding as well as longer term activities already in planning stages to enhance and strengthen the state’s HCBS programs.” The state plan suggests that this balanced approach has allowed the state Department of Health and Human Services “to identify initiatives that are sustainable and support the agency’s overall HCBS strategy.”<sup>166</sup>
- **Vermont** “will place a strong emphasis on one-time, transformational investments to minimize ongoing sustainability concerns while achieving the goals of this funding opportunity.”<sup>167</sup>

States will likely face numerous challenges in sustaining and building on the initiatives proposed in their plans. Some may face lean budget years and appropriators that are unwilling to commit general fund dollars to maintaining some investments. Others may face challenges in applying savings from innovative investments in one area to help sustain initiatives in another. While this one-time federal funding provides an abundance of opportunities for states to enhance services and transform the future of long-term care, it also presents uncertainty that states and their federal partners will have to be vigilant to address in the years ahead.

While states are required to provide quarterly reports on their activities, some experts also suggest the need for a post-action analysis of the entire process, examining these investments for their efficiency, their uses and their effectiveness. In the event of a similar future funding opportunity, states may also want to consider whether the ideal group of stakeholders was involved in shaping these investments and leading these initiatives forward.



# State Case Study: Minnesota's Home and Community-Based Services Spending Plan

## What's in the Plan?

Minnesota's Home and Community-Based Services (HCBS) spending plan, which received the endorsement of the state legislature, proposes investments of \$680 million in services and supports for people with disabilities, older adults and behavioral health services. The plan included more than 50 initiatives spread across five categories:

- Increasing provider rates to enhance, expand and strengthen access to HCBS.
- Expanding services available under HCBS.
- Supporting people receiving HCBS to live in their homes.
- Planning for and implementing reforms to expand, enhance and strengthen the Medicaid HCBS system.
- Supporting and strengthening the infrastructure for HCBS.<sup>168</sup>

The initiatives include a parent-to-parent program for families with children with disabilities (\$344,000), HCBS Workforce Grants (\$11.6 million), and housing stabilization services, community living infrastructure and housing transition costs (\$32.9 million). Many of Minnesota's HCBS investments are intended to provide a starting point to address direct care workforce shortages. They include:

- Provider rate increases (60% of the plan).
- Provider capacity grants.
- Workforce development grants.
- Loan forgiveness for health professionals.<sup>169</sup>

**Plan Highlight:** One innovative initiative could have an impact on HCBS in the state long after its initial funding is depleted and perhaps help address disparities in care between communities. While most states devoted significant funding to wage and compensation increases, Minnesota is also looking to expand its network of HCBS providers by establishing employee-owned cooperatives.<sup>170</sup> The state is expected to award \$24 million in capacity building grants over three years for HCBS in rural and/or underserved communities. Current HCBS providers and organizations interested in becoming HCBS providers are eligible for the grants, which can fund things like staff training, recruitment, technical assistance and community engagement. The purpose of the grant program is to increase the number and ability of HCBS providers in six communities: American Indian and indigenous people; Asian and Pacific Islander; Black and African-born; Latino; LGBTQ and rural and regional centers outside the seven-county Minneapolis-St. Paul metropolitan area.<sup>171</sup> The state received nearly 150 applications for those grants, which are capped at \$50,000. They hope to fund many providers through the program and plan to identify lessons learned to inform future grant programs.<sup>172</sup>

**Secrets to Success:** The number of funded activities under Minnesota's plan speaks to its scope and the foresight and ambition of state officials to address some of the state's most pressing needs. Individual specific initiatives fund housing stabilization services, mobile psychiatric residential treatment facilities (which provide transition services to children and youth with complex mental health conditions) and a consolidation of the state's disability waiver system to promote equitable distribution of resources, program sustainability and





increased choice for Minnesotans with disabilities.<sup>173</sup> Making sure the multitude of initiatives are implemented properly and sustained over time presents a variety of complex logistical challenges. Fortunately, even as Minnesota’s plan was still working its way through the approval process at the Centers for Medicare & Medicaid Services, state officials were engaged in learning how to best manage those challenges. Minnesota is among the states that have received technical assistance on HCBS plan implementation as part of two projects hosted by ADvancing States. This organization, which represents the directors of the 56 state and territorial agencies on aging and disabilities and long-term services and supports, received funding support from several foundations and consultancies for the assistance project. Minnesota was among a cohort of seven states to receive “quick strike” technical assistance in the Fall of 2021 in the development of a comprehensive project management plan identifying the tasks to be accomplished to achieve major objectives in each category of activities.<sup>174</sup> In 2022, Minnesota has participated in a second round as part of a 12-state cohort sharing common challenges and innovative solutions on recruitment and retention strategies and enabling technology to expand access to HCBS.<sup>175</sup>

## Overview of All Initiatives from Minnesota HCBS Plan

Medical Assistance (MA) Rate Increases	Expanded Medical Assistance Services	Support for People Receiving HCBS to Live in Their Homes
Adult Foster Care Residential Crisis Stabilization	Expansion of Telehealth Services	Community Living Infrastructure
Home Health Services	Community First Services and Supports Implementation	Housing Transitional Costs
Personal Care Assistance Rate Framework	Community First Services and Supports Providers Allowed to Drive Recipient to Appointments	Grants for Technology for HCBS Recipients
Disability Waiver Rate System Services	Temporary Paid Parents and Spouses in Personal Care Assistance	Transition to Community Initiative
Enhanced Rates for Personal Care Assistance Recipients with 10+ Hours/Day	Housing Transitional Costs	Mobile Psychiatric Residential Treatment Facility and Child and Adolescent Mobile Transition Unit
Elderly Waiver, Alternative Care and Essential Community Supports Services	Integrated Community Supports Service Expansion	Additional Funding for Respite Care Grants and Own Your Own Future Study
Rate Floor for Elderly Waiver Customized Living Services	Budget Cap Increases in Elderly Waiver and Alternative Care	Centers for Independent Living HCBS Access Grant
Substance Use Disorder Services		Department of Corrections and Department of Human Services Joint Initiative

System Reforms		
Waiver Reimagine Phase II	PCA Cost Reporting and Study on Workers	Research on Access to Long-Term Care Services and Financing
Case Management Redesign	Safety Net Services Report	Medical Assistance Outpatient and Behavioral Health Services Rates Study
Mental Health Uniform Service Standards	Development of Individual HCBS Portal for Recipients	Develop New Service for Personal Care Assistance Services in Acute Care Hospitals
Culturally Informed and Culturally Responsive Mental Health Task Force	Moving to Independence: Subminimum Wage Phase-out	Parenting with a Disability Pilot Project
Substance Use Disorder Provider Reduction in Regulatory Requirements	Legislative Task Force on Human Services Background Studies	

Supporting the HCBS Infrastructure		
Customized Living Quality Improvement Grants	Self-Advocacy Grants for People with Developmental Disabilities	Continuity of Care for Students with Behavioral Health and Disability Support Needs
Adult Mental Health Initiative Grants	Grants for Child Care Providers to Serve Children with Disabilities	Provider Capacity Grants for Rural and Underserved Communities
Recovery Community Organization Grants	Minnesota Inclusion Initiative Grant	Expand Mobile Crisis Services
Service Employees International Union Bargaining Contract Provisions	Culturally and Linguistically Appropriate Services Grants	Reducing Reliance on Children's Congregate Care Settings
Sober Housing Oversight Study	Lead Agency Process Mapping	HCBS Workforce Development Grants
Statewide Parent-to-Parent Program for Families with a Child with a Disability	"Age Friendly" Minnesota Grants	Health Professionals Loan Forgiveness

Source: Task Force Presentation by Carol Anthony. April 29, 2022.

**What's Next for Minnesota?** The state is also working on projects that could have an impact on the future of long-term care outside of Medicaid. Minnesota is using ARPA funds to issue a request for proposals to look at a range of policy options in the financing arena between public sources and private insurance. For example, Life Stage is a hybrid insurance product that starts as term life insurance during a person's working years and transitions to long-term care insurance as they enter retirement.<sup>176</sup> The Minnesota legislature passed, and Gov. Tim Walz signed legislation in 2022 that removes regulatory barriers so the product could be offered in the future.<sup>177</sup>

# Revitalizing the Direct Care Workforce and Supporting Family Caregivers

## Background and Introduction

There are 4.6 million direct care workers in the United States. This includes 2.4 million home care workers, 675,000 residential personal care aides, 527,000 nursing assistants in nursing homes and approximately one million direct care workers employed in other settings. Statutory and regulatory definitions of the roles and titles of direct care workers can vary from state to state, and overall, each job has a slightly different scope of practice depending on the number of hours of required training and other criteria.<sup>178</sup>

Additionally, an estimated 53 million Americans — often adult children, spouses or friends — served as informal caregivers to an older adult or individual with disabilities in 2020, up from 43.5 million in 2015. Of those, 24% were caring for more than one person and 26% were caring for someone with Alzheimer’s disease or dementia. These caregivers often experience burnout, adverse health conditions and other challenges as a result of their duties.<sup>179</sup>

## Key Findings

Among the challenges facing the direct care and family caregiving workforces are insufficient compensation, inadequate training, limited career advancement opportunities, imbalanced worker supply and demand, a lack of reliable workforce data and a variety of structural and societal inequities among those who work in the direct care field. But some states are exploring strategies to increase compensation, offer employment supports, enhance training and education, facilitate career advancement, expand the direct care employee pipeline, improve workforce data collection and monitoring, and support family caregivers.

### DEFINITION //

#### Direct Support Professionals

Individuals directly responsible for assisting people with intellectual and developmental disabilities in a variety of settings including family homes, private homes, intermedia care facilities, small community residential group homes, community job sites, vocational and day training programs, and more. Like other direct care workers, they experience low wages and few benefits despite the high skill requirements of their jobs.

There are no federal training requirements for direct support professionals, and training programs for other direct care personnel are neither required nor aligned with their training needs. While direct care professionals may need skills similar to personal care aides and others in the direct care workforce to support people with medical, self-care and other activities of daily living, they also require training that supports independence, supports people to learn new skills, teaches people how to make informed decisions, and facilitates community involvement and social participation.

Source: “Community Supports in Crisis: No Staff, No Services,” from the Institute on Community Integration, University of Minnesota; Human Services Research Institute; and National Association of State Directors of Developmental Disabilities Services.



# Challenges Facing the Direct Care and Family Caregiving Workforces

The direct care and family caregiving workforces face a variety of challenges:

- **Compensation:** Nationwide, workers struggle in poverty-level jobs across all long-term care settings.<sup>180</sup> Few of these jobs offer any paid sick leave or other common employee benefits, such as employer-sponsored health insurance.
- **Training:** Training requirements do not always reflect the necessary skills and competencies needed to address the evolving complexity of direct care jobs. Federal law requires that home health aides and certified nursing assistants complete at least 75 hours of training, but there are no such federal training requirements for personal care aides. In fact, 26 states have at least one set of training regulations for personal care aides but with no required training hours.<sup>181</sup> States are in need of high-quality training for personal care aides because the demand for these services is expected to increase exponentially in the next decade, and the individuals they serve require higher levels of care. Additionally, the likelihood that these providers experience injuries on the job is 44% higher than the average U.S. worker.<sup>182</sup> Untrained, unpaid family caregivers can face even greater challenges including chronic stress, which could lead to compromised physical and psychological health and depression.<sup>183</sup>
- **Career Advancement and Economic Mobility:** Professional caregivers in long-term care settings often face flat organizational structures that offer limited career advancement. Such opportunities could allow workers to take on advanced caregiving roles, become mentors for newer workers, serve as part of effective integrated care teams, and perform supervised health maintenance tasks. Direct care professionals in particular need access to career ladders — formal processes that outline how employees may advance to higher salaries and levels of responsibility. On-the-job training through apprenticeship programs offer another way for professional caregivers to demonstrate the aptitude to advance professionally.<sup>184</sup>
- **Worker Supply and Demand:** Between 2018 and 2028, there will be 8.2 million job openings in the direct care workforce.<sup>185</sup> The home care workforce is projected to add one million jobs by the end of the decade (more than any other occupation in the U.S.) and there will be 4.5 million job openings in these fields as a result of increased demand, workers moving into other occupations and workers exiting the labor force.<sup>186</sup> Additionally, many states report worsening labor shortages during the pandemic.<sup>187</sup> An estimated 420,000 direct care workers left the nursing home workforce over the last two years.<sup>188</sup> For all direct care workers, the national annual turnover rate is estimated to be 40-60%, with home care agencies reporting even higher rates (65-89%).<sup>189</sup> The United States could experience a shortage of 151,000 direct care workers by 2030 and a shortage of 355,000 workers by 2040.<sup>190</sup>
- **Workforce Data:** A lack of reliable data about the direct care workforce is a challenge to the efforts to quantify concerns, identify priorities, implement solutions and evaluate outcomes. More data is needed on workforce volume, stability and compensation.<sup>191</sup>
- **Structural, Gender, Racial and Other Inequities in Direct Care:** Of the current direct care workers, 87% are women, 61% are people of color and 27% are immigrants. Analysts suggest the poor job quality and traditionally low wages associated with direct care jobs perpetuate long-standing societal disadvantages that these populations face.<sup>192</sup> The full weight of a lack of value and stigma placed on these jobs are substantial challenges.<sup>193</sup> Analysts suggest that policies driven by stereotypes about gender and race have weakened workforce protections. However, they also suggest that higher pay and improved conditions could make it easier to attract and retain workers and substantially benefit population groups that are often financially disadvantaged, such as women of color.<sup>194</sup>

# State Strategies to Revitalize the Direct Care Workforce

## Increasing Compensation

Low compensation is one of the biggest challenges in recruiting direct care workers. In 2017, the average national wage of home health and personal care aides was \$11.12 per hour. Among home care workers, 49% were dependent on some form of public assistance and 51% lived below 200% of the federal poverty level.<sup>195</sup>

Pay raises that provide direct care workers with a living wage enhance their financial security, reduce turnover and staffing shortages, boost caregiver productivity, enhance quality of care for patients, and increase economic growth.<sup>196</sup> Recent state initiatives to increase compensation for direct care workers have included temporary pandemic-era measures, initiatives to address Medicaid rate changes, 1915(c) waivers and Appendix K measures to pay family caregivers, managed care contracts, and wage pass-throughs.

The COVID-19 pandemic prompted several states to implement temporary measures to raise the compensation of direct care professionals or offer hazard pay.<sup>197</sup> As of November 2020, 36 states had temporarily increased provider payment rates through 1915(c) home and community-based services waivers, and 18 of these states have increased reimbursement for nursing home and home care. According to analysts, permanent changes to compensation are desperately needed, including a base rate that guarantees a living wage and health and other benefits, merit and longevity pay, bonuses, child care and transportation.<sup>198</sup>

### DEFINITION //

## 1915(c) waivers and Appendix K

**1915(c) Waiver:** Medicaid waivers authorized by Section 1915 of the Social Security Act that allow states to provide certain services to specific populations.

**Appendix K:** A standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers.

### Increasing Medicaid reimbursement

rates and tying rates to wages is one way to provide a living wage. Approximately half the states made a commitment to increasing wages through Medicaid rate changes in 2019 and 2020. However, among states that raised reimbursement rates, the increases tended to be marginal and did not keep up with inflation.<sup>199</sup>

For example, **Illinois** Gov. J.B. Pritzker signed nursing home rate reform legislation in 2022 that holds facility owners accountable by tying new funding to staffing levels and to improvement in key quality measures. A new pay scale for certified nursing assistants will increase wages based on years of experience. This reform model is believed to be the first for any state.<sup>200</sup>

States are allowed to develop Medicaid 1915(c) waivers for home- and community-based services to meet the needs of people who prefer to receive long-term care services outside institutional settings.<sup>201</sup> During emergency situations like the pandemic, states can request amendments to their waivers to guarantee continuity of services.<sup>202</sup> Appendix K was created by the Centers for Medicare & Medicaid Services to help states accelerate changes to their 1915(c) waiver operations or to request emergency amendments.<sup>203</sup> Just a few months into the pandemic, nearly all states had an approved Appendix K<sup>204</sup>, and many included language to pay family caregivers for services normally performed by direct care workers or others.<sup>205</sup> Prior to the pandemic, many states were already pursuing strategies to support family caregivers but since 2020, states have accelerated not only the pursuit of new Medicaid flexibilities but also coordination with Area Agencies on Aging and other system stakeholders to assess the needs of family caregivers and the pooling of state resources across interagency teams.<sup>206</sup>

Some states have passed legislation to support improved benefits and worker protections for aides that are hired through managed care contracts.

- **Tennessee** pays managed care organizations a nursing home rate based on quality performance, with 25% of the score focused on staffing and staff competency measures, such as retention, training and consistent assignment.<sup>207</sup>
- A 2017 **Wisconsin** appropriations bill increased the portion of funds in managed care contracts that goes toward aid wages, bonuses, time off and benefits.<sup>208</sup>

Some states have used wage pass-throughs, which allow an additional allocation for increasing compensation for direct care support staff.<sup>209</sup>

- **Arizona**'s 2017 wage pass-through law responded to the passage of Proposition 206 that raised the minimum wage from \$8.35 to \$12.00. The law designates a certain percentage of a reimbursement rate increase to be used for wages, and it applies to all direct care workers in facilities and in-home and community-based services.<sup>210</sup>
- **Colorado** established a new hourly minimum wage for employees who provide direct care.<sup>211</sup>
- The **Hawaii** Kupuna Caregiver Program, which initially provided family caregivers direct payments of \$350 per week has been incorporated into the state's overall long-term services and supports program called Kupuna Care and now provides family caregivers support of up to \$210 a week of services such as adult day care to ensure they can maintain employment.<sup>212</sup>
- **Maryland** increased the rate of reimbursement for community service providers, including direct care staff, each fiscal year.<sup>213</sup>
- **Michigan** direct care workers received a \$2 per hour wage increase in 2020 from Coronavirus Aid, Relief, and Economic Security Act funding. The raise was bumped to \$2.35 in fiscal year 2022.<sup>214</sup>
- **New Jersey** established a minimum wage that is \$3 higher than the state minimum wage for certified nurse aides working in nursing facilities. When it reaches \$15 per hour in 2024, the statewide minimum wage will be indexed to the Consumer Price Index.<sup>215</sup>
- **New York**'s \$20 billion health care plan included in the 2022-23 state budget will allow home health care workers to receive a \$2 per hour increase in the minimum wage on Oct. 1, 2022, followed by an additional \$1 increase in October 2023.<sup>216</sup>
- **Virginia** law gives home health care workers one hour of paid sick leave for every 30 hours worked.<sup>217</sup>





However, increasing the pay for typically low-wage direct care workers may cause some to lose access to public benefits such as Medicaid and food and nutrition assistance. This issue is often called a benefit cliff. The Federal Reserve Bank of Atlanta developed a set of tools, called the Career Ladder Identifier and Financial Forecaster, to address these benefits cliffs. The bank worked with the **Oklahoma** Department of Commerce to pilot these tools at job centers around the state, so workers are supported as they move into in-demand jobs and earn higher wages.<sup>218</sup>

The **Pennsylvania** 2022-23 state budget includes \$25 million to extend program eligibility to people at higher wages for Child Care Works, a program that helps low-income families pay for child care.<sup>219</sup> The budget also provided \$25 million for the Child and Dependent Care Enhancement Program, a child care tax credit to benefit working families with children in daycare who already qualify for a similar federal program.<sup>220</sup> Pennsylvania policymakers believe individuals who are part of the direct care workforce may be among those to benefit.

## Employment Supports

During the pandemic, several states explored offering supports for the direct care workforce.

- **Massachusetts** Gov. Charles Baker authorized the Exempt Emergency Child Care Program to offer free backup child care for parents working in health care, human services, public health, public safety and law enforcement.<sup>221</sup>
- **Minnesota** Gov. Tim Walz signed an executive order in March 2020 providing free child care to “emergency workers,” which includes all direct care workers.<sup>222</sup>
- **New Jersey** offered emergency child care assistance to essential employees, including direct care workers, through May 2020.<sup>223</sup>

## Enhancing Training and Education

Researchers have long recommended increasing the 75-hour federal training requirement for certified nursing assistants and home health aides, but it is also important to ensure that the training is competency-based and addresses the full range of skills required for these jobs.<sup>224</sup>

- The curriculum for **Arizona**’s state-sponsored personal care aide training program covers core fundamental skills for personal care aides and has population-specific modules. The effectiveness of the training is demonstrated through standardized test results.<sup>225</sup>
- **California** requires certified nursing assistants in residential care facilities to receive 12 hours of additional dementia care training.<sup>226</sup>
- **Georgia** established licensure and dementia training for all direct care workers and other long-term care staff in memory care centers.<sup>227</sup>
- **Illinois** established minimum training requirements for employees of home health agencies providing services for people with Alzheimer’s Disease and dementia.<sup>228</sup>
- **Indiana** law requires registered home health aides to complete dementia training.<sup>229</sup> Assisted living facilities providing memory care services must complete a disclosure form outlining how they provide dementia-specific care, staffing levels and transfer/discharge policies.<sup>230</sup>
- **Minnesota** provides scholarships and student loan repayment for nursing facility staff, including nursing assistants.<sup>231</sup>
- **Mississippi** provides short-term tuition, vouchers and health care credentials to unemployed and underemployed certified nursing assistants.<sup>232</sup>
- **Oregon** outlines specific training on dementia care for direct care workers.
- The **Tennessee** Quality Improvement in Long-Term Services and Supports value-based payment program allows direct care workers to earn a series of competency-based micro-credential badges, earn college credit and advance along clearly articulated career pathways.<sup>233</sup>

- **Virginia** has updated regulations for staff training in memory care and assisted living settings to require a certain number of hours in dementia training for various personnel.<sup>234</sup> The measure does not cover nursing homes, where an estimated 48% of residents overall have Alzheimer’s or other dementias.<sup>235</sup>
- **Washington** requires 75 hours of entry-level training (along with 12 hours of continuing education for personal care aides) to prepare individuals to work across all long-term care settings as “universal workers.”<sup>236</sup> Analysts suggest the program could be the basis for developing a cross-setting professional caregiver occupation.<sup>237</sup>

Several states adopted permanent or temporary changes to staff training requirements during the COVID-19 pandemic to expand the pool of staff available to work in nursing homes.

- **Wisconsin**, for example, lowered from 120 hours to 75 hours the training requirement for nurse aides.<sup>238</sup>

## Facilitating Career Advancement

Career advancement and career ladders allow direct care workers to take on advanced roles on care teams and become specialists in dementia care, chronic condition management, behavioral health and medication and pain management. Federal and state policymakers could work with providers to create meaningful career lattices through competency-based job descriptions and work with educational institutions to create training programs.<sup>239</sup>

- **Arizona**’s plan for spending American Rescue Plan Act funds highlights initiatives to develop and implement a formal credentialing process for direct care workers and a caregiver career development pathway.<sup>240</sup>
- **Delaware** provides certified nursing assistants with an opportunity to become Senior Certified Nursing Assistants.<sup>241</sup>
- The **Indiana** Governor’s Health Workforce Council commissioned a study to examine career pathways for certified nursing assistants.<sup>242</sup>
- The **Missouri** Department of Mental Health Division of Developmental Disabilities launched Missouri Talent Pathways, a registered apprenticeship program that features a combination of technical instruction and on-the-job mentoring.<sup>243</sup>
- A **Pennsylvania** Workforce Innovation and Opportunity Act State Plan update emphasizes career pathways to encourage more specialty health care professionals like those who provide dementia care.<sup>244</sup>

In addition, **Arizona, Florida, Illinois, Nevada** and **Washington** are among the states that have authorized medicine disbursement credentials, licensing or endorsements for certified nursing assistants who meet certain requirements.

## Expanding the Pipeline

Individuals who are not usually attracted to long-term care jobs, such as high school students and displaced and post-retirement age workers, could be encouraged with the right incentives from government and the right messaging from community agencies.<sup>245</sup> For example, a long-term care council in **Pennsylvania** recommended that the commonwealth implement incentives — such as loan forgiveness, tuition assistance and academic credit — to encourage college students to enter the direct care workforce.<sup>246</sup> Apprenticeships and other paid work-based learning opportunities can recruit workers by removing training costs as a barrier. Such programs create more coordination across state agencies focused on employment, education and workforce development.<sup>247</sup>

- The **Colorado** Department of Higher Education partners with institutions on a collegiate apprenticeship program that combines classroom content with paid training opportunities in entry-level health care and direct care jobs.<sup>248</sup>
- **Hawaii**’s Hana Career Pathways program employs a grant from the U.S. Department of Education to provide tuition assistance for short-term training in high-demand health care roles including those in



long-term care.<sup>249</sup> In recent years, the state has expanded career and technical education career pathways into areas like health services after an alignment study using state economic and workforce data was conducted to determine high-skill, high-wage and high-demand occupations and state economic priorities and initiatives.<sup>250</sup>

- **Massachusetts** partnered with Northeastern University to create an employment website to connect nursing homes with potential job candidates.<sup>251</sup>
- The **Michigan** Department of Health and Human Services worked with the Department of Labor and Economic Opportunity Career and Technical Institute to adapt a campus-based certified nursing assistant training program to make it more accessible to individuals with disabilities who are receiving Temporary Assistance for Needy Families.<sup>252</sup>
- The **Missouri** Apprentice Connect program identifies in-demand occupations and connects potential workers with apprenticeship programs where they can receive training and work experience while earning wages.<sup>253</sup>
- **Rhode Island's** American Rescue Plan Act spending plan directs \$6.1 million to an initiative designed to expand career pathways for direct care workers and focuses outreach efforts to increase the diversity of the workforce.<sup>254</sup>

States are also developing additional strategies for recruiting and retaining workers.

- The **Arizona** Department of Education has implemented 27 home health aide programs in public high schools.<sup>255</sup> Arizona's American Rescue Plan Act plan proposed an investment in the Workforce Data Reporting System that will help state agencies monitor trends affecting recruitment and retention in the health care workforce.<sup>256</sup>
- **Arkansas** provides \$1,000 recruitment and retention bonuses to certified nursing assistants, behavioral health aides, residential care assistants, technicians and supervisors.<sup>257</sup>
- **Maine** tasked a commission with studying ways to support and strengthen the direct care workforce.<sup>258</sup>
- **Maryland** established a Direct Care Workforce Innovation Program to award matching grants to create and expand successful recruitment and retention strategies. **New York** and **North Carolina** have similar programs.<sup>259</sup>
- **Minnesota** launched Direct Support Connect, a statewide job board that helps consumers find direct care workers and workers find employment.<sup>260</sup>
- **North Carolina** provides grant funding for job training programs and internships for individuals seeking careers in various direct care roles. Historically marginalized populations are a focus.<sup>261</sup>
- A **Michigan** statewide direct care workforce advisory committee brings together stakeholders from all care settings, state-funded programs and populations to address the state's direct care worker shortage and make policy, regulatory and programmatic recommendations.<sup>262</sup>



- The **New Jersey** Caregiver Task Force was created to research the availability of caregiver support services in the state and provide recommendations for service improvement and expansion.<sup>263</sup>
- **New Mexico**<sup>264</sup> and **Texas**<sup>265</sup> also had commissions on the direct care workforce in recent years that have issued recommendations.<sup>266</sup>
- A **New York** bill in 2021 enabled the study, development and implementation of a long-term strategy to support the growth of the caregiving industry in the state.<sup>267</sup> A second bill established a reimagining long-term care task force.<sup>268</sup>
- The **Tennessee** Direct Support Professionals Apprenticeship Program is a public-private partnership to address workforce shortages in the state. The program compensates individuals for on-the-job training, increases wages by \$3.50 per hour upon program completion and partners with community colleges and universities to train students in direct care work.<sup>269</sup>
- **Washington** invests \$450,000 to support an apprenticeship pathway for direct care workers.<sup>270</sup>
- A **Wisconsin** task force created by executive order in 2019<sup>271</sup> developed a report containing 16 policy proposals. They include creating a tiered career ladder, designing a statewide marketing strategy and developing a pilot program to establish a home care provider registry.<sup>272</sup>

Federal legislation proposed last year by U.S. Sen. Tim Kaine of **Virginia** and others sought to establish a grant program for initiatives to train, educate, retain and promote the direct care workforce and provide education and training support for family caregivers. Under the measure, grants could be used for pre-apprenticeship and on-the-job training opportunities, apprenticeship programs, career ladders or pathways, specialization or certification, or other activities to recruit and retain professionals.<sup>273</sup> **Hawaii** has used state funds from employer contributions to the unemployment insurance fund to offer incentives to employers to train, hire and retain health care workers and others in high-demand industries.<sup>274</sup>

## Data Collection and Monitoring

A number of states have taken initial steps to improve direct care workforce data collection. Knowing more about the volume, stability and compensation of the workforce can help policymakers quantify concerns, identify priorities, implement solutions and evaluate outcomes. Policymakers can look to state agencies and various professional organizations that collect workforce data.

- **California's** Data Dashboard on Aging tracks the number of direct care workers by type and tracks licensed workers per 1,000 older adults by county.<sup>275</sup>
- A **Massachusetts** law requires the creation of a public registry for home care workers in its State Home Care Program. The registry verifies the type of training received and credentials earned.<sup>276</sup>
- **Texas** requires reports on the size, stability and compensation of the direct care workforce from long-term services and supports providers.<sup>277</sup>
- **Utah's** American Rescue Plan Act spending plan includes \$500,000 for a study to evaluate and recommend ways to address the direct services workforce shortage and to support one-time projects based on the study.<sup>278</sup>

## State Strategies to Support Family Caregivers

One of the biggest challenges states have faced in trying to support family caregivers is the ability to identify and reach them. States have started to adopt strategies that can help them understand the population of caregivers.<sup>279</sup> For example, the **New York** State Office for the Aging partnered with other state agencies to survey businesses and their employees to identify family caregivers in the workforce.<sup>280</sup> The agency also distributed a caregiver guide to employers to help working family caregivers find resources.<sup>281</sup> The **Iowa** Department of Aging partnered with AAA offices on a standardized family caregiving assessment.<sup>282</sup>

States have also moved forward with programs to assist caregivers in meeting fiscal challenges. State Appendix K amendments are set to end six months after the end of the public health emergency. Policymakers will need to assess these flexibilities to determine if they should remain in place.<sup>283</sup>

States have additional flexibility through Medicaid waivers to provide education, training and counseling to family caregivers.<sup>284</sup> For example, **Georgia's** 1915(c) waiver provides targeted supports to unpaid caregivers who live with a Medicaid beneficiary, including training, care coordination and a per diem stipend. The family caregiver can receive a minimum of eight hours of training each year and support from other care team members.<sup>285</sup> Seventeen states proposed to use some portion of their rescue plan funding on training and education, while seven states proposed direct payments to family caregivers.<sup>286</sup>

States have implemented caregiver supports in state rescue plan spending in other ways.<sup>287</sup>

- **Connecticut** incorporated supports for caregivers of those with Alzheimer's disease and related dementias into permanent initiatives.<sup>288</sup>
- An **Indiana** caregiver support grant for technology is designed to reduce caregiver loneliness and fund a gap analysis of family caregiving services.<sup>289</sup>

Another source of federal funds for caregiver supports is the Lifespan Respite Care Program. Funded programs provide accessible, community-based short-term relief services for family caregivers of children and adults with special needs.<sup>290</sup> In 2021, **Arkansas** began awarding sub-grants to respite organizations for specialized respite programs, activities and events.<sup>291</sup>

Additional examples of state strategies designed to improve the financial and workplace security of family caregivers include:

- Enhancing family leave requirements (**New Jersey** and **Washington**).
- Establishing tax credits for caregiving expenses (**Nebraska, Oklahoma** and **Oregon**).
- Establishing protections against workplace discrimination based on family responsibilities (**Delaware** and the **District of Columbia**).
- Including family caregiving in unemployment insurance eligibility (**Alaska** and **South Carolina**).
- Exploring options for long-term services and supports beyond Medicaid (such as **Washington's** Long-Term Care Trust Act).
- Promoting financial education and planning for family caregivers (**Georgia** and **New York**).<sup>292</sup>



# State Case Study: New York's increase in the home care worker minimum wage

## What did they address?

New York has an estimated 250,000 – 400,000 home care workers and 530,000 direct care workers. About 100,000 new home care workers are needed each year, including about 27,000 to meet rising demand and 72,000 to replace departing workers.

Home care workers provide a wide range of services from relatively low-intensity support for “independent activities of daily living” (such as cooking and shopping) to more intensive support for “activities of daily living” (such as bathing and toileting). Some home care worker roles provide in-home skilled nursing services for medically complex patients.<sup>293</sup>

Among the lowest-paid professions in New York, home health care workers have an hourly minimum wage of \$15 in New York City, Long Island and Westchester and \$13.20 in other parts of the state.<sup>294</sup>

LiveOn NY, a network of nonprofit organizations, found that the median annual income of home care workers in the state was \$22,000 in 2021, compared to a median salary for fast food workers of \$24,429. Low wages for emotionally and physically demanding work has likely led to an average of 17% of home care positions going unfilled in New York.<sup>295</sup>

During the last decade, New York began transitioning the manner in which it pays for home care services from fee-for-service to managed care. New York is one of 24 states that operates managed long-term services and supports programs. States have turned to managed care as one of several strategies to improve care coordination and manage costs for populations with complex needs.<sup>296</sup> The managed care organizations in the state are intended to serve as intermediaries, passing federal and state Medicaid funds on to the providers who deliver services. But home care agencies have complained they do not receive timely or adequate reimbursement for services from managed care organizations, which they say often impose new terms and conditions for payment after the services have been delivered and billed.<sup>297</sup>

Meanwhile, home care agencies have struggled to recruit and retain qualified staff, a problem that predates the pandemic but one that has been exacerbated by it.<sup>298</sup>

## What Did New York Do?

As part of the FY 2023 state budget, lawmakers passed a \$20 billion, multi-year health care investment. It includes a \$7.7 billion component that will increase the hourly minimum wage for home health care workers over two years.<sup>299</sup> Effective October 1, 2022, the minimum wage will increase by \$2 per hour. It will increase by another dollar beginning on Oct. 1, 2023.<sup>300</sup>





## History of the Measure

Support for home care workers was not originally included in Gov. Kathy Hochul's initial budget proposal, which prompted calls from advocates and others to include increased wages for care workers in the final budget. The governor revised the budget to include an increase in the hourly minimum wage for home health workers. Sen. Rachel May, a member of The Council of State Governments long-term care task force, supported this budget revision by introducing a "Fair Pay for Home Care" measure. That measure called for home care aides to make 150% of the regional minimum wage and also would have made wage increases commensurate with reimbursement increases for Medicaid-based home care providers.<sup>301</sup> While the budget does include an increase in the minimum wage, it does not currently link increasing wages to Medicaid reimbursement.<sup>302</sup>

## Future Policy Opportunities

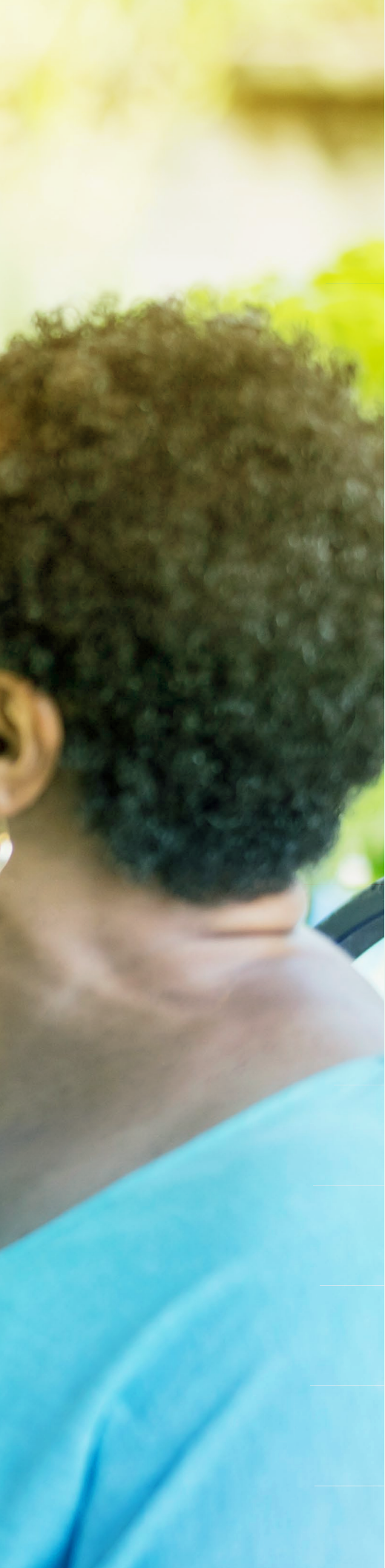
Health care provider groups and advocates called the budget measure "a step in the right direction" and an "amazing accomplishment." But there remain concerns about whether the wage increases will be enough, even at a cost to the state of \$7.7 billion over the next four years.<sup>303</sup> Some suggested the wages will not be competitive enough as workers seem particularly willing to leave the industry entirely for other opportunities in fields like retail and fast food.<sup>304</sup> Others say the legislation's goal of addressing worker shortages is undermined by the fact that workers in the New York City area are likely to be paid more than three times as much as those in other parts of the state where workers are in shorter supply.<sup>305</sup> State officials say the issues of home care worker pay and Medicaid reimbursement likely will need to be at the forefront of policy considerations for years to come.<sup>306</sup>

## What Else is New York Working On?

In her FY 2023 budget proposal, Hochul called for the creation of a statewide Master Plan for Aging. The New York State Office for the Aging, under the direction of Acting Director Greg Olsen (also a member of the CSG long-term care task force), is taking the lead in the process of creating the plan. The office is working with public and private sector partners on a plan they hope will create communities that promote state goals of healthy living, access to care, community connectedness, walkability and more. State officials expect the plan to be the culmination of policymaking over the last decade.<sup>307</sup> New York has also enacted legislation in 2021 and 2022 to promote and strengthen the role of the state long-term care ombud, who investigates problems at nursing homes and long-term care facilities.<sup>308</sup>







# Conclusions

The challenges across long-term care are significant. However, state governments in their role as laboratories of democracy have begun to explore numerous strategies to address many of them and in the American Rescue Plan Act funding for home- and community-based services have been given a once-in-a-generation opportunity to reshape and redefine long-term care, how it is regulated, where it takes place, how it is paid for, how it can be reconfigured for a post-pandemic age, and how a well-trained, adequately compensated workforce can be employed to provide essential care to older Americans and people with disabilities.

One common thread across the three focus areas for this project was the need for improved data collection — whether it is data on the volume, stability and compensation of the direct care workforce, data on quality of nursing home care or, particularly, data on the care provided in home and community-based settings. More data can help policymakers assess the efficiencies and inequities across programs, calculate the return on investments, and help consumers and their families make informed choices about their care — but only if that data is accurate, collected in a consistent and timely manner, compiled in an easy-to-understand format, centered on the needs of residents in long-term care settings and regularly acted upon by decision-makers.

## How This Study Was Conducted

The Council of State Governments convened an interbranch task force of state policymakers from eight states, including at least one state legislator and one executive branch official from a long-term care-focused agency from each state. The three identified project focus areas (state regulation of long-term services and supports, American Rescue Plan Act home- and community-based services investments, and the direct care workforce) were the focus of virtual meetings of the full task force in April, June and September 2022. Issues related to those focus areas were also explored at other task force meetings and during state-specific conversations with officials and stakeholders from each state. Prior to each task force meeting on a project focus area, CSG presented members with a background summary of the issues in that focus area and list of resource links to inform the discussions. The author drew upon those summaries and resource collections, input from participants during the meetings and in other exchanges, input from other stakeholder groups and additional research in writing this report.



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