



**Commission on Long-Term Care
Public Hearing on “Populations in Need of LTSS and Service Delivery Issues”**

**Testimony of Carol Regan, MPH
Government Affairs Director, PHI
1620 Eye Street, NW, Suite 210, Washington, DC 20006
Tel. 202-888-1972
Email: cregan@PHInational.org
www.PHInational.org**

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Chairman Chernof, Vice-Chairman Warshawsky, and Members of the Commission, good afternoon. My name is Carol Regan and I’m the Government Affairs Director at PHI, a national nonprofit based in the Bronx, New York that works to improve the lives of people who need home or residential long-term care—by improving the jobs and lives of the workers who provide that care. We develop recruitment, training, supervisory, and client-centered caregiving practices—along with the public policies necessary to support these practices.

INTRODUCTION

Today, nearly everyone is connected to a family member or friend living with functional limitations and requiring hands-on direct-care services, or personally requires these supports and services. And often from these very personal connections flow stories of care services that are daunting, difficult, or even impossible to find; care that is unreliable, hurried, and inconsistent; and care that lacks important competencies and cultural sensitivities. These lived experiences stand in sharp contrast to what we all want and expect: care that is easily found, qualified and competent, and trustworthy and reliable.

Accompanying these stories are also the testimonies of direct-care workers, many of whom take deep satisfaction and meaning from their caregiving roles, yet receive near-poverty wages. As a result, they often rely on public assistance to make ends meet, and go without health insurance even though they work in what are indisputably among the most dangerous jobs in America.

In 2008, the Institute on Medicine delivered a fresh analysis and set of recommendations concerning the direct-care workforce and its role in the health care workforce for an “aging



Headquarters:

400 East Fordham Road, 11th Floor
Bronx, NY 10458
Tel: 718.402.7766 ■ Fax: 718.585.6852

Washington DC Office:

1620 Eye Street, NW, 2nd Floor
Washington DC 20006
Tel: 202.888.1972

E-mail: info@PHInational.org ■ www.PHInational.org

America.”ⁱ Five years later, very little has changed — there remains a glaring absence of coordinated federal policy leadership directed at augmenting and improving the nation’s direct-care workforce, despite the ever escalating demand for long-term care services and supports. Direct-care workers now account for 31 percent of the U.S. health care workforce, far outnumbering other health care practitioners such as physicians, nurses, and therapists. They also outnumber by nearly three to one all allied health occupations, such as medical and dental assistants, and physical therapy assistants and aides.ⁱⁱ

The long-term care system currently invests \$88 billion annually—42 percent of all long-term care services and support spending—on the direct-care workforce. Such a massive investment, 42 cents of every dollar spent, suggests that issues of the direct-care workforce should be considered not in isolation, but rather linked directly to issues of financing and payment.

PHI applauds this Commission’s commitment to addressing workforce issues concurrently with the need for a better system for financing and paying for long-term services and supports. And in our recommendations below, PHI urges the Commission to take one step further, by embedding minimum workforce standards as an *essential design element* in all of the Commission’s finance and payment recommendations to Congress.

We urge you to consider four key workforce domains.

KEY WORKFORCE DOMAINS

1. Payment and Procurement

The first domain is payment and procurement policies which implicitly determine the parameters of worker compensation. These policies are a key driver of the problematic quality of direct-care jobs. Across the country, *ad hoc* approaches to rate setting for Medicaid Home and Community-Based Services (HCBS) are the norm, not the exception. Without a commitment to, or systematic methods for, setting, rebasing, or updating payment rates, these rates tend to be tied to the ups and downs of a state’s fiscal condition with occasional improvements attributable to effective advocacy by consumer groups, provider trade associations, and unions. In contrast, Medicaid nursing facility reimbursement rates are derived largely from systematic and regular rebasing methodologies, and they are usually updated annually based on an inflation factor.

The impact of these different Medicaid rate settings approaches on direct-care jobs is readily apparent in national and most state data. Nationally, direct-care workers employed in nursing facilities earn, on average, over \$2.00 more per hour and are 30 percent more likely to have health coverage than their counterparts employed in HCBS settings.ⁱⁱⁱ

The federal government has not developed requirements regarding the design of state reimbursement rates across long-term care settings that convey minimum standards, support quality outcomes, or even encourage cost effectiveness. Nor does it provide any guidance to states concerning the development of effective rate-setting policies that ensure adequate payments.

2. Training

The second domain concerns training. Our country's approach to direct-care worker training is in urgent need of modernization.

Federal training requirements for home health aides, hospice aides, and certified nursing assistants were first established 25 years ago. These requirements have not been updated to reflect the increasingly complex needs of today's long-term care consumers, nor the challenge that many workers face providing services in home- and community-based settings. In addition, current federal training requirements focus too much on clinical tasks and too little on teaching communication and relational skills that help workers deliver person-centered care.^{iv}

Further, there are no federal training requirements for upwards of a million personal care aides who provide personal assistance services and make up what is now the fastest-growing occupation in the nation. Billions of state and federal Medicaid dollars are spent on home-based services without a commitment to support a competently trained workforce.

Finally, current federal direct-care worker training requirements are often setting- or program-specific with insufficient attention to rationalizing job titles based on the competencies required to perform the job successfully. We have failed to articulate clear career pathways by mapping how one direct-care job relates to another and outlining core competencies to serve all populations as well as the additional competencies and training necessary to serve in new roles. These outdated systems limit the ability of workers to move between settings or to advance in their occupations, thereby inhibiting the development of a flexible workforce needed to support a better-coordinated, more efficient system for providing long-term services and supports.

Modernizing training for direct-care workers will require efforts on several fronts:

- Federally mandated pre-employment training hours must be increased and both state and federal requirements should be revised to align with competency-based approaches to training.
- The content of federal pre-service and advanced training should be enhanced using competency-based curricula, with consistent standards set across occupations requiring similar skills.
- Finally, state infrastructure for training direct-care workers should be improved by fostering an array of training entities and aligning government payment policies to create parity for reimbursing training costs across all direct-care occupations and provider types.^v

3. New Models of Coordinated Care

The third workforce domain relates to realizing the promise of new models of coordinated care that look more holistically at health and long-term care needs with the aim of improving care while lowering the costs. If these models are to be successful, we need to explicitly allow for expanded direct-care worker roles. Because these paid caregivers are uniquely embedded in the lives of their clients—providing 70 to 80 percent of all paid long-term supports and services—they are well-situated for observing and reporting changes in their clients' conditions.

With enhanced training in health education, disease prevention, and system navigation, direct-

care workers could assist with transitions from one care setting to another, recognize early warning signs that can prevent hospital readmissions, participate in team approaches to chronic disease management, provide support and information to family caregivers, and support positive health-related behaviors, thereby improving quality, client satisfaction, and lowering costs.

4. Infrastructure to Support Independent Living

Finally, we're beginning to understand that caregiving infrastructure is as essential to a well-functioning economy as roads and bridges. But we have very little of it.

In this age of on-line communities, dating platforms, and automated human resource management systems,^{vi} there is no reason that we can't develop scalable business models for connecting independent providers and self-directing consumers that are high-volume, low-price, high-efficiency, and low-cost. These types of solutions are desperately needed to support otherwise highly decentralized models of service delivery where consumers self-manage their care and hire their own direct-care workers with and without public funding.

For example, multifaceted matching service registries can support consumers and workers to find each other and can be linked to other intermediaries that provide access to training, respite, and emergency back-up services.

RECOMMENDATIONS

We urge the Commission to make the following recommendations to Congress:

1. Payment and procurement

- a. Recommend that Congress revise the Conditions of Participations (CoPs) which health care organizations must meet in order to participate in Medicare and Medicaid programs, by requiring that providers adopt minimum compensation standards for direct-care workers.^{vii}
- b. Instruct MACPAC to conduct a thorough analysis of state HCBS reimbursement policies in order to develop guidance that CMS would direct to states regarding effective payment and procurement methods that generate rates adequate to elicit a sufficient supply of competent direct-care workers.^{viii}

2. Training

- a. Implement the IOM's recommendation for increasing minimum training standards for home health aides and certified nurse assistants.^{ix}
- b. Take action to implement minimum federal training standards for personal care aides based on the results of the Personal and Home Care Aide State Training demonstration projects which will conclude in September 2013.

3. Infrastructure to Support Community-Based Living

Direct the Administration for Community Living to create demonstration projects in collaboration with CMS that develop infrastructure to support self-directed services, including matching service registries that allow both consumers and independent providers to access resources that encourage and empower independent living and quality employment practices.

4. Workforce Monitoring

- a. Instruct CMS to make workforce an explicit part of its review processes by including greater oversight and guidance to states about the adequacy and quality of their direct-care workforce in the provision of Home and Community-Based Services. This should include reviews of Waivers, personal care option services, and community living supports applications and renewals; Medicaid State Plan Amendments; and managed care contracts being negotiated as part of demonstration projects targeted to dually-eligible individuals.
- b. Instruct DOL to review the occupational and industry codes^x used by federal and state governments in employer surveys that sample market-wide wages and employment in order to better count direct-care workers and capture where they work—this includes an estimated 800,000 independent providers working public programs who fail to be counted in current survey formats.
- c. Instruct CMS to support the development of national job quality/workforce indicators for direct-care occupations—such as turnover rates, job vacancies, staffing levels, wages, and benefits—that can be used by policymakers and industry leaders to create incentives for adequate and safe staffing, better recruitment and retention, and greater workforce stability. Incorporate these measures into national provider quality standards.

5. Home Care Workforce Advisory Panel

Appoint a home care workforce advisory panel to provide guidance on issues including increasing the supply of personal care aides, improving wages and benefits for workers, and ensuring access to personal care services for consumers. The CLASS Act faced a number of structural challenges, which is the reason we are here today, but one thing it got right was the need to address workforce issues in a focused and comprehensive manner.

CONCLUSION

In closing, the direct-care workforce offers tremendous value as an underutilized asset of our healthcare infrastructure –one that can be leveraged toward the goals of improving access, promoting quality, increasing efficiency, and controlling costs. It is an historic workforce, both in terms of overall size and pace of growth, that has only begun to receive the policy and practice attention that will allow it to realize its potential value for the healthcare system, for communities, for individual consumers, and for workers. Direct-care workforce investments become more urgent with each day as our social fabric strains to support the hands-on caregiving requirements of so many of us who live with functional limitations.

Thank you very much for this opportunity to testify.

ⁱ IOM (2008) *Retooling for an Aging America: Building the Health Care Workforce*, Washington, DC: The National Academies Press.

ⁱⁱ PHI (2012) *America's Direct-Care Workforce*, FACTS 3. Available at:

<http://phinational.org/sites/phinational.org/files/phi-facts-3.pdf>

ⁱⁱⁱ D. Seavey with A. Marquand (2011) *Caring in America*, Bronx, NY: PHI. Available at: [caringinamerica-20111212.pdf](#)

^{iv} As a consequence, the experience of some persons with disabilities who have been served by CNAs or home health aides has been mixed. In some instances, they have found workers are not adequately oriented to the philosophy of consumer direction, and too bound to the medical model.

^v Currently, the Centers for Medicare and Medicaid Services only authorizes federal reimbursement of CNA training delivered through a nursing home or for a person who paid for their CNA training and who then goes to work in a nursing home.

^{vi} Every weekday, an average of 10 percent of the nation's 2.8 million teachers call in sick. Some public school districts are using sophisticated automated substitute management systems (both telephone- and Web-based) to help schools find and retain substitutes and to help substitute teachers search for multiple jobs.

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

^{viii} One desirable feature of such methods would be parity between the compensation received by certified nursing assistants and direct-care workers who provide similar supports in home and community-based settings. The IOM's recommendation regarding compensation is as follows: ***Recommendation 5-2: State Medicaid programs should increase pay and fringe benefits for direct-care workers through such measures as wage pass-throughs, setting wage floors, establishing minimum percentages of service rates directed to direct-care labor costs, and other means.***

^{ix} The IOM's training recommendation is as follow: ***Recommendation 5-1: States and the federal government should increase minimum training standards for all direct-care workers. Federal requirements for the minimum training of certified nursing assistants (CNAs) and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification. States should also establish minimum training requirements for personal-care aides.***

^x Occupational codes are found in the Standard Occupational Classification system and industry codes are specified in the North American Industry Classification System (NAICS). Each of these systems is revised on a regular basis.