

# Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers

Published by the  
North Carolina Division of Facility Services  
September 1999

## Background Information

Nurse aides and other paraprofessional aide workers are key players in the delivery of health and long term care services. They provide most of the paid long-term care needed by impaired persons whether at home or in a facility. This workforce tends to some of the most basic needs of patients such as dressing, bathing, toileting, eating, assisting with medications, monitoring blood pressure, changing bandages, housekeeping, etc. Their work is fundamental to quality of care and preserving the dignity of persons who must rely on others to help meet many of the routine daily tasks most of us take for granted.

To illustrate the importance of this workforce, the US Bureau of Labor projects that between 1996 and 2006, these workers will be among the top ten occupations having the **largest** job growth. They are also among the top 10 occupations projected to have the **fastest** job growth.

Recruiting difficulties and turnover rates are reported to be a very serious problem for all major long-term care settings in North Carolina (home care, assisted living, and nursing homes). Our state's low unemployment rate (2.7% in June '99 compared to 4.3% nationally) is a cyclical factor that contributes to current worker shortages. However, there are an array of job factors that are structural in nature that also have a direct and significant bearing on worker shortages such as:

- low wages and few, if any, benefits
- no career path
- physically demanding work
- lack of opportunity for meaningful input into patient care
- inadequate recognition and appreciation
- inadequate exposure to "real life" job demands during training

In 1997 NC's median hourly wage for aide workers was \$7.26 per hour (\$15,101 annually) or 65% of the state's average annual per capita income of \$23,168. The 1997 average annual income for aide workers equates to 183% of the current poverty level for an individual, 136% of poverty for a family of 2, and 109% for a family of 3.

*In 1998 NC spent more than \$1.4 billion for services that rely heavily on aide workers including nursing home care; intermediate care for the mentally retarded (ICF-MR); CAP-MR/DD; home health aides; in-home aide services including Medicaid funded Personal Care Services (PCS) and CAP-DA; and PCS for adult care homes (does not include any Medicare funds).*

*NC will need approximately 21,000 more nurse aides and other aide workers over the next 5-6 years. This is well before 2011 when the first wave of baby boomers begins reaching 65. We can expect continued growth in demand for these workers long after 2030 when the last wave of boomers reaches age 65.*

*2.7% is the lowest seasonally adjusted unemployment rate the state has seen in 20 years.*

*Annual turnover rates for aides in nursing homes exceed 100%. For 1999, the industry projects the average hourly wage (wages only-no benefits) for nurse aides to be \$8.61.*

*Annual turnover rates in adult care homes are reported to be over 140% annually. Based on cost reports submitted to the Department of Health and Human*

## Background Information -- Continued

Listed below are median hourly wages for North Carolina for several major job categories in the state likely to be a competing employment option for aide workers (1997 data).

- food service -- \$5.95 (\$12,376 annually)
- sales persons/retail -- \$7.20 (\$14,976 annually)
- hand packers/packagers --\$7.36 (\$15,308 annually)
- information clerks/receptionists -- \$8.63 (\$17,950 annually)
- factory workers (unskilled) --\$9.05 (\$18,824 annually)

**Note:** Attachment # 1 includes a state by state comparison of 1997 hourly and annual wages for aide workers; annual aide wages as a percentage of the state's average annual per capita income; whether or not aide recruitment and retention is a major workforce issue in states; and state unemployment data for May 1999.

*Services (DHHS), the average hourly wage for aides was \$7.13(wages only) in 1998.*

*The number of inactive nurse aides on NC's nurse aide registry is greater than the number of active nurse aides (approximately 104,000 inactive and 85,000 active – as of September 21, 1999).*

## Purpose

### The purpose of this report is to:

1. Determine the extent to which aide recruitment and retention is currently a major workforce issue in other states.
2. Compare unemployment and wage data for aide workers across states and see how aide wages stack up as a percentage of per capita income.
3. Compare wage data for aides with workers in several competing employment fields.
4. Identify any public policy trends among states with regard to state actions to address aide wages and/or benefits for publicly funded services.
5. Determine to what extent states use uniform reimbursement rates across public funding streams for in-home aide services – and examine how this may impact a state's ability to address wage issues for these workers.
6. Identify major actions states are taking or considering to address aide recruitment and retention issues, if any.

*This paper focuses primarily on wage and benefit issues associated with the aide workforce.*

## Methodology

The Division of Facility Services developed a survey to collect information from all 50 states addressing several public policy issues related to aide wages and benefits and identification of any major actions underway or being considered to address shortages of aide workers. Surveys were sent to both state Medicaid agencies and State Units on Aging. The survey was conducted during May and June of 1999. As necessary, follow-up contacts were made with states to clarify information provided or solicit missing information. Based on self-reported responses provided by states, data for key items was compiled and analyzed. Unemployment data, per capita personal income data and median wage data for selected employment sectors (i.e. aides, retail sales, factory, etc.) was obtained from the US Bureau of Labor Statistics. Other sources of data contained in this report are identified in the "Notes" section on page 12.

*46 states responded to the survey (either Medicaid agency, State Unit on Aging or both). No survey responses were received from the states of California, Wisconsin, Ohio, or Vermont. Non-state agency contacts provided information for California and Wisconsin as to whether or not aide recruitment and retention is a major work force issue in the state.*

## Major Trends Among States

- 1) Of the 48 states from whom information was obtained, 88% (42) said that aide recruitment and retention is currently a major workforce issue.
- Both the state with the lowest unemployment rate (Minnesota at 2.1%) and the highest unemployment rate (West Virginia at 6.8%) indicated that aide retention and recruitment is a major concern.
  - 33 (79%) of the 42 states indicating this was a major work force issue have either taken action (30 states) or are considering action (3 states) to address the issue.
- (See Attachment #2 for more detailed information on survey results.)

- 2) With regard to public policy actions to specifically address aide wages and/or benefits, a recent but prevalent trend is the concept of a “pass through” wage increase-- the result of a reimbursement increase to providers of which all or some specified portion of the increase is earmarked exclusively for aide salaries and/or benefits.

### Wage and Benefit Pass Throughs

- 16 states have approved/implemented some form of a wage pass through.
- Most states implementing mandatory wage pass throughs have done so only in the last year or two. Some states have been providing reimbursement increases that were intended to go to front line and/or aide wages specifically, but the requirement that the increase go to these workers is a recent occurrence.
- 1 state, Iowa, is considering implementation of a pass through.

### States have chosen two methods to implement wage pass throughs

- 10 of the 16 states implement pass throughs based on a set dollar amount for workers per hour or patient day. The pass through amounts ranged from \$.50 per hour to \$2.14 per hour and \$4.93 per patient day.

#### Dollar Amount Pass Through

Arkansas*	Rhode Island
Colorado	South Carolina
Massachusetts	Texas
Missouri	Virginia
Oregon	Washington

\* Arkansas indicated their pass through is pending HCFA approval.

- 6 of the 16 states established wage pass throughs as a percentage of the increased reimbursement rate. For example, 80% of Minnesota’s recent 40% rate increase was earmarked for wages and benefits, while Illinois has a law requiring 73% of all rate increases be used for wages and benefits.

*Many states indicated that low unemployment was a factor in poor recruitment and retention. However, several specifically commented that they now view this issue as a more intractable problem that will persist for an extended period regardless of the state of the economy--due to the aging of the population.*

*The following quote captures the extent to which this workforce issue impacts the nation.*

*“As a social scientist, I don’t use the word “crisis” lightly, but I do think that over the next 10 years we face a true crisis regarding frontline workers in long-term care”*

*(Karl Pillemer, Director, Applied Gerontology Research Institute –at Cornell University)*

*7 states are known to have established minimum wage rates that are higher than the federal minimum wage. The amount above the federal minimum wage ranges from \$.10 to \$1.35 p/hour. Oregon has the highest minimum wage rate among these states at \$6.50 p/hour.*

*One administrator with a state Unit on Aging stated that while he was pleased that the state legislature had approved a dollar wage pass through for nurse aides, he questioned the end results. He pointed out that without setting up a structured pass through system, perhaps a percentage of any annual increase in reimbursement rates, the problem had not been permanently solved. In a few years wages in other low level jobs will catch up to aide wages, and the state would once again face the same recruitment and retention problem.*

## Major Trends Among States -- Continued

### Percentage Pass Through

California	Michigan
Illinois	Minnesota
Maine	Montana

- Of the states implementing wage pass throughs, 9 targeted only home care aide workers (no facility based care); 4 targeted only direct service workers in nursing facilities, and 3 targeted both home care and nursing facilities. At least one state which provided a wage pass through only to its home care workers stated that it was likely that their nursing facility workers would receive a wage pass through in the near future.

### Home care only:

Colorado  
Illinois  
Massachusetts  
Missouri  
Oregon  
Rhode Island  
South Carolina  
Texas  
Washington

### Nursing facilities only:

Arkansas  
Maine  
Michigan  
California

### Both/all LTC:

Minnesota  
Montana  
Virginia

- It is interesting to note that of the 9 states providing increases to only home care aides over half had uniform reimbursement rates across multiple funding streams. Of the 16 states implementing wage pass throughs, that provided information on the pass throughs funding source(s), 6 appear to use multiple funding streams (Medicaid plus additional sources). Of the remaining 10 states, 6 appear to use only Medicaid or only non-Medicaid funding sources, and 4 did not provide this information.
- The majority of states who have a wage pass through in place stated that monitoring providers' compliance with the wage and benefits requirement has not been, or is not expected to be, an undue burden for their agencies. Some states have required/will require providers to submit an initial plan describing usage of the additional funds, and then confirm compliance when the state audits providers. Other states provide additional funding to providers without an initial plan but ensure compliance by reviewing fund usage during annual audits. For some states, implementing a wage pass through system is still very new and they have not yet determined the most effective, low-cost way to monitor providers and ensure compliance.

*The majority of wage pass throughs in place in states are intended to be distributed equally to all nurse aides. However, some states allow the long term care facilities/agencies to determine which front line staff receive the additional funding and what percentage is used for wages versus benefits.*

*Sanctions against providers who failed to use the funds for wages or benefits usually consist of immediate repayment by the provider of the inappropriately used monies. In Missouri, however, the state has linked failure to comply with the wage increase and reporting requirements to the possible revocation of the provider's Medicaid status.*

## Major Trends Among States -- Continued

### 3) **Enhancement Incentives**

Another trend closely related to the concept of a wage pass through is the effort by states to tie increased reimbursement rates to increased performance by providers and staff. Rhode Island recently authorized a \$1.50 hourly rate increase to be used for direct service staff wages, but in addition to these monies, the state also authorized additional monies to be used as an incentive to enhance standards. As of September 1999, the state will offer additional hourly reimbursement in seven primary areas: shift differentials, client satisfaction, level of patient acuity, level of provider accreditation, continuity of care, and level of worker satisfaction. Rhode Island currently has an enhancement system in place with bonuses ranging from \$.50 per hour to \$2.00 per hour but this new system is more intricate with the possibility of up to \$6.00 per hour in additional reimbursement above the base rate.

*Rhode Island is still working to find an effective means of operationalizing these additional incentives. While the state, providers and associations all see the measures as a step in the right direction, state staff stated that it has been difficult to get all parties to agree on the measures and systems to be used.*

### 4) **Higher State Reimbursement Rates for Shift Differentials**

Like Rhode Island, New Jersey has focused on the idea of establishing higher reimbursement rates for in-home aide services provided at night, weekends and holidays. States focusing on shift differentials think that the increased reimbursement rates for certain time periods will help provider's recruit and retain aide staff.

*Home care aides in New Jersey are paid \$14/hour for weekday services, while aides working weekend hours are paid \$16/hour. In NC, many individual providers (home care agencies and facilities) pay shift differentials. However, this initiative is different in that the state reimbursement rates are stratified based on the time that home care services are provided.*

### 5) **Transportation Reimbursement**

One state, Washington, also indicated that they recently passed legislation requiring home care providers to pay their aides for "windshield time." Windshield time is the time spent by the staff traveling from one site to another. At this time, the additional funding for the travel time is paid from the state reimbursement rate for personal care services. Florida's Department of Elder Affairs Work Group has also recommended that the state review transportation reimbursements for aide staff.

### 6) **Nurse Aide Career Ladders**

Several states noted that they had considered creating some form of a career ladder for aide staff. Mississippi has established two separate sets of standards, one applying to homemaker and another to personal care aides, as a basic career ladder. Maine and Alaska are both considering ways to create some form of a career ladder, while Illinois has a bill pending which would authorize the creation of a resident attendant category of worker for nursing homes. These workers will undergo training to provide basic support services to fully trained nurse aides. Delaware's State Legislative and Citizens Investigative Panel on Nursing Home Reform has also recommended the development of a career ladder including at least three levels; intern, team member, and team-preceptor. Each level would result in an increased pay level.

*States indicating they were considering or taking action on the creation of a career ladder for nurse aides include Mississippi, Maine, Alaska, Illinois, Delaware, and Michigan.*

## Major Trends Among States – Continued

### 7) Nurse Aide Training

In addition to the creation of a career ladder for nurse aides, states are focusing on the training provided to this population. By providing or proposing different levels of training, states like Mississippi, Delaware and Maine hope to provide nurse aides with an incentive to continue in the profession. Virginia also recently increased the minimum training hours for nurse aide programs from 80 to 120 hours.

*North Carolina currently requires a minimum of 75 hours of training and a competency test, or only the competency test in order to be certified to work as a Nurse Aide I.*

### 8) Training Former Welfare Recipients

Multiple states indicated that their welfare reform efforts have been seen as a potential source for nurse aide trainees. Workgroups in New Mexico and Florida have recommended funneling welfare recipients into nurse aide training programs, while New Jersey's welfare reform training has resulted in some new home health aides.

*States indicating they were making a concerted effort to broaden the pool of potential aide workers by looking at former welfare recipients as potential nurse aides include New Jersey, New Mexico, Florida and Arkansas.*

### 9) Training of Volunteer Populations

Along with the idea of tapping into new populations to increase the number of nurse aides, including former welfare recipients, is the trend to expand the use of volunteers. State workgroups looking at the issue of recruitment and retention have suggested expanding the use of Americorps volunteers, local and state volunteer programs, student volunteers, and senior citizens. The Maine Health Care Association Long Term Care Task Force has also advocated modifying aspects of the nurse aide job in order to encourage seniors to become a part of this workforce.

### 10) Pilot Programs

Three states discussed the implementation of pilot incentive programs to encourage aide recruitment and retention. Wisconsin, Iowa and Oklahoma each have either funded or proposed pilot programs that focus on enhancing the quality of life for direct care workers and reducing staff turnover.

*The NC Division of Facility Services has received funding from the Kate B. Reynolds Charitable Trust to pilot an array of incentives intended to improve aide recruitment and retention in long-term care settings.*

### 11) Overall Labor Shortage Area

At least one state, Florida, said it is looking at the nurse aide issue as part of an overall labor shortage in low-wage jobs. While Florida was the only state to note that they were looking at the issue from this standpoint, several states did note that due to low levels of unemployment, they were faced with a far tighter labor market than they have previously encountered.

## Major Trends Among States -- Continued

### 12) Work Groups / Task Forces / Data Collection

Though many states have not yet implemented specific programs focusing on nurse aide recruitment and retention issues, Work Groups or Task Forces have been or will be established in the next fiscal year by 31% (13) of the states that felt that this was an issue of concern. Participants in the Work Groups represented people from a wide range of groups, including representatives of the state Boards of Nursing, provider groups, state Departments of Health and Human Services and Aging, patient advocates, and certified nursing assistants. For the most part, these groups are charged with obtaining data and analyzing the situation, and then providing both short and long-term recommendations. The legislatures of an additional two states, Iowa and Virginia, have requested the appropriate state agencies to collect data on the issue of nurse aide recruitment and retention in order to determine appropriate next steps.

*States that have established or plan to establish a Work Group or Task Force include: Alaska  
Arizona Rhode Island  
Maryland Delaware  
Minnesota Florida  
Nebraska Maine  
Nevada Oklahoma  
Pennsylvania Missouri*

*The Legislatures of Iowa and Virginia have mandated data collection efforts by state agencies.*

## Conclusion

Nurse aide and paraprofessional worker shortages are a serious problem for North Carolina and the nation as a whole. Although low unemployment rates both in the state and nation increase competition for all workers, shortages and turnover rates among the aide workforce cannot be attributed solely to the state of our booming economy. Structural job factors contribute heavily to the problem and, in the absence of examining and alleviating these structural job factors, other employment opportunities of similar or even better pay or benefits and perhaps less demanding work will drain an already shrinking pool of potential aide workers.

Many states are taking action to address this workforce issue. They recognize that demand for these workers will only increase as the population ages. Certainly North Carolina's health and long-term care providers have a major responsibility to help address this workforce issue. However, given the level of the state's financial investment in services that heavily rely on the aide workforce, the state too shares in the responsibility for addressing this workforce issue. Confirmation of the public sector's responsibility is evident from the growing number of states that are taking action or considering actions to alleviate worker shortages and turnover. Collaboration with various trade associations representing various health and long-term care providers will be key to success both now and over the long haul.

The Department of Health and Human Services is already taking steps to tackle this workforce issue. While current efforts can lead to major steps in the right direction, additional action is needed now. Outlined below are a number of actions North Carolina could consider in addition to those efforts already underway with funding from the Kate B. Reynolds Charitable Trust. The potential of each of these possible actions will need to be fully assessed. They are provided as a starting point for further discussion and analysis.

*Ensuring an adequate and stable supply of nurse aide and other paraprofessional workers is essential to meeting future health and long-term care demands. This issue effects both public and privately funded health and long-term care. Many family and informal caregivers rely on this workforce so they can continue to work and support their families.*

*Because this paper focuses primarily on wages and benefits, so, too, do the possible actions considered in this paper. Obviously, there are other areas that could be examined such as possible actions to broaden the workforce.*

## Some Actions North Carolina Could Consider

*The actions below focus primarily on wage and benefit issues. The Division of Facility Services is currently working on several grant funded initiatives intended to address other job factors that impact the recruitment and retention of a stable and qualified aide workforce. The actions below are in addition to efforts already underway through a grant from the Kate B. Reynolds Charitable Trust.*

- 1) The Department of Health and Human Services (DHHS) could help facilitate a discussion among representatives of major state level associations that rely on aide workers to determine interest in, and the feasibility of, leveraging their collective purchasing power (and broaden the risk pool) for purposes of offering one or more group health insurance plan(s) to member providers that do not currently offer health insurance coverage to their employees or provider members who could benefit from either improved coverage or pricing as a result of such an effort. This could potentially improve access to health care insurance coverage for all employees of provider member organizations.
- 2) The Division of Facility Services could include, with letters sent to newly listed certified nurse aides, general information about NC's Health Choice for Children insurance program. Last year, the Division sent letters verifying listing on the nurse aide registry to approximately 15,000 persons. This would enhance efforts taken by state level trade associations to inform member organizations about the availability of this program. Similar action could be taken by other DHHS agencies that send correspondence to provider organizations as a way of reminding providers to notify their employees of the availability of this program.
- 3) Medicaid reimbursed providers have an avenue to increase wages for workers in that calculations for inflationary increases awarded by the Division of Medical Assistance assume that 75% of increases for PCS services (in-home and adult care home) and 80% of the direct care portion of inflationary increases for nursing homes are to support increases in direct labor costs. Do providers use the same proportion of inflationary increases for direct labor costs as the calculation assumes? Examination is needed to determine whether those providers that pay higher wages also have retention rates that are better than those that pay the average or lower wages.
- 4) Consider a wage pass through (an amount or percentage increase in the reimbursement rate in addition to any planned inflationary increase) for Medicaid funded Personal Care Services (PCS: in-home and adult care homes) as well as for nursing home care. The wage pass through amount would be built into the reimbursement rate.

*Key activities underway through funding from the Kate B. Reynolds Charitable Trust include:*

- *developing an automated data tracking system to track this workforce over time.*
- *provide nurse aide I trainees with more hands-on-care time so they get a more realistic view of what this type of work entails.*
- *pilot a variety of employee incentives intended to improve job skills, job satisfaction and performance thus resulting in improved recruitment and retention. (The results of these incentives will not be known until late 2001.)*
- *conduct a public education and awareness campaign about the importance of this workforce.*

*The Division of Facility Services is working with the Institute on Aging, representatives of state level long-term care related trade associations and others to implement the grant activities above.*

*If inflationary increases do not reflect the actual annual inflation rate (i.e. increases are awarded less than annually and/or in amounts less than the overall inflationary rate for the year) the direct labor component of the calculation is eroded (as are the remaining components of the inflationary increase) -- even if the provider uses the entire 75% -80% allocated for direct labor costs.*

*As part of the Kate B. Reynolds Grant, a survey of major provider types (home care, adult care homes, nursing homes) will be done to determine, among other things, whether facilities that pay higher wages also have better retention rates. Generally, this type of information is not now available from major state level long-term care related associations.*

## Some Actions North Carolina Could Consider -- Continued

- Recognizing that the state's unemployment rate is 1 factor in the availability of a stable and quality aide workforce, inclusion of the wage pass through in the base reimbursement rate in subsequent years could be pegged to the state's overall unemployment rate so that when unemployment rates climb (to some predetermined level) and competition for workers across various competing employer types presumably would decline somewhat, the reimbursement rate could be correspondingly adjusted downward to account for likely reductions in wage pressures for new hires.
- The fiscal impact of a wage pass through (by care setting) and associated compliance monitoring costs by the Division of Medical Assistance, if any, would be needed.
- Action to implement a similar wage pass through for non-Medicaid funded in-home aide services (e.g. Social Services Block Grant or Home and Community Care Block Grant) is impeded by the fact that there are not uniform reimbursement rates across multiple funding streams for in-home aide services. As such, the impact of a wage pass through for providers who have considerable latitude in setting their own reimbursement rates is questionable (regardless of whether reimbursement rates are calculated in a competitive or non-competitive environment). Monitoring efforts to verify compliance with any wage pass through would likely be complicated by the fact that reimbursement rates vary so widely across providers.

**While it may appear that the following items do not directly relate to improving aide recruitment and retention, they do relate to service access and making the most efficient use of public resources available for in-home aide services. Government is a major payor and by established rates can have a significant influence on wages and benefits paid to the long-term care workforce. Outlined below are several issues that need further study to ensure that the public policy goal of strengthening the long-term care workforce is met through public payors.**

- 1) Consider establishing a uniform reimbursement rate(s) across state administered funding sources for in-home aide type services. This is consistent with other Department of Health and Human Services efforts to establish uniform reimbursement rates for like services funded by multiple agencies or with multiple public funding sources.
  - The Department of Health and Human services recognizes 4 different levels of in-home aide services – Medicaid (in-home) Personal Care Services (PCS) pays for 2 of these levels -- the levels that include personal care tasks.
  - Having multiple rates that are tied to the different levels of in-home aide services is one way the department could help to establish a career ladder for workers in the home care setting.
  - Development of Medicaid PCS rates is based on cost information submitted by providers. If a uniform rate(s) across state

*Things North Carolina needs to consider with regard to consideration of a wage pass through:*

- *this is a relatively new concept*
- *NC doesn't currently have substantial reliable data available to confirm that higher aide wages translate into improved aide recruitment and retention. (This is, however, one component of the data collection activities being undertaken through the aide recruitment and retention grant made to DHHS by the Kate B. Reynolds Charitable Trust.)*
- *Compliance monitoring efforts by states vary. Given the short history of wage pass throughs, it is likely that states will need additional time to determine overall compliance with wage pass through requirements as well as the administrative and cost efficiency of compliance monitoring efforts.*

*The current Medicaid reimbursement rate for Personal Care Services is \$12.32 per hour.*

*SFY 2000 average hourly reimbursement rates for the two levels of in-home aide services that include personal care for agencies providing these services through the Home and Community Care Block Grant are as follows:*

*Level II -- \$13.04 (includes personal care tasks that do not require a nurse aide)*

*Level III --\$13.39 (includes personal care tasks that require a nurse aide)*

*Note: reimbursement rates may or may not reflect total cost.*

## Some Actions North Carolina Could Consider – Continued

administered public funding streams were pursued, there may be a need to have uniform cost information submitted by providers across these public funding streams. Cost data submitted would need to be reviewed for accuracy and reasonableness for purposes of establishing a reasonable uniform rate(s) that would be paid across public funding streams for provision of in-home aide services.

- 2) Consider requiring that all licensed home care agencies that receive state administered funds for in-home aide services or in-home respite services (i.e. SSBG, Home and Community Care Block Grant (HCCBG), etc.) be enrolled to provide Medicaid PCS services and serve some Medicaid PCS clients each year. The Division of Aging would need to monitor providers for compliance with such a requirement.
- For SFY 99, of the 112 agencies funded to provide level II and III in-home aide services through the Home and Community Care Block Grant (levels that include personal care), 60 of the 112 were either not currently enrolled to provide Medicaid funded PCS or were enrolled but did not bill Medicaid for any PCS services between January and May of 1999.
  - Of the 60 providers that did not bill Medicaid for any PCS services between January and May 1999:
    - ⇒ Half (30) had reimbursement rates equal to or less than the current PCS reimbursement rate of \$12.32.
    - ⇒ Half (30) had reimbursement rates higher than \$12.32 and of these:
      - 16 (53%) had reimbursement rates of \$18 per hour or more
      - 5 (17%) had reimbursement rates within 60 cents of \$12.32
  - The adequacy of the reimbursement rate for Medicaid PCS needs to be assessed prior to implementing such a requirement as some providers have expressed concern about their inability to provide the service for the amount of reimbursement paid by Medicaid. This is directly related to aide wages/benefits as some of these providers indicate they pay aides better from other funding sources that are not tied to the Medicaid rate for PCS. For instance, calls made to several HCCBG providers with rates higher than the Medicaid PCS rate who were not enrolled in Medicaid as a PCS provider showed that generally, these agencies were providing benefits such as retirement and health insurance (at least partial pay) as well as other group insurance offerings on an employee pay all basis. Some of these same agencies also indicated that they had a fairly stable aide workforce. Further examination is needed to determine whether agencies paying higher than average wages for both new hires and/experienced aides and whether or not there is any correlation between higher wages and turnover. Further examination is needed to determine why HCCBG providers with rates at/below the Medicaid PCS rate are either not enrolled as a PCS provider or not billing Medicaid for PCS services.

*Requiring HCCBG providers to provide PCS services could possibly help alleviate an unexpected situation that occurred in 42 counties during SFY 97-98 where more elderly (60+) CAP-DA clients were served than elderly persons receiving PCS services. In-home aide is the predominant service provided to CAP-DA clients. As such, given the high level of impairment required for participation in CAP-DA (participants must need nursing home level care) and the average annual cost of waiver services per CAP-DA participant (\$13,561 in 97-98), one would certainly expect there to be more elderly persons in need of (and receiving) Personal Care Services in a county than persons participating in the highly targeted CAP-DA program. (CAP-DA provides a package of home and community based services for Medicaid eligible persons 18+ who otherwise need nursing home care.)*

*Requiring HCCBG providers to be enrolled as PCS providers in and of itself would not necessarily result in agencies serving more in-home aide clients (including Medicaid PCS). The potential impact of this action would hinge, in part, on the ability of agencies to hire and retain enough qualified aides to operate aide services at full capacity. However,*

## Some Actions North Carolina Could Consider -- Continued

This step could have multiple benefits including:

- expanding the state's capacity to meet the PCS needs of Medicaid eligible persons-- particularly the elderly since persons 65+ accounted for 71% of total PCS spending in SFY 97-98.
  - increasing the number of active PCS providers would be especially beneficial in areas of the state where Medicaid clients currently have limited access to PCS services due to a limited number of providers.
    - For instance, in SFY 97-98 **16** counties had total PCS expenditures for the elderly of \$50,000 or less. Based on an average per person cost of \$4,387 for persons 60+ in SFY 97-98, \$50,000 in PCS expenditures would equate to 11 persons served during the year.
  - increased numbers of PCS providers could help address waiting lists for the Community Alternatives Program for Disabled Adults (CAP-DA) – either as a gap filling service until a CAP-DA space is available or perhaps in some cases, provide an adequate and less costly alternative to CAP-DA -- since the overwhelming majority of CAP-DA expenditures are for aide services.
  - improving continuity of care and consumer satisfaction by avoiding having to shift clients from one agency to another based on the public funding source used to provide care.
  - reducing the chances of inappropriately using non-Medicaid funds (which are capped) to meet the personal care service needs of Medicaid eligible clients.
- 3) In lieu of establishing uniform rates for in-home aide services, consider limiting the amount of indirect costs that can be included in the calculation of reimbursement rates for non-Medicaid funded in-home aide services. In fact, such a requirement may be appropriate for all services provided under these auspices.
- this would also help ensure that a minimum percentage of the provider's reimbursement rate is used for direct care costs.
  - this would also help to eliminate the possibility of some providers being paid reimbursement rates that exceed what an informed consumer would be willing to pay for services on the private market.
    - ⇒ Shown below are the number and percentage of HCCBG in-home aide provider contracts (by level) for SFY 2000 with reimbursement rates of \$18 p/hour or higher. It is interesting to note that level I, the level requiring the lowest skill level (contains no personal care tasks), has the highest percentage of contracts exceeding \$18 p/hour.

	<u>Total Contracts</u>	<u>Contracts Over \$18 p/hr.</u>	<u>Percent</u>
Level I	88	14	16%
Level II	111	14	13 %
Level III	56	8	14%

*given that the Medicaid PCS rate is fairly consistent with the average reimbursement rate for agencies providing in-home aide services through the Home and Community Care Block Grant (\$12.92) many providers could conceivably benefit positively from accessing this revenue stream.*

*As mentioned earlier, the average reimbursement rate for Home and Community Care Block Grant providers for SFY 2000 is \$12.92 per hour. There is, however, a wide variation in reimbursement rates across providers with contract reimbursement rates for SFY 2000 ranging from a low of \$6.62 per hour to a high of \$37.11 per hour.*

*Calls randomly made to 7 home care agencies in a large urban area to determine private pay rates for nurse aide services showed that rates charged by these 7 agencies ranged from \$13 to \$16 per hour. Fifteen dollars was the most prevalent rate with 4 of the 7 charging this rate. Some agencies noted that they required a minimum visit time of 2 hours. One agency charged a shift differential of \$1.00 per hour for night and weekend work increasing their private pay rate to \$16 for night and weekend work.*

## Acknowledgements

This paper was developed by:

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## Notes

- Expenditures for aide related services were compiled based on expenditures reported by the Division of Medical Assistance in their annual report for SFY 97-98 including Personal Care Services (in-home and adult care homes) and nursing home care, ICF-MR, CAP-MR/DD and CAP-DA. CAP-DA calculated at 90% of Medicaid CAP-DA expenditures reported for SFY 97-98 which is consistent with the percentage of aide service costs for waiver year 96-97. Aide related expenditures also include in-home aide service expenditures reported by the Divisions of Aging and Social Services.
- Projected 1999 wages for nurse aides working in nursing homes were obtained from the NC Health Care Facilities Association.
- 1998 average aide wages for aides in adult care homes were calculated by Financial Operations staff in the Division of Medical Assistance. Calculations were based on data contained in audited cost reports for 1998 submitted to the Department of Health and Human Services from adult care homes.
- Information about whether aide recruitment and retention is a workforce issue in the state of California was obtained from staff with the Center for Health Professions – University of California at San Francisco.
- Information about whether aide recruitment and retention is a workforce issue in Wisconsin based on efforts by Wisconsin's Alzheimer's Institute and University of Wisconsin-Madison Medical School to obtain grant funding to address aide recruitment and retention in the state.
- Data regarding providers both billing Medicaid for PCS and providing Home and Community Care Block Grant providers was determined by cross referencing active PCS providers from Medicaid's "DRIVE" system with SFY 98-99 Home and Community Care Providers funded for level II and III in-home aide services through the Division of Aging. The report on Medicaid PCS providers was created by staff in the Division of Facility Services using NC Medicaid data.) *Note: The Division of Medical Assistance has not reviewed the active provider report and, therefore, cannot validate the accuracy of the information contained in the report.*
- Average reimbursement rates and the range of contracted rates, by in-home aide level, for Home and Community Care Block Grant providers were calculated based on contract information for SFY 2000 (ZGA515 – run date: 8/31/99) – average rates are not inclusive of any cost-sharing revenues collected.
- Data regarding counties serving more Medicaid CAP-DA clients than PCS clients is based on county-by-county expenditure data for SFY 97-98 for persons 60+ as compiled by the Division of Aging.
- State by state unemployment and compensation data for 1997 was obtained from the US Bureau of Labor Statistics.
- Ratio's of PCS expenditures (elderly vs. non-elderly) based on expenditure data reported in the Division of Medical Assistance's annual report for SFY 97-98
- The average annual PCS expenditure for persons 60+ is based on expenditure and service data (persons served) provided by the Division of Medical Assistance to the Division of Aging for SFY 97-98.
- Average annual per participant expenditures for CAP-DA for 97-98 based on data reported in the Division of Medical Assistance's annual report on CAP-DA for waiver year 97-98 (published April 30, 1999).

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