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STATE HAZARD PAY AND SICK LEAVE POLICIES
FOR DIRECT CARE WORKERS DURING COVID-19

AUTHORS

Kezia Scales, PhD
Senior Director
of Policy Research
Stephen McCall
Data and Policy Analyst

CONTRIBUTOR
Rachel Miller-Selzer

DESIGN
RD Design

PHOTO CREDITS
Constanza Hevia H.
@constanzaheviah
(cover, inside front cover)
Rachael Porter (p.4)
Kristen Blush
(inside back cover)



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EXECUTIVE SUMMARY

The COVID-19 pandemic brought unprecedented attention to the critical role of direct care workers in long-term care. Especially during the first waves of the pandemic, these workers struggled against steep odds to safeguard the health and lives of their clients and residents, often without adequate access to personal protective equipment, targeted training, and other much-needed supports.

To document how states responded to the challenges faced by direct care workers and other essential workers and to generate lessons for the future, PHI conducted a study of hazard pay and paid sick leave policies enacted across all 50 states and the District of Columbia (DC) from March 2020 to August 2021. As well as developing a comprehensive catalogue of relevant state policies, we explored their impact on the direct care workforce through a modest set of quantitative analyses using publicly available data from the Current Population Survey.

Overall, this review found that:

- 17 states implemented at least one hazard pay policy and four states implemented a new paid sick leave policy during the study period.
- Of the 14 states that already had an existing paid sick leave policy in place, four made amendments or issued supplementary policies.
- Just 10 states implemented both types of policies: California, Connecticut, Massachusetts, Michigan, New Jersey, Oregon, Rhode Island, Vermont, Virginia, and Washington State.

With regards to hazard pay policies:

- The starting date of hazard pay policies ranged from March 1, 2020 to December 1, 2020.
- Six states implemented a one-time bonus payment, while 11 states implemented hourly wage increases or weekly bonuses.
- Many of the hourly or weekly increases were in place for no more than three months, while three policies lasted closer to one year. Michigan's wage increase was made permanent through the state budget.
- Several states implemented policies that applied to most occupational groups within particular long-term care settings. Other states focused their policies more narrowly, while some included direct care workers in a much broader category of essential workers.
- One-time bonus payments ranged from \$250 to just over \$2,200, weekly bonuses ranged from \$100 to \$500, and hourly wage increases ranged from \$2 to \$5. Three states implemented a reimbursement rate increase with a wage pass-through requirement (meaning a certain amount of the increase had to be passed directly through to workers).
- In nearly every state, hazard pay was administered through the state Medicaid agency using federal COVID-relief funding, primarily via the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

- In terms of accountability and enforcement, most states required eligible providers to submit a payment or reimbursement claim, while some also stipulated that providers agree to a potential audit of their records.

Our quantitative analysis of Michigan’s hazard pay policy found a clear impact on home care workers’ hourly wages and weekly earnings (which increased by \$2.43 and nearly \$90, respectively)—but not on the wages and earnings of nursing assistants in nursing homes. The latter finding raised questions about the implementation and enforcement of the policy in nursing homes.

“Home health aides are just as essential as the doctors and the nurses. We’re putting our lives at risk, and we get lower pay. That hurts. We should be entitled to hazard pay every time we get our paychecks until the pandemic is over.”

—Kim Williams, Home Health Aide at Cooperative Home Care Associates (CHCA), Bronx, NY

With regards to paid sick leave policies:

- Most states with existing paid sick leave policies issued guidance about allowable COVID-related reasons for taking leave.
- Among the states that amended their paid sick leave policies or enacted new policies during the first 18 months of the pandemic, the timeline varied considerably—from as early as March 1, 2020, to as late as July 1, 2021. Two states passed paid sick leave laws that did not come into force during the study period.

- Most paid sick leave policies cover or covered all industries and occupations, but with notable exceptions. As two examples, California’s COVID-19 paid sick leave policies covered first responders and health care workers, and Connecticut’s permanent law is restricted to “service workers.”
- Many paid sick leave policies have eligibility criteria based on tenure, hours worked, and/or employer size.
- The generosity of paid sick leave laws varies somewhat across states, but generally ranges from 30 to 40 hours per year. Accrual rates often vary by hours worked and/or employer size.
- Most paid sick leave policies cover reasons related to medical care for an employee or their family member as well as stalking, domestic violence, or sexual abuse. Many states have also included broader public health emergency language in their policies.
- Paid sick leave laws are for the most part financed by employers, with few exceptions.
- Employers are generally required to keep payroll records for a certain length of time, to submit to an audit if needed, to communicate with employees about their accrued and available leave, and to refrain from retaliation against employees who exercise their rights to take leave.

In our quantitative analysis of paid sick leave policies, we compared direct care workers in states that implemented such policies prior to or during the pandemic period versus those in states that did not. We found that paid sick leave policies did not appear to affect the likelihood of being absent from work: a similar proportion of direct care workers took time off in both groups of states. However, 59 percent of workers were paid for their time off in states with such policies, versus just 23 percent of those in the other states—indicating that paid sick leave policies do play a role in ensuring that direct care workers can take time off work without incurring lost wages and potentially catastrophic financial consequences.



“When people think of frontline workers, they often think of doctors, nurses, or police. But COVID-19 affects caregivers, too, and many of us are not being given the safety and protection that other workers are getting during this pandemic.”

—Teresita Sattar, Caregiver at Courage LLC and Worker Leader at Pilipino Workers Center, Los Angeles, CA

From these findings, we distilled the following lessons learned for improving direct care jobs and stabilizing long-term services and supports for the future:

Extend supportive policies across direct care occupations and settings. Universal or broad-based policies are the most promising strategy for promoting equity and bolstering services across the long-term care continuum.

Sustain short-term wage enhancements for all direct care workers. Hazard pay policies make a difference, but in reimagining the long-term care system beyond the pandemic, states must develop strategies to permanently raise the wage floor for direct care workers.

Develop a national compensation strategy for direct care workers. There is a clear need for national leadership in establishing livable, competitive wages for direct care workers, in order to achieve equitable job quality improvements and stabilize this workforce across all states.

Establish permanent paid sick leave laws. The COVID-19 crisis has underscored the critical need for universal access to paid sick leave. Building on the growing momentum among states, paid sick leave—along with paid family and medical leave—must be established at the federal level.

Incorporate supplemental public health emergency clauses into paid sick leave laws. Paid sick leave laws at the state (and ultimately at the federal level) should include provisions for future public health emergencies, ideally with additional leave allocations for essential workers.

Create a state or regional paid care advocate. A paid care advocate can help direct care workers and other workers learn about and access their employment rights—as well as ensure that employers have sufficient information to uphold their employment responsibilities.

Evaluate the implementation and impact of direct care workforce-related policies. States must monitor the implementation of direct care workforce-related policies to ensure they achieve their intended impact on individual workers, on the workforce overall, and on the delivery of quality services.

INTRODUCTION

The COVID-19 pandemic brought unprecedented attention to the essential role of direct care workers in long-term care. This workforce—numbering nearly 4.6 million nursing assistants, home health aides, and personal care aides—provides critical daily assistance to older adults and people with disabilities and serious illness across settings.¹ Especially during the first waves of the pandemic, direct care workers struggled against steep odds to safeguard the health and lives of their clients and residents—those most at risk of illness and death due to COVID-19—without adequate access to personal protective equipment, targeted training, and other much-needed supports.²

The full impact of COVID-19 on direct care workers is difficult to quantify, but impossible to ignore. According to recent data from the Centers for Disease Control and Prevention (CDC), nearly 1.1 million nursing home staff, including nursing assistants, have been infected with COVID-19 since the end of May 2020 and 2,357 have lost their lives.³ Although equivalent data are not available for direct care workers employed in home and community-based settings, they have also faced nearly untenable risks and challenges in their day-to-day work.⁴

Considering the economic impact of COVID-19, we know that only four percent of direct care workers lost or left their jobs during the first wave of the pandemic (March through May 2020)—a small proportion when compared, for example, to the 28 percent of food service workers who were displaced from their jobs in the same period.⁵ But countless more direct care workers had to reduce their hours or take time off to quarantine or to care for themselves or family members, and many saw their total family income decrease due to their partners' job losses.⁶ For a workforce that already struggled to get by on poverty-level wages and limited employment benefits, these economic impacts have been devastating.

Explicitly recognizing the life-and-death realities faced by direct care workers and other essential workers during the pandemic, some states took action. Specifically, a number of states implemented "hazard pay" policies—short-term wage enhancements designed to recognize direct care workers' contributions and offset the financial pressures they were experiencing. Michigan, for example, led the field by implementing an hourly wage increase for direct care workers beginning in April 2020.

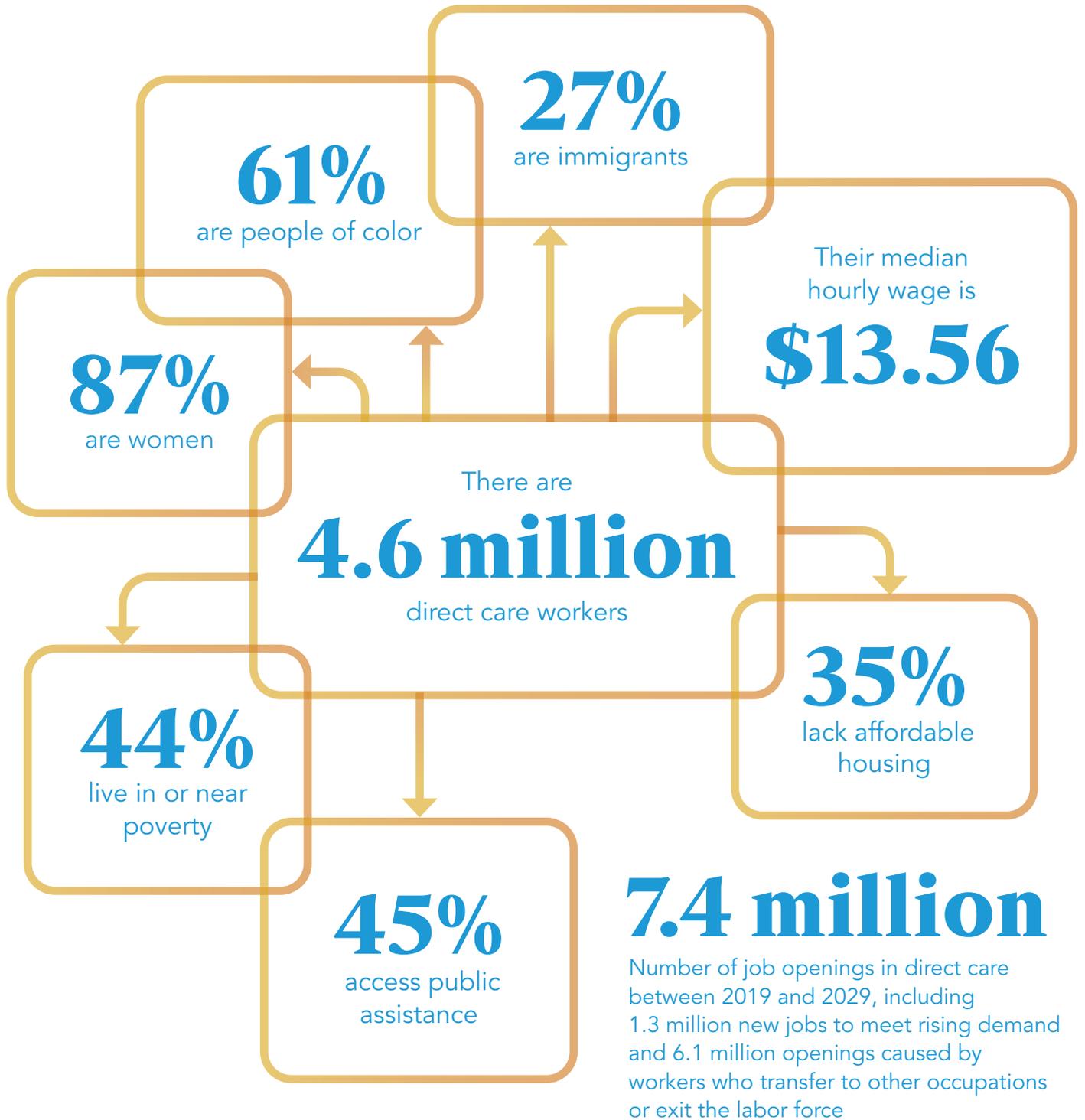
Paid sick leave was another important state policy intervention. The federal Families First Coronavirus Response Act (FFCRA) enacted emergency paid sick leave from April through December 2020, but certain groups of workers were exempt. To augment the federal provisions, some states passed their own paid sick leave laws that specifically covered direct care workers, pertained to all essential workers, or extended across the workforce. New York, for example, enacted temporary legislation to ensure quarantine-related paid leave coverage for all New Yorkers, then implemented a permanent statewide paid leave policy effective January 2021. A number of states with existing paid sick leave policies issued COVID-19-related guidance or supplementary coverage.

"The circumstances we're working under during the pandemic are unprecedented, and the payment we're receiving is not proportionate to all we're doing and the risks we're taking. There are so many challenges, between short staffing and wearing masks and gowns all the time. Sometimes the work is doubled. It's exhausting. We are providing lots, but we're not getting what we deserve in return."

—Bilel Dekhill, Direct Support Professional and Lead Job Coach at Misericordia, Chicago, IL

To document these policy responses and generate lessons learned from the COVID-19 crisis, PHI conducted a study of hazard pay and paid sick leave policies enacted across all 50 states and the District of Columbia (DC) from March 2020 to August 2021. As well as developing a comprehensive catalogue of relevant state policies, we explored their impact on the direct care workforce through a modest set of quantitative analyses. This report presents the study findings and discusses the implications for improving direct care jobs and stabilizing long-term services and supports for the future.

Direct Care Workers at a Glance



Source: PHI. "Workforce Data Center." Accessed 5/11/2022.
<https://phinational.org/policy-research/workforce-data-center/>.

STUDY PURPOSE AND METHODS

The purpose of this study was to understand how states supported direct care workers during the COVID-19 pandemic and explore how these policy responses affected workers' economic stability and wellbeing.

Specifically, we addressed the following research questions:

1. Which states enacted hazard pay and/or paid sick leave policies benefitting direct care workers during the first 18 months of the COVID-19 pandemic?
2. How did these policy interventions affect direct care workers' economic stability?
3. What lessons can be learned from these policy interventions for the long-term economic stability of the direct care workforce?

The project was conducted in two phases. In Phase I, we completed a broad analysis of hazard pay and paid sick leave policies enacted in all 50 states and DC from March 2020 to August 2021 (see Appendix A). We primarily gathered this information through online research, supplementing the findings through outreach to state experts in some cases. For each relevant policy, we distilled details on the implementation date and duration, eligibility criteria, amount of coverage, financing of the policy, and any enforcement or accountability mechanisms. For paid sick leave policies, we also documented the allowable reasons for coverage.

In Phase II of the project, we explored the impact of these policies on the direct care workforce using data from the Current Population Survey (CPS). Sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, the CPS is the primary source of labor force statistics for the United States. We used three different samples from the CPS to address the research questions: the Basic Monthly Sample, the Outgoing Rotation Group, and the March Supplement.

For the hazard pay analysis, we used CPS Outgoing Rotation Group data from 2017 through 2021 to assess the impact of Michigan's hazard pay policy—the most generous and sustained example across all states—on average hourly wages and weekly earnings for home care workers and for nursing assistants in nursing homes.

We also compared the findings from Michigan against average wages and weekly earnings for home care workers and nursing assistants in Ohio, a nearby state that did not implement hazard pay for this workforce. Workforce demographics in these two states are similar, and neither has widespread unionization of direct care workers (which tends to correlate with improved job quality for direct care workers). For this analysis, we used t-tests to determine statistical significance.

To assess the impact of paid sick leave policies on the direct care workforce, we categorized states into two groups: those which implemented paid sick leave policies prior to or during the first 18 months of the pandemic period, and those that did not. We then used data from the 2021 Basic Monthly CPS to compare the proportions of direct care workers that took time off in the previous week and the 2021 March Supplement to compare access to paid time off among direct care workers across these two groups of states. Here, we used Rao-Scott chi-squared tests and Fisher's exact test to determine statistical significance.

“We're exposing ourselves so much and putting our lives on the line, too. It's hard for everybody right now, but I just want to make sure that the people working out in the field don't get forgotten.”

—Janet Folsom, Home Health Aide, Certified Nursing Assistant, and Peer Mentor at Knute Nelson, Alexandria, MN

We had hoped to evaluate the impact of these policy interventions across direct care occupations and by gender, race/ethnicity, and other factors. Unfortunately, small sample sizes for the relevant CPS data precluded comparison by occupation for the paid leave analysis or by demographic characteristics for either analysis, although we did generate descriptive statistics for the sample in each case (see Appendix B and C). Despite small sample sizes for the quantitative component of this study, we were still able to generate meaningful findings to inform policy recommendations for the future.

FINDINGS: THE PREVALENCE AND IMPACT OF HAZARD PAY AND PAID LEAVE POLICIES

In our 50-state review, we found that 17 states implemented at least one hazard pay policy impacting direct care workers and four states implemented new paid sick leave policies. Fourteen states already had paid sick leave or general paid leave policies in place; four of these states amended or supplemented their existing policies. Ten states implemented both types of policies. Here, we present these findings in detail and discuss their impact on direct care workers' wages and ability to take paid time off.

Hazard Pay for Direct Care Workers During COVID-19

POLICY BACKGROUND

During the COVID-19 pandemic, states received several infusions of federal funding, including to bolster their Medicaid programs and providers. The Families First Coronavirus Response Act (FFCRA), which was signed into law on March 18, 2020, established a 6.2 percentage-point increase in federal matching funds for most Medicaid enrollees from January 1, 2020, through the end of the public health emergency period, provided that states met certain conditions.⁷ (Among many other provisions, the FFCRA also established paid sick leave coverage, which will be described in the next section.) The FFCRA was amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, a \$2.2 trillion economic stimulus bill that passed on March 27, 2020.⁸

States commonly used their enhanced Medicaid funds to increase reimbursement rates for providers through Disaster-Relief State Plan Amendments (SPAs), Home and Community-Based Services (HCBS) Appendix K Waivers, or Section 1115 Waivers.⁹ States most commonly used these COVID-19-related payment changes to support nursing facilities (27 states) and HCBS providers (26 states).¹⁰

Providers registered with Medicare and Medicaid could also directly access Provider Relief Funds, which were established by the CARES Act and subsequently supported through the Paycheck Protection Program and Health Care Enhancement Act and the Consolidated Appropriations Act of 2021.¹¹ These funds could be used to address workforce capacity concerns, among other purposes. However, fewer than half of eligible HCBS providers were able to access these funds, compared to a higher proportion of nursing home providers.¹²

In addition, the American Rescue Plan Act (ARPA), which passed on March 10, 2021, allocated \$350 billion in federal funds for eligible state, local, territorial, and Tribal governments. One of the allowed uses of ARPA funds is to offer “premium pay to eligible workers who perform essential work during the pandemic.” The Act also provides a temporary 10-percentage point increase in federal matching funds for Medicaid-funded HCBS programs. However, because state spending plans for this enhanced funding (some of which include bonus payments for direct care workers and other relevant policies) were implemented after August 2021, which was the end point of this research, they are not reflected in our findings.

Reports from the field indicate that many long-term care providers did leverage their increased rates and other federal funds (as available) to offer hazard pay and related supports to their staff. Many states encouraged this approach; as one example, the state legislature in Maine passed an emergency supplemental budget in March 2020 that included a Medicaid rate increase to support enhanced wages for home care workers and other workers—but the actual allocation of the funds was left to the discretion of providers, despite Governor Janet Mills’ exhortation that “we want that money to go to the direct care workers.”¹³

But some states went further by mandating enhanced wages or bonus payments for direct care workers, as described in the next section.

HAZARD PAY POLICIES ACROSS STATES

In total, 17 states implemented at least one hazard pay policy impacting one or more segments of the direct care workforce: Arkansas, California, Connecticut, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, and Washington State. Five of these states implemented

more than one hazard pay policy, either through different collective bargaining agreements (Connecticut, Oregon, and Washington) or for distinct segments of the workforce (Louisiana and New Jersey).

To note, other hazard pay proposals were introduced but failed to pass during the pandemic period. For example, a bill was introduced in California in February 2021 that would have provided bonus payments to health care workers of up to \$10,000 per person, for an estimated cost of \$6 billion; however, the California Assembly declined to vote and the bill was rendered inactive in June 2021.¹⁴ Many other states and localities implemented hazard pay for other essential workers—such as police officers and firefighters—but not direct care workers.

Here, we summarize the hazard pay policies in terms of their key features: implementation date and duration, eligibility criteria, amount of coverage, financing, and accountability requirements. Overall, despite variations in design and implementation, the policies tended to be short term and modest in scope. All policies were supported by federal COVID-relief funding, primarily through the CARES Act, and mainly administered through state Medicaid agencies.

Hazard Pay Policies Across States (3/2020-8/2021)

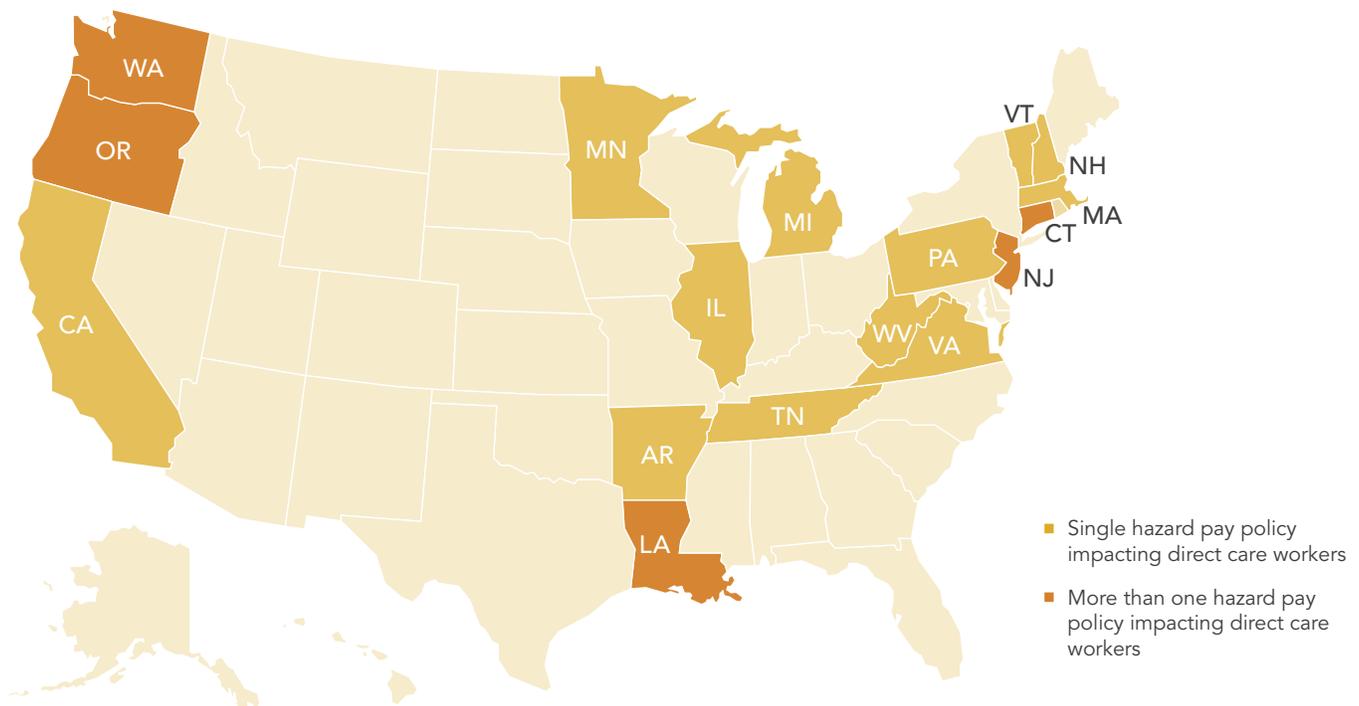


TABLE 1 | Key Characteristics of State Hazard Pay Policies

STATE	HAZARD PAY TYPE	POLICY START DATE	POLICY END DATE	ELIGIBILITY	AMOUNT
Arkansas	Weekly payment	April 5, 2020	May 30, 2020	All those providing direct care under the AR Choices and Living Choices HCBS waiver programs	\$125 - \$500 per week, depending on hours worked and clients' COVID status
California	One-time bonus	April 14, 2020	Until funds expired	Licensed vocational nurses and certified nursing assistants in nursing homes	\$500
Connecticut	One-time bonus	April 1, 2020 (round 1); November 1, 2020 (round 2)	June 30, 2020 (round 1); February 28, 2021 (round 2)	Direct care staff in nursing homes	\$250
	One-time bonus	April 1, 2020	June 30, 2020	Independent providers supporting self-directing consumers	Equal to 7.5 percent of wages for all hours worked during eligibility period
Illinois	Hourly wage increase	May 7, 2020	Funds available for 45 days, or 90 days in nursing homes with COVID outbreaks	Nursing home workers covered by collective bargaining agreement between the Illinois Association of Health Care Facilities and SEIU Healthcare Illinois and Indiana	\$2 per hour minimum
Louisiana	Hourly wage increase	October 29, 2020	Six months post-public health emergency period	Direct care workers in in developmental disabilities waiver program supporting consumers with COVID-19 or with COVID-positive household members	\$0.50 per 15-minute increment for no more than 40 days
	One-time bonus	July 15, 2020	October 31, 2020	"Essential critical infrastructure workers," broadly defined	\$250
Massachusetts	One-time sign-on bonus	April 8, 2020	May 15, 2020	MassHealth COVID-19 Long Term Care Facility Staffing Team portal applicants	\$1,000
Michigan	Hourly wage increase	April 1, 2020	Renewed several times, then made permanent	Direct care workers employed under HCBS waiver programs, initially; extended to staff in nursing homes	\$2 per hour, increased to \$2.25, then \$2.35
Minnesota	Hourly wage increase	December 1, 2020	February 7, 2021	Direct care workers in Medicaid HCBS programs	8.4 percent reimbursement rate increase with 80 percent wage pass-through requirement

TABLE 1 | Key Characteristics of State Hazard Pay Policies (cont.)

STATE	HAZARD PAY TYPE	POLICY START DATE	POLICY END DATE	ELIGIBILITY	AMOUNT
New Hampshire	Weekly bonus	April 1, 2020	December 31, 2020	Direct care workers in Medicaid HCBS programs	\$150 - \$300 per week, depending on hours worked
New Jersey	Hourly wage increase	May 1, 2020 (initial); October 1, 2020 (first renewal); January 1, 2021 (second renewal)	July 1, 2020 (initial); December 31, 2020 (first renewal); March 31, 2021 (second renewal)	Direct support professionals supporting clients in group homes and supervised apartments	\$3 per hour
	Hourly wage increase	October 1, 2020	June 30, 2021	Certified nursing assistants in eligible nursing homes	10 percent Medicaid rate increase with 60 percent wage pass-through requirement
Oregon	One-time bonus	March 1, 2020	April 30, 2021 (issued on December 31, 2021)	Home care workers, personal care attendants, and personal support workers	\$1,410.35 - \$2,261.99, depending on role and payer
	Hourly wage increase	May 1, 2020	September 30, 2020	Employees working for nursing homes that provided enhanced compensation during COVID-19 exposures or outbreaks	2.5 percent reimbursement rate increase; no minimum wage pass-through requirement
Pennsylvania	Hourly wage increase	August 16, 2020	October 24, 2020	Employees in "life-sustaining occupations," broadly defined	\$3 per hour, not to exceed \$1,200 per person
Rhode Island	Weekly bonus payment	May 4, 2020	June 30, 2020	Frontline workers earning under \$20/hour in congregate long-term care settings	\$100 - \$200 per week, depending on hours worked
Tennessee	Hourly wage increase	March 13, 2020	July 24, 2020	Direct care workers in HCBS programs supporting consumers with COVID-19	\$5 per hour for no more than 30 days
Vermont	One-time bonus	March 13, 2020	May 15, 2020	"Frontline employees," broadly defined	\$1,200 - \$2,000, depending on hours worked
Virginia	One-time bonus	March 12, 2020	June 30, 2020	Direct care workers in Medicaid HCBS programs	\$1,500
Washington	Hourly wage increase	July 1, 2020	June 30, 2021	Independent providers and agency-employed home care workers	\$2.56 per hour, revised to \$2.54 per hour

DATE AND DURATION

As shown in Table 1, the starting date of hazard pay policies ranged from March 1, 2020 (Oregon, retroactively) to December 1, 2020 (Minnesota). The other policies launched throughout the intervening months.

In terms of policy duration, six states implemented a one-time bonus payment disbursed during a limited time period, while 11 states implemented hourly or weekly wage increases. The shortest of such policies were in Louisiana and Tennessee, which provided an hourly wage increase for eligible workers caring for clients with a COVID diagnosis; these wage increases were valid for up to 40 and 30 days, respectively. At the other end of the spectrum, Michigan first implemented an hourly wage increase for direct care workers on April 1, 2020, renewed and expanded the policy several times, and then made it permanent through the fiscal year 2022 state budget. Several other hazard pay policies were only in place for two to three months, while three policies (New Hampshire, New Jersey, and Washington) lasted up to one year.

ELIGIBILITY

Eligibility criteria for the hazard pay policies also varied considerably (see Table 1). Several states implemented policies that applied to a broad range of occupational groups within a particular setting, often including licensed nurses, therapists, and other staff as well as personal care aides, home health aides, and/or nursing assistants. Arkansas, Massachusetts, and Rhode Island all followed this approach.

By contrast, some states focused their policies on specific segments of the direct care workforce in particular settings. New Jersey, for example, implemented two targeted policies: a temporary wage increase for direct support professionals serving clients with intellectual and developmental disabilities living in group homes and supervised apartments, and a rate adjustment with a wage pass-through requirement for certified nursing assistants in eligible nursing homes. Some states established even more specific requirements; hazard pay in Louisiana and Tennessee, as mentioned above, was only available to those supporting clients who were quarantining at home due to a COVID diagnosis.

Other states included direct care workers in a much broader definition of essential workers. Vermont's one-time bonus for "frontline employees" was available to those working in grocery stores, food service, homeless shelters, morgues, and many more settings in addition to long-term care. Similarly, Louisiana offered a one-time bonus to a broad range of "essential critical infrastructure workers," as long as their adjusted gross income was at or below \$50,000 on their 2019 tax return, and Pennsylvania offered a short-term hourly wage increase for employees earning less than \$20 per hour in "life-sustaining occupations," including direct care.

CRISIS RESPONSE, LASTING REFORM: SPOTLIGHT ON MICHIGAN

Michigan took immediate action to support direct care workers during the COVID-19 pandemic by implementing an hourly wage increase—then sustained that investment as a permanent \$2.35 per hour wage increase through the fiscal year 2022 state budget.¹⁵ In the words of Michigan Governor Gretchen Whitmer: "[W]e owe a special thank you to frontline health care workers, including direct care workers who provide nursing and health care for seniors and Michiganders with disabilities. We gave these heroes a \$2 an hour raise... Now it's time to make that pay raise permanent. Because it's not enough to just say 'thank you'—we need to show support."

AMOUNT

One-time bonus payment rates ranged from \$250 in Louisiana to just over \$2,260 in Oregon. As an intermediary example, eligible home care workers in Connecticut received a single bonus payment that was equivalent to 7.5 percent of their total wages from April 1 to June 30, 2020.

Hourly wage increases ranged from \$2 per hour (Illinois) to \$5 per hour (Tennessee), with the majority set at \$2 to \$3 per hour. Weekly wage increases varied by employment status and ranged from \$100 (for those working 15-21 hours per week in Rhode Island) to \$500 per week (for those in Arkansas working 40 or more hours per week and supporting clients with a COVID diagnosis).

Three states implemented a reimbursement rate increase for Medicaid-funded providers with a wage pass-through requirement (meaning a certain amount of the increase had to be passed directly through to workers).

UNIONS DRIVE SUPPORT FOR DIRECT CARE WORKERS DURING COVID-19

Unions played a significant role in securing hazard pay for direct care workers during the COVID-19 pandemic through collective bargaining and other agreements with states or individual employers, including in Connecticut, Illinois, Massachusetts, Oregon, and Washington. In Washington, SEIU 775 secured a wage increase of approximately \$2.50 per hour for both independent providers (i.e., home care workers employed directly by consumers using Medicaid funds) and agency-employed workers. A survey conducted by SEIU 775 and the Center for American Progress found that the wage increase, which was in effect for a full year, had a positive impact on every indicator of economic security measured by the survey, including overall economic wellbeing, housing, food security, and access to health care, among others.¹⁶

Minnesota implemented an 8.4 percent rate increase to home care providers, requiring that at least 80 percent of the additional revenue be used to increase wages, salaries, and benefits for direct care workers (and related payroll expenses). New Jersey raised the reimbursement rate for long-term care facilities by 10 percent with the

requirement that 60 percent of the increase be used for enhanced wages or supplemental pay for certified nursing assistants. Oregon took a similar approach but without defining the amount of the wage pass-through: nursing facilities that increased wages and access to paid leave for direct care staff in the case of COVID-19 exposures or outbreaks were eligible for a 2.5 percent increase in their reimbursement rate for a 90-day period between May 1 and September 30, 2020.

FINANCING AND ACCOUNTABILITY

In nearly every state, hazard pay was administered through the state Medicaid agency using a combination of state dollars and federal COVID-relief funding, primarily via the CARES Act. As one exception, Louisiana's \$250 rebate for "essential critical infrastructure workers" was administered by the Louisiana Department of Revenue, but still financed with federal dollars. As another exception, California's Skilled Nursing Facility Hero Awards were administered through the state's Office of Statewide Health Planning and Development but funded by a \$25 million donation from Facebook (and only available to the first 50,000 applicants).

In terms of accountability and enforcement, most states required eligible providers to submit a payment or reimbursement claim, while some also stipulated that providers agree to a potential audit of their records. For example, providers in Rhode Island were required to sign an agreement stating they would participate in audit requirements and that they would reimburse the Executive Office of Health and Human Services if found to have used the funds for unauthorized purposes. For providers in Tennessee, acceptance of the temporary rate increase (for services rendered to COVID-positive consumers) was considered their attestation that the increase would be invested in workers' wages. As in Rhode Island (and other states), the payments were subject to audit and recoupment if the conditions of payment were not met. Providers in Minnesota and New Jersey that received a rate increase with wage pass-through requirement had to document their allocation of the enhanced funds, and New Jersey providers also had to submit wage and cost data and adhere to specified infection control policies and testing requirements.

THE IMPACT OF HAZARD PAY ON WAGES AND EARNINGS

After cataloguing hazard pay policies across all 50 states and DC, we also conducted a limited quantitative analysis of the impact of these policies on direct care workers’ financial wellbeing. Specifically, as described above, we drew on CPS Outgoing Rotation Group data from 2017 through 2021 to assess how Michigan’s hazard pay policy—the most generous policy in terms of eligibility, amount, and duration—affected average hourly wages and average weekly earnings for home care workers and nursing assistants in nursing homes. We compared the findings from Michigan against average wages and weekly earnings for home care workers and nursing assistants in Ohio, a nearby state that did not implement any equivalent policies.

For the home care workforce analysis, we compared the period before Michigan’s hazard pay policy was enacted (January 2017 through April 2020) to the period after the policy took effect (June 2020 to December 2021). We excluded May 2020 to allow one month for

implementation.¹⁷ To compare nursing assistants in nursing homes, we defined the baseline period as January 2017 through August 2020 and the intervention period as October 2020 to December 2021 (excluding September 2020, again to allow one month for implementation).¹⁸

The findings from this analysis clearly indicate the beneficial impact of Michigan’s hazard pay policy for home care workers (Chart 1). Home care workers’ average hourly wages increased from \$11.37 to \$13.80 (an increase of \$2.43), which was statistically significant ($p < .1$). By comparison, wages only increased from \$11.07 to \$12.00 in Ohio (a \$.93 increase; $p < .05$). In other words, home care workers’ wages increased in both states, but the increase was much larger in Michigan. The impact of Michigan’s hazard pay policy was reflected in average weekly earnings as well: home care workers’ average weekly earnings in Michigan increased from \$390.57 to \$480.03 after the policy took effect (a nearly \$90 increase; $p < .1$), while average weekly earnings fell from \$402.84 to \$384.10 in Ohio (not statistically significant).

CHART 1 | Home Care Worker Average Hourly Wages and Weekly Earnings in Michigan and Ohio Before and After Michigan’s Hazard Pay Policy Took Effect (2017-2021)



* Statistically significant ($p < .1$); ** Statistically significant ($p < .05$)

Source: Flood, Sarah, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren and Michael Westberry. 2021. *Integrated Public Use Microdata Series, Current Population Survey: Version 9.0*. <https://doi.org/10.18128/D030.V9.0>; analysis by PHI (April 2022).

CHART 2 | Average Hourly Wages and Weekly Earnings for Nursing Assistants in Nursing Homes in Michigan and Ohio Before and After Michigan’s Hazard Pay Policy Took Effect (2017-2021)



** Statistically significant (p<.05)

Source: Flood, Sarah, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren and Michael Westberry. 2021. *Integrated Public Use Microdata Series, Current Population Survey: Version 9.0*. <https://doi.org/10.18128/D030.V9.0>; analysis by PHI (April 2022).

The impact of Michigan’s hazard pay policy on nursing assistants’ financial wellbeing was less clear (Chart 2). Nursing assistants’ average hourly wages did increase from \$13.43 to \$14.12 in Michigan (a \$0.69 increase; not statistically significant) but in Ohio, nursing assistants’ wages increased by a larger amount (from \$12.23 to \$13.88, a \$1.65 increase; p<.05). However, wages were lower at baseline in Ohio than in Michigan, and still lower by the end of 2021. Average weekly earnings increased from \$501.58 to \$549.84 (a nearly \$50 increase; not statistically significant) for nursing assistants in Michigan and from \$452.33 to \$469.65 for nursing assistants in Ohio (a \$17.32 increase; not statistically significant).

The lack of wage growth among nursing assistants in Michigan’s nursing homes raises concerns about how effectively the state’s hazard pay policy was implemented and enforced. Conversely, in Ohio, wages may have increased more for nursing assistants than home care workers—despite the lack of any statewide hazard pay policies—because individual nursing homes had more access to federal support and therefore more capacity to raise wages than home care providers. More research is needed to explain these nuanced findings.

Paid Sick Leave Available to Direct Care Workers During COVID-19

POLICY BACKGROUND

As mentioned above, the Families First Coronavirus Response Act (FFCRA) established federal emergency paid sick leave provisions effective April 1, 2020. The law pertained to private employers with less than 500 employees and certain public employers, while employers with fewer than 50 employees could seek an exemption. Under the FFCRA, employers were required to provide up to 80 hours of paid sick leave for employees who were subject to a quarantine or isolation order; advised by a health care provider to self-quarantine; or experiencing symptoms of COVID-19 and seeking a medical diagnosis. For these covered reasons, employees were entitled to receive their regular rate of pay up to \$511 per day, for a maximum of \$5,110 over the benefit period.

Paid sick leave could also be taken under the FFCRA by employees who were unable to work or telework because they were caring for someone who was subject to a quarantine or isolation order; caring for children in the event of daycare or school closures; or experiencing “any other substantially similar condition” specified by the Secretary of Health and Human Services. For these covered reasons, employees were entitled to two-thirds of their regular rate of pay, up to \$200 per day or \$2,000 over the benefit period.

Covered employers under the FFCRA qualified for dollar-for-dollar tax credits for paid sick leave expenditures. Although the federal coverage expired on December 31, 2020, employers could continue to provide paid leave for a voluntary tax credit through March 31, 2021.

In an effort to ensure adequate staffing of critical health and safety services, the FFCRA allowed employers to exclude “health care providers” from the emergency paid sick leave coverage. With regards to direct care workers, this exemption clearly applied to nursing assistants in nursing homes but was originally also interpreted to apply to home care workers.¹⁹ In August 2020, the Southern District of New York found that the U.S. Department of Labor’s definition of “health care providers” was overly broad and thereby

exempted too many workers from the FFCRA’s coverage. As a result of that ruling, home care workers became eligible for paid leave under the federal law, but nursing assistants remained exempt.

PAID SICK LEAVE POLICIES ACROSS STATES

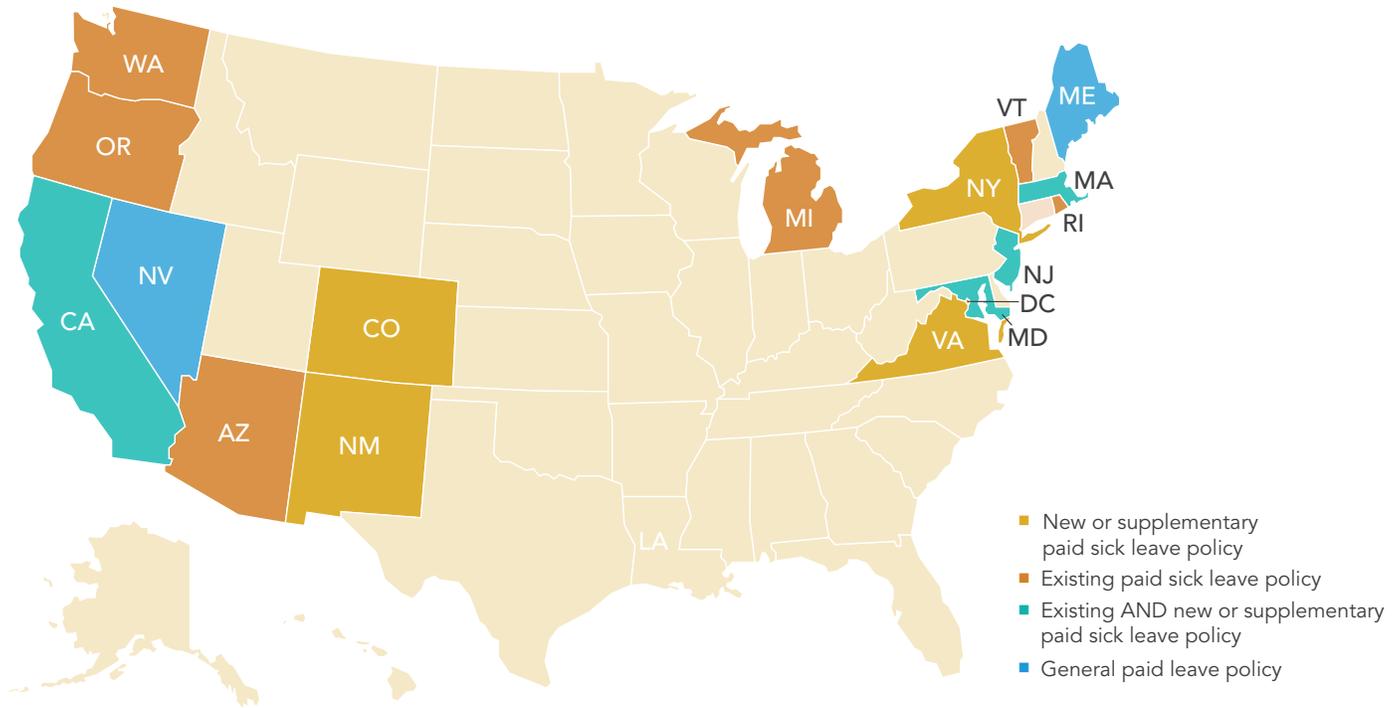
For this analysis, we focused exclusively on paid sick leave policies, meaning coverage for short-term absences from work for injury, illness, or related reasons. Paid sick leave is usually provided by employers to employees on an accrual basis up to an annual maximum, with 100 percent wage replacement.²⁰

“Working during the pandemic has caused a lot of stress, and we are taking on new challenges with our clients. We are there taking care of others, and not being able to have paid time off to take care of our family members is tough. For me, that doesn’t make a sense. I think we deserve it.”

—Maria Marrero, Certified Home Health Aide (CHHA) at HomeCare Options, Totowa, NJ

We did not examine workers’ compensation or unemployment policies that may have also provided coverage for COVID-19-related reasons for some workers in some states. Nor did we assess paid family and medical leave policies, which provide coverage for longer-term health conditions, to care for a family member or bond with a new child, or for related reasons. Paid family and medical leave policies have been enacted so far in 10 states and DC (although the policies are not yet active in three of those states).²¹

Paid Sick Leave Policies Across States (3/2020-8/2021)



Focusing on short-term paid sick leave policies, we identified five categories of states. Four states implemented a new paid sick leave policy during the study period (Colorado, New Mexico, New York, and Virginia), and four states with existing paid sick leave policies added supplementary coverage or enacted new policies (California, Maryland, Massachusetts, and New Jersey). Eight states had existing paid sick leave policies that remained the same, although many of those states issued guidance about using the policy for COVID-related reasons (Arizona, Connecticut, District of Columbia, Michigan, Oregon, Rhode Island, Vermont, and Washington). Two states had general paid leave policies in place that covered sick leave (Maine and Nevada). The remaining 33 states did not have any existing or new paid sick leave policies.

In this section, we summarize the 18 paid sick leave policies in terms of their key features: implementation date and duration, eligibility criteria, amount of coverage and reasons for coverage, financing, and accountability requirements.

Although they are not described here, a number of cities and counties have also passed paid sick leave laws, prior to or during the COVID-19 pandemic, including in California, Illinois, Maryland, Minnesota, New York, Pennsylvania, and Washington. However, “preemption laws” have been enacted to block the passage of local paid sick leave policies in many other states; as of 2020, 18 states without paid sick leave policies and 9 states with paid sick leave policies had passed such preemption laws.²²

TABLE 2 | Key Characteristics of State Paid Sick Leave Policies

STATE	PAID SICK LEAVE POLICY	EXISTING OR NEW	TEMPORARY OR PERMANENT	ELIGIBILITY
Arizona	Fair Wages and Healthy Families Act of 2016	Existing	Permanent	All industries and occupations
California	Healthy Workplaces, Healthy Families Act of 2014	Existing	Permanent	All industries and occupations
	AB 1867	New (effective April 15, 2020)	Temporary (expired December 31, 2020)	First responders and health care workers
	SB 95	New (effective January 1, 2021)	Temporary (expired September 30, 2021)	First responders and health care workers
Colorado	Health Emergency Leave with Pay (HELP)	New (effective March 11, 2020)	Temporary (expired July 14, 2020)	Employees in certain industries, including but not limited to home care, nursing homes, and community living facilities
	Healthy Family and Workplaces Act	New (effective July 15, 2020)	Permanent	All industries and occupations
Connecticut	Paid Sick Leave Law	Existing	Permanent	“Service workers,” including but not limited to direct care workers
District of Columbia	Accrued Sick and Safe Leave Act of 2008	Existing (temporarily amended to include COVID-19-related reasons but all health care providers, including those employing direct care workers, were exempt)	Permanent	All industries and occupations
Maine	Earned Paid Leave Law	Existing	Permanent	All industries and occupations
Maryland	Healthy Working Families Act of 2018	Existing	Permanent	All industries and occupations
	Essential Workers’ Protection Act	New (not in effect)	Permanent	Those performing essential duties during an emergency period
Massachusetts	Earned Sick Time Law	Existing	Permanent	All industries and occupations
	COVID-19 Emergency Paid Sick Leave Act	New (effective January 1, 2021)	Temporary (expired September 30, 2021)	All industries and occupations
Michigan	Paid Medical Leave Act	Existing	Permanent	All industries and occupations
Nevada	Paid Leave Act	Existing	Permanent	All industries and occupations

TABLE 2 | Key Characteristics of State Paid Sick Leave Policies (cont.)

STATE	PAID SICK LEAVE POLICY	EXISTING OR NEW	TEMPORARY OR PERMANENT	ELIGIBILITY
New Jersey	Earned Sick Leave Law of 2019	Existing but amended (effective March 25, 2020)	Permanent	All industries and occupations
New Mexico	Healthy Workplaces Act	New (effective July 1, 2022)	Permanent	All industries and occupations
New York	COVID-19 Paid Sick Leave Law	New (effective March 18, 2020)	Temporary (expired December 31, 2020)	All industries and occupations
	Sick Leave Requirements	New (effective January 1, 2021)	Permanent	All industries and occupations
Oregon	Paid Sick Leave Law	Existing	Permanent	All industries and occupations
Rhode Island	Healthy and Safe Families and Workplaces Act	Existing	Permanent	All industries and occupations
Vermont	Earned Sick Time Law	Existing	Permanent	All industries and occupations
Virginia	Paid Sick Leave for Home Health Workers	New (effective July 1, 2021)	Permanent	Independent providers supporting self-directing consumers
Washington	Paid Sick Leave Law	Existing	Permanent	All industries and occupations

DATE AND DURATION

Early in the pandemic period, most states with existing paid sick leave policies issued guidance about allowable COVID-related reasons for taking leave, while one state (Michigan) issued an executive order along the same lines. Two states did not issue COVID guidance (Maine and Vermont).

Among the states that amended their paid sick leave policies or enacted new policies during the first 18 months of the pandemic, the timeline varied considerably (see Table 2). Colorado was first in passing the temporary Health Emergency Leave with Pay (HELP) Rules effective March 11, 2020. Toward the end of the 18-month period, Massachusetts enacted the temporary COVID-19 Emergency Paid Sick Leave Act (effective June 7 through September 30, 2021), and Virginia passed a permanent paid leave law, Paid Sick Leave for Home Health Workers, effective July 1, 2021.

Finally, two states passed paid sick leave laws that did not come into force during the review period for this study (i.e., before August 2021). New Mexico’s Healthy Workplaces Act passed on April 8, 2021, but did not go into effect until July 1, 2022. Maryland’s Essential Workers’ Protection Act—which provides paid leave for essential workers, including direct care workers, during declared emergency periods—passed on May 30, 2021, but has not been funded or implemented during COVID-19.

ELIGIBILITY

Most paid sick leave policies cover all industries and occupations, but with notable exceptions. Connecticut’s Paid Sick Leave Law, for example, is restricted to “service workers,” including nursing assistants, home health aides, and personal care aides (among other occupational groups). Maryland’s Essential Workers’ Protection Act, which was established but not funded

during the COVID-19 period, covers workers who are deemed to perform a duty during an emergency that cannot be performed remotely and who provide services that are determined to be essential or critical to their employers' operations.

California's existing paid sick leave law covers all employees in the state, with limited exceptions under collective bargaining agreements and other conditions—but the supplemental laws focused on first responders and health care workers. Similarly, Colorado's short-term HELP Rules pertained only to employers in certain industries, including home care providers, nursing homes, and community living facilities (among other employer types). Virginia's Paid Sick Leave for Home Health Workers mandates paid sick leave just for home health workers, defined as those who provide personal care, respite, or companion services to individuals receiving consumer-directed services under Virginia's Medicaid state plan.

Many paid sick leave policies have eligibility criteria based on tenure (i.e., time since hire), hours worked (calculated weekly or monthly), and/or employer size. (See Appendix A for more details.) As one example, Connecticut's law only pertains to service workers who are employed for 10 or more hours per week and to employers with 50 or more employees. Paid leave laws in DC, Michigan, and Nevada also all pertain to employers with at least 50 employees, while other states have set a lower limit, including 10 employees (Maine, Oregon), 11 employees (Massachusetts's Earned Sick Time Law), or 18 employees (Rhode Island). Most policies cover both part- and full-time workers, though some exclude or excluded per diem, contract, on-call, seasonal workers, and/or government employees.

AMOUNT

The generosity of paid sick leave policies varies somewhat across states (see Appendix A). A number of states allow up to 40 hours of paid sick leave per year (Connecticut, Maine, Nevada, Oregon, Rhode Island, Vermont, and New Jersey). Some states allow more: New Mexico's Healthy Workplaces Act provides up to 64 hours per year, and in Washington State, there is no annual cap on the number of hours accrued.

Some states set different accrual rates for full- and part-time workers: for example, DC allows up to 80 hours of paid leave per year for full-time workers, while part-time workers can accrue the equivalent of the average number

of hours worked in a two-week period. Some states vary the amount of paid sick leave by employer size: in Arizona, for example, those working for employers with 15 or more employees are entitled to up to 40 hours of leave per year, while those working for employers with fewer than 15 employees are entitled to 24 hours. Most states require employers to allow employees to carry over a certain amount of accrued sick leave from year to year, often up to the defined cap, with some variations and stipulations.

LEVERAGING AND EXTENDING FEDERAL SUPPORT: SPOTLIGHT ON NEW YORK

The Families First Coronavirus Response Act (FFCRA) extended emergency paid sick leave nationwide in 2020—but with notable gaps. Among others, health care workers and those working for employers with more than 500 or fewer than 50 employees were potentially exempted. To bridge these gaps, New York implemented the COVID-19 Paid Sick Leave Law in March 2020—expanding paid sick leave coverage to those not covered by the federal provisions, including those working for employers with fewer than 10 employees (depending on the employer's net income). Through the fiscal year 2021 state budget, these provisions were replaced with permanent paid sick leave coverage for all New Yorkers.

California's supplementary laws added additional coverage for eligible employees. Under the existing paid sick leave law, employees accrue one hour of paid sick leave for every 30 hours worked, up to three days per year. Under the supplemental laws, eligible full-time employees were entitled to an additional 80 hours, while part-time workers were entitled to the number of hours they normally worked during a two-week period. In a similar vein, Colorado's permanent Healthy Family and Workplaces Act ensures up to 48 hours of paid sick and safe leave annually, but also includes up to 80 hours of supplemental leave (or an amount equivalent to two weeks of regular hours) during a public health emergency period.

REASONS FOR COVERAGE

Most state-level paid sick leave policies cover: preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's physical or mental illness, injury, or medical condition; or reasons related to stalking, domestic violence, or sexual abuse. There is some variation in language and coverage between states, as detailed further in Appendix A.

LEARNING FROM TODAY, PREPARING FOR TOMORROW: SPOTLIGHT ON MARYLAND

Workers from across industries and occupations in Maryland have had access to paid sick leave through the Healthy Working Families Act since 2018. However, recognizing the extraordinary challenges faced by essential workers and their employers during the COVID-19 pandemic, lawmakers passed the Essential Workers' Protection Act in May 2021. Among other provisions, the law provides up to 112 hours of paid leave for essential workers during declared emergencies, subject to the availability of state or federal funding. This law exemplifies the imperative to learn from the current crisis and prepare more effectively for the future.

Several states issued guidance or passed amendments or supplemental policies to cover COVID-19 related reasons, such as: if an employee or their family member needed COVID-19 testing, contracted COVID-19, or had to be quarantined; if the employee's place of business closed due to the spread of COVID-19; or if the employee needed to care for a child whose daycare or school closed due to COVID-19.

Most states have also included broader public health emergency language in their paid sick leave policies. For example, Colorado's new Healthy Family and Workplaces Act includes public health emergency leave

that can be used to: self-isolate due to a diagnosis or symptoms of a communicable illness related to the emergency; seek a diagnosis, treatment or care for that illness; miss work due to an employer or government mandate; care for a family member who must remain home for one of the above reasons; care for a child or other family member in the case of daycare or school closures; or avoid work due to a health condition that may increase susceptibility to the communicable illness.

Maine and Nevada are outliers among states with paid sick leave policies, in that they do not stipulate any reasons for coverage. Maine's law does specify that, even though accrued leave may be used for any reason, employees may be required to provide up to four weeks' advance notice for any reason other than emergency, illness, or sudden necessity.

FINANCING AND ACCOUNTABILITY

Paid sick leave laws are for the most part financed by employers. As one exception, the COVID-19 Emergency Paid Sick Leave Act in Massachusetts was created to support employers that chose to provide additional paid sick leave during the COVID-19 emergency period. Under this law, employers could submit an application to the Executive Office for Administration and Finance for reimbursement from the COVID-19 Emergency Paid Sick Leave Fund (which was funded by ARPA dollars). Maryland's Essential Workers' Protection Act is another exception because, as mentioned above, it is designed to be financed by state or federal funding during an emergency period.

In terms of accountability, most paid sick leave policies require employers to keep payroll records (including on accrual, use, payout, and carryover) for one to six years, depending on the state, and to submit to an audit of those records if needed. Most states also set requirements for how employers should communicate with employees about their accrued, used, and available paid sick time in the current year. Most paid sick leave policies also include language that prohibits retaliation against employees who exercise their rights to take paid leave and describes how employees can file grievances related to their employers' paid leave practices.

THE IMPACT OF PAID SICK LEAVE ON ABILITY TO TAKE TIME OFF

As with the hazard pay analysis, we drew on data from the CPS Basic Monthly Sample and the March Supplement to assess the impact of state paid sick leave policies on direct care workers’ ability to take paid time off. We used the “absent from work” variable from the CPS, which captures both part- and full-time workers who report being absent from their jobs for the entire previous week. Unfortunately, this variable does not account for workers who were only absent from work for part of the week, which is a limitation in the data.

For this analysis, we compared two groups of states: all those that implemented paid sick leave policies prior to or during the pandemic period versus all those that did not. We only analyzed data from 2021 (the second year of the pandemic), because states implemented paid leave policies at various times throughout 2020 and because the FFCRA extended paid sick leave protections to some (albeit not all) direct care workers nationwide from April through December 2020. We included New Mexico in the sample of states without paid sick leave policies, since the Healthy Workplaces Act was not in effect in 2021, and we excluded home care respondents from Virginia altogether, because the Paid Sick Leave for Home Health Workers went into effect halfway through the year.

First, we determined whether the proportion of direct care workers who took time off from work in the previous week (regardless of whether they were paid) differed between states that did and did not have paid sick leave policies in place. As shown in Chart 3, a similar proportion of direct care workers took time off in states with and without paid sick leave policies (3.7 percent and 4.3 percent of the sample, respectively). This finding appears to refute the theory that paid leave policies drive up absenteeism, leading to staffing shortages and service disruptions.²³

In the second step of the analysis, we examined whether direct care workers who took time off in the previous week were paid for that time off—and found that 59 percent were paid for their time off in states with paid sick leave policies, versus just 23 percent in states without such policies (Chart 4). This finding was statistically significant at the 90 percent confidence level ($p < .1$). These findings support, at a high level, the argument that states’ paid sick leave policies play a role in ensuring that workers are able to take time off work without incurring lost wages and potentially catastrophic financial consequences.

CHART 3 | Direct Care Workers Who Were Absent from Work in the Previous Week, by Paid Sick Leave Policy Status (2021)

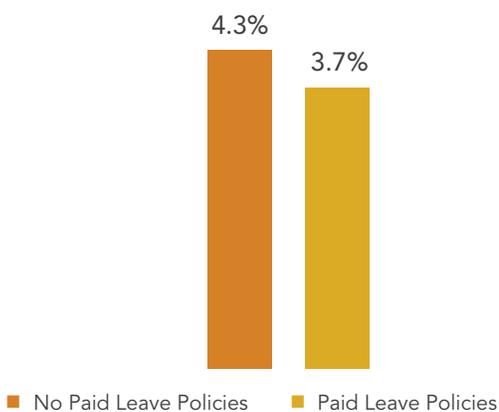
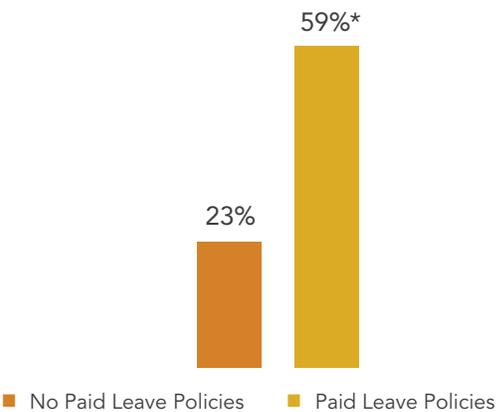


CHART 4 | Direct Care Workers Who Were Paid for Absence from Work in the Previous Week, by Paid Sick Leave Policy Status (2021)



* Statistically significant ($p < .1$)

Source: Flood, Sarah, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren and Michael Westberry. 2021. Integrated Public Use Microdata Series, Current Population Survey: Version 9.0. <https://doi.org/10.18128/D030.V9.0>; analysis by PHI (April 2022).

CONCLUSION AND LESSONS LEARNED

As the long-term care sector recovers from the tragic impact of the COVID-19 pandemic, it is imperative that we document and learn from what happened and how the sector responded. With this knowledge, we can take steps to build better jobs and better services to meet the needs of older adults and people with disabilities—now and into the future.

To that end, the purpose of this study was to examine how states supported direct care workers during the first 18 months of the pandemic, with a focus on hazard pay and paid sick leaves policies, and to explore how these policy responses affected workers' economic stability and wellbeing. Overall, we found that 17 states implemented at least one hazard pay policy and four states implemented a new paid sick leave policy during the study period (March 2020 through August 2021). Of the 14 states that already had an existing leave policy in place, most issued guidance related to COVID-19, while four made amendments or issued supplementary policies. Just 10 states implemented both types of policies: California, Connecticut, Massachusetts, Michigan, New Jersey, Oregon, Rhode Island, Vermont, Virginia, and Washington State.

Among states that implemented hazard pay, there was wide variation in terms of eligibility, amount, duration, and accountability—but for the most part, the policies were short-term and modest in scope. Most states offered one-time bonuses, ranging from \$250 to a maximum of approximately \$2,260 per worker, while a few states implemented wage increases or proportional wage pass-throughs. Even among the latter states, there was variation. For example, Louisiana and Michigan both implemented a wage increase of about \$2 per hour for direct care workers, but Louisiana's policy was restricted to direct care workers providing home care through a single Medicaid waiver program to clients who were exposed to COVID-19 (for a maximum of 40 days)—while Michigan's hazard pay policy initially covered direct care workers across all Medicaid HCBS programs, was expanded over time to cover nursing homes and increased to a higher amount, and made permanent through the 2022 state budget.

We found more consistency in paid sick leave policies across states, with most policies covering 30 to 40 hours of sick leave per year for eligible employees for a consistent set of reasons. However, there is still

considerable variation in these policies with regards to employer and employee eligibility, accrual and carryover rules, and more—and two states (Maine and Nevada) do not stipulate any reasons for taking paid leave.

A small but significant set of states passed emergency paid sick leave policies focused on essential or frontline workers during the pandemic, such as California's supplemental laws covering first responders and health care workers and New York's COVID-19 sick leave law, which filled the gaps in the federally mandated emergency sick leave coverage.

In terms of enforcement and accountability, we found that most states that implemented hazard pay policies required providers to submit a claim to receive the funds, and in some cases, agree to a possible audit of their records. Paid sick leave policies tend to include more detailed and explicit requirements related to record-keeping and communication with employees. But overall, details on enforcement and accountability were sparse, and questions remain about the extent to which direct care workers and their employers knew about, implemented, and benefited from these policies.

Notwithstanding these policy variations and outstanding questions about implementation, our brief quantitative analyses support the assumption that state-level policies targeting direct care workers did make a difference during the pandemic period—over and above the federal support that all long-term care providers received (to varying extents). In broad strokes, we found that Michigan's hazard pay policy had a significant impact on wages and earnings for home care workers, particularly, and that workers in states with paid sick leave policies were no more likely to take time off than those in states without such policies—but were much more likely to be paid for their time off.

From these findings, we have distilled the following lessons to inform longer-term efforts to improve direct care jobs and support this essential workforce.

EXTEND SUPPORTIVE POLICIES ACROSS DIRECT CARE OCCUPATIONS AND SETTINGS

Most of the challenges faced by direct care workers are not unique to a single direct care occupation or long-term care setting. Persistently low wages and limited benefits are a reality for all direct care workers—and the acute physical, mental, emotional, and financial toll of providing care during the COVID-19 pandemic reverberated across this entire workforce. Yet many hazard pay policies enacted during the first 18 months of the pandemic were restricted to individual Medicaid programs or provider types, reflecting the fragmented nature of long-term care financing and service delivery.²⁴ By contrast, a small number of states designed policies to reach direct care workers across settings, most notably Michigan. Such inclusive policies are the most promising strategy for promoting equity and bolstering services across the long-term care continuum.

SUSTAIN SHORT-TERM WAGE ENHANCEMENTS FOR ALL DIRECT CARE WORKERS

The COVID-19 public health emergency has been in effect for over two years (and direct care workers have struggled with low wages for decades)—yet most of the hazard pay policies catalogued in this study were disbursed as one-time bonuses or short-term wage increases. As exceptions, Washington State’s wage increase for home care workers lasted for a year, and Michigan’s wage increase has been made permanent. Since the end of the study period, other states have also proposed or adopted wage increases for direct care workers; for example, Colorado established a \$15 minimum hourly wage for direct care workers in Medicaid HCBS programs as of January 1, 2022, which is nearly \$2.50 more than the statewide minimum wage.²⁵ Although the rate increase will initially be supported by American Rescue Plan Act (ARPA) funds, the legislature has committed to sustaining it through recurring funds. New York State also implemented a \$2 per hour wage increase for home care workers through the fiscal year 2023 budget, with an additional \$1 per hour raise planned for the following year. However, the state budget does not link the wage increases to reimbursement rate changes for home care providers, causing significant concern about how providers will cover the higher costs over time.²⁶ In reimagining the long-term care

system post-pandemic, states must develop strategies to permanently raise—and sufficiently fund—the wage floor for direct care workers.

DEVELOP A NATIONAL COMPENSATION STRATEGY FOR DIRECT CARE WORKERS

Only a third of states implemented any type of hazard pay policy for direct care workers during the first 18 months of the COVID-19 pandemic, despite the immense challenges they faced—and most of those policies were modest in scope. This inconsistent and largely inadequate response across states signals the need for national leadership in establishing livable, competitive wages for direct care workers. The Centers for Medicare & Medicaid Services (CMS) could partner with other federal agencies, including the Administration on Community Living (ACL), the Health Resources and Services Administration (HRSA), and the Department of Labor (DOL), to develop a national direct care workforce compensation strategy, with implementation guidance and technical assistance for states.²⁷ The compensation strategy should include a formula for calculating minimum reimbursement rates that cover the full cost of services, including all labor costs—and also account for possible unintended consequences, such as loss of service hours or the risk of “benefit cliffs” for workers (which occur when incremental wage increases lead to reduced eligibility for essential public assistance).²⁸ Only with national leadership will it be possible to achieve equitable job quality improvements for direct care workers and stabilize this workforce across all states.

ESTABLISH PERMANENT PAID SICK LEAVE LAWS

The COVID-19 crisis has underscored the critical need for universal paid sick leave coverage, as countless essential but low-wage workers have been forced to make impossible choices between protecting themselves, their families, and their clients or residents (by staying home if exposed or infected) versus avoiding financial catastrophe (by going to work). In response, four states have established new, permanent paid sick leave policies during the pandemic, joining 10 others that already had these policies in place—a trend that must continue. States without paid sick leave policies can draw on the legislative language and implementation experience of these other states.

But as with compensation, national leadership is required to ensure that all U.S. workers—like workers in most other countries around the world²⁹—have access to paid leave. Promising recent developments include the introduction of the Healthy Families Act in 2019, which would have required most employers to provide paid sick leave, and the national paid family and medical leave program proposed in the Build Back Better Act.³⁰ As efforts to establish national paid leave policies continue, the unique employment characteristics and needs of low-wage workers, such as direct care workers, should be kept front and center. Key considerations with regards to direct care workers include: the need for full wage replacement, the importance of accounting for multiple employment relationships, and the imperative to extend paid leave benefits to those with part-time or intermittent work schedules.³¹

INCORPORATE SUPPLEMENTAL PUBLIC HEALTH EMERGENCY CLAUSES INTO PAID SICK LEAVE LAWS

This analysis found that most state-level paid sick leave policies cover a similar set of reasons for taking leave, including for preventative care, diagnosis, or treatment for an employee or their family member and for care related to stalking, domestic violence, or sexual abuse. Many but not all policies also include—or were amended or supplemented during the COVID-19 pandemic to include—reasons related to public health emergencies, such as quarantining or caring for children in the case of daycare or school closures. Going forward, states could learn from Colorado’s example by requiring employers to provide additional paid sick leave for emergency-related reasons—recognizing that employees’ leave requirements increase during such times. An alternative approach, as with Maryland’s Essential Workers’ Protection Act, is to pass supplemental legislation that provides additional paid leave for essential workers during emergencies. Public health emergency provisions should also be built into federal paid sick leave policy proposals.

CREATE A STATE OR REGIONAL PAID CARE ADVOCATE

Across the policies that we examined, enforcement and accountability details were often sparse. And our analysis of Michigan’s hazard pay policy found that the policy did not translate into an equivalent increase in nursing assistants’ wages across the state, which raised concerns

about how well the policy has been communicated and implemented. To bolster the impact of future policies that are designed to support direct care workers, states could consider establishing a statewide or regional paid care advocate. A paid care advocate can support direct care workers and other workers in knowing about and accessing their employment rights—and ensure that employers have sufficient information to uphold their employment responsibilities. New York City’s Paid Care Division provides a leading example. Responsibilities of this office include conducting research on the challenges facing paid care workers; directly assisting workers, such as by mediating wage disputes, connecting workers to public benefits, and more; and enforcing relevant laws through investigations and corrective actions.³² Under DOL leadership, the federal government could also consider establishing a national division of paid care to guide states in providing these services.

EVALUATE THE IMPLEMENTATION AND IMPACT OF DIRECT CARE WORKFORCE-RELATED POLICIES

Finally, as illustrated by the modest quantitative analyses presented in this report, states must monitor the implementation of direct care workforce-related policies and evaluate their impact. Did eligible direct care workers receive the bonuses or wage increases to which they were entitled? Were they able to take paid sick time when needed, without fear of retaliation? What were the outcomes of these policies, including among individual workers (e.g., financial stability), for the full workforce (e.g., turnover, retention, equity), and on the delivery of care? Again, there is a role for the DOL to play at the federal level in funding states to build their data collection infrastructure and undertake such monitoring and evaluation efforts. It is also critically important to directly survey workers and providers, among others, about their experiences, challenges, and recommendations.

The imperative to invest in long-term care and the direct care workforce has never been greater.

Now is the time to translate the lessons learned from the COVID-19 crisis into long-term transformation of these essential jobs and services.

APPENDIX A

State Hazard Pay and Paid Sick Leave Policy Summaries

NOTE FOR ONLINE READERS: hover over the bolded title of each hazard pay policy, paid sick leave law, or guidance document to access a hyperlink (where available).

ALABAMA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

ALASKA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

ARIZONA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Fair Wages and Healthy Families Act

Description: Guidance from the Industrial Commission of Arizona clarified that employees may use paid sick leave accrued under the Fair Wages and Healthy Families Act of 2016 for COVID-19-related reasons. The details here pertain to both the existing sick leave law and the COVID-19 guidance, as relevant.

Eligibility: All employees, including part-time and temporary employees.

Amount: Varies by employer size:

- One hour for every 30 hours worked (up to 24 hours per year) at firms with fewer than 15 employees; and
- One hour for every 30 hours worked (up to 40 hours per year) at firms with 15 or more employees.

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's mental or physical illness, injury, or health condition; for reasons related to domestic violence, sexual violence, abuse, or stalking; or for reasons related to a public health emergency. COVID-19-specified reasons include: if an employee or family member needs COVID-19 testing, contracts COVID-19, or must

be quarantined due to potential exposure; if the employee's place of business is closed due to the spread of COVID-19; or if the employee needs to care for a child whose school has closed by public order.

Financing: Employer-financed.

Accountability: Employers' payroll records should include the amount of earned paid sick leave available to the employee, the amount of paid sick leave taken to date in the current year, the amount of pay received as paid sick leave, and the employee's earned sick leave balance. These records should be kept for at least four years.

ARKANSAS

HAZARD PAY

Enhanced Payments for Direct Care Workers

Description: Weekly bonus payments to direct care workers providing Medicaid-funded services as authorized through Arkansas's Medicaid Appendix K: Emergency Preparedness and Response and COVID-19 Addendum.

Eligibility: Direct care workers employed by adult day services, adult family homes, attendant care, and respite care providers under the AR Choices Waiver and nursing services, personal care, and attendant care providers under the Living Choices Waiver. Definition of "direct care workers" included registered nurses, licensed practical nurses, and respiratory therapists as well as nursing assistants, home health aides, and personal care aides.

Amount: Varied by hours worked:

- \$125 weekly bonus for those working 20 to 39 hours per week; and
- \$250 weekly bonus for those working 40 or more hours per week or more than 150 hours per month.

For those supporting individuals with COVID-19 diagnoses:

- \$125 weekly bonus for those working 1 to 19 hours per week;
- \$250 weekly bonus for those working 20 to 39 hours per week; and

- \$500 weekly bonus for those working 40 or more hours per week or more than 150 hours per month.

Duration: April 5, 2020 through May 30, 2020.

Financing: Division of Aging, Adult, & Behavioral Health Services.

Accountability: Eligible providers were required to submit a letter of intent to the Arkansas Department of Human Services (DHS), followed by requests for payment weekly or in accordance with their payroll schedule. DHS retained the right to perform periodic audits.

PAID SICK LEAVE

No policy implemented.

CALIFORNIA

HAZARD PAY

Skilled Nursing Facility Hero Awards

Description: One-time bonuses provided via Visa gift cards for nursing home workers through the Skilled Nursing Facility Hero Awards program.

Eligibility: Certified nursing assistants (CNAs) and licensed vocational nurses (LVNs) working in skilled nursing homes in the state.

Amount: \$500 issued to the first 50,000 CNAs and LVNs who applied.

Duration: April 14, 2020 until all the gift cards had been claimed.

Financing: Financed by a \$25 million donation from Facebook, administered through the Office of Statewide Health Planning and Development (OSHDP).

Accountability: Eligible workers applied directly; no accountability mechanisms described.

PAID SICK LEAVE

Healthy Workplaces, Healthy Families Act and COVID-19 Supplemental Paid Sick Leave

Description: California has had a paid sick leave policy in place since the enactment of the Healthy Workplaces, Healthy Families Act of 2014, but passed two supplemental paid sick leave laws during the COVID-19 pandemic: AB 1867 and SB 95.

The details here pertain to both the existing sick leave law and supplemental provisions, as relevant.

Eligibility: The existing law covers all employees in California, with limited exceptions under collective bargaining agreements and other conditions. The first supplemental law (AB 1867) pertained to first responders, health care workers, and those working for employers with more than 500 employees nationwide. SB 95 expanded eligibility to employees of employers with more than 25 employees nationwide.

Amount: Under the existing law, employees accrue 1 hour of paid sick leave for every 30 hours worked, up to 3 days per year. Under the supplemental laws, full-time employees were entitled to an additional 80 hours, while part-time workers were entitled to the number of hours normally scheduled over a two-week period.

Duration: Permanent law; AB 1867 was in effect from September 9, 2020 (retroactive to April 16, 2020) through December 31, 2020; SB 95 was in effect from March 19, 2021 (retroactive to January 1, 2021) through September 30, 2021.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's health condition; or for reasons related to domestic violence, sexual assault, or stalking. The supplemental laws also permitted employees to use paid sick leave if: subject to a COVID-19 quarantine or isolation order; attending an appointment for a COVID-19 vaccine; experiencing symptoms related to COVID-19 or the vaccine; caring for a family member who was subject to a COVID-19 quarantine or isolation order; or caring for a child whose school or care center was closed.

Financing: Employer-financed.

Accountability: Employers must keep records of paid sick leave provided to and used by employees for at least three years.

COLORADO

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Policy 1: Colorado Health Emergency Leave with Pay (HELP)

Description: The Colorado Health Emergency Leave with Pay (HELP) Rules required employers in certain industries to provide paid sick leave at two-thirds the regular pay rate to employees for COVID-19-related reasons.

Eligibility: Employees working for home care providers, nursing homes, and community living facilities, among other employer types.

Amount: Up to 80 hours over 14 calendar days.

Duration: March 11 through July 14, 2020; personal care services added April 27, 2020.

Reasons: Paid sick leave could be used by employees with flu-like or respiratory symptoms who were being tested for COVID-19 or who had been instructed by a health care provider or authorized government official to quarantine or isolate due to the risk of exposure. Paid sick leave ended if an employee received a negative COVID-19 test result after being asymptomatic for 72 hours, but no earlier than seven calendar days (or 10 calendar days for health care workers).

Financing: Not stated.

Accountability: Reporting requirements unclear, but the HELP Rules state that denial of paid leave may subject the employer to "a penalty of not less than one hundred dollars for each day such violation, failure, neglect, or refusal continues."

Policy 2: Healthy Family and Workplaces Act (HWFA)

Description: Colorado's Healthy Family and Workplaces Act (HWFA), effective July 15, 2020, replaced the HELP Rules with emergency paid sick leave, permanent paid sick and safe time leave, and supplemental future "public health emergency leave."

Eligibility: All employees, including government employees. Employers with 15 or fewer employees nationwide are not required to comply with the paid sick and safe time provisions of the HWFA until 2022 (but all employers required to offer public health emergency leave as of January 1, 2021).

Amount: Varies by leave type:

- 48 hours annually of paid sick and safe time leave; and

- Up to 80 hours of supplemental leave (or an amount equivalent to two weeks of an employee's regular hours) in the case of a public health emergency.

Duration: Emergency paid sick leave effective July 15 through December 31, 2020; paid sick leave and public health emergency leave effective January 1, 2021, with no expiration.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's mental or physical illness, injury, or health condition; for reasons related to domestic abuse, sexual assault, or harassment; or for reasons related to a public health emergency. Supplemental public health emergency leave can be used to: self-isolate due to a diagnosis or symptoms of a communicable illness related to the emergency; seek a diagnosis, treatment or care for the illness; miss work due to an employer or government mandate; care for a family member who must remain home for one of the above reasons; care for a child or other family member whose school or care center is closed due to the public health emergency; or avoid work due to a health condition that may increase risk of the communicable illness.

Financing: Funded jointly by employees and employer through payroll contributions.

Accountability: Employers must retain records of each employee's hours worked and paid sick leave accrued and used for at least two years. State regulators must be allowed access to the records to check compliance.

CONNECTICUT

HAZARD PAY

Policy 1: Coronavirus Relief Fund Nursing Home Grants

Description: "Incentive payments" to direct care staff in nursing homes (and indirect care staff, at the discretion of the provider) disbursed in two phases.

Eligibility: Direct care staff in skilled nursing homes, defined as nursing staff and nursing pools as well as nurse aides.

Amount: Varied by hours worked:

- \$250 for those working 10 to 27.5 hours per week; and
- \$500 for those working more than 27.5 hours per week.

Duration: Phase 1 was implemented from November 1 through December 31, 2020; Phase 2 was implemented from January 1 through February 28, 2021.

Financing: Connecticut Department of Social Services (DSS).

Accountability: Nursing facilities were required to attest to the full terms of the funding through grant agreements with DSS. The Department of Public Health promised to document compliance through reported data and surveys.

Policy 2: Hazardous Duty Payments for Independent Providers

Description: One-time “hazardous duty payments” to independent providers, meaning home care workers who are employed directly by consumers under Medicaid self-direction programs, as stipulated through a Memorandum of Agreement between the Personal Care Attendant Workforce Council and New England Health Care Employees Union, District 1199 SEIU.

Eligibility: All independent providers covered by the existing collective bargaining agreement between the Personal Care Attendant Workforce Council and New England Health Care Employees Union, District 1199 SEIU.

Amount: Calculated at 7.5 percent of the worker’s wages paid for all hours worked from April 1, 2020 through June 30, 2020.

Duration: Signed June 13, 2020, covering the period April 1, 2020 to June 30, 2020.

Financing: Connecticut Department of Social Services (DSS).

Accountability: The Memorandum of Agreement states that “any disputes regarding the amount of payments will be handled according to the parties’ collective bargaining agreement.”

PAID SICK LEAVE

Paid Sick Leave Law, COVID-19 Guidance

Description: Guidance from the Connecticut Department of Labor specified that the state’s Paid Sick Leave Law should cover certain absences caused by COVID-19. The details here pertain to both the existing sick leave law and the COVID-19 guidance, as relevant.

Eligibility: “Service workers,” who include nursing assistants, home health aides, and personal care aides, among other occupations. The law only pertains to service workers employed 10 or more hours per week and to employers with 50 or more employees.

Amount: One hour for every 40 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee’s own or a family member’s mental or physical illness, injury or health condition; or for reasons related to family violence or sexual assault. The guidance confirmed that paid sick leave may be used for COVID-19-related reasons.

Financing: Employer-financed.

Accountability: Record-keeping requirements for employers not clear; but the paid sick leave law states that any employee aggrieved by a violation of the provisions of the act may file a complaint with the Labor Commissioner.

DELAWARE

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

DISTRICT OF COLUMBIA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Accrued Sick and Safe Leave Act

Description: The Accrued Sick and Safe Leave Act of 2008 requires employers to provide paid sick leave to employees working in the District of Columbia. The Act was expanded to include COVID-19-related reasons for paid leave, effective March 1, 2020 through November 5, 2021, but “health care providers” (including all providers employing direct care workers) were exempt. Therefore, the details here pertain to the existing legislation.

Eligibility: All private sector and government employees, including part-time employees; does not cover independent contractors, students,

or health care workers who participate in a premium pay program.

Amount: Varies by employer size:

- One hour for every 87 hours worked (up to 3 days per year) at firms with fewer than 25 employees;
- One hour for every 43 hours worked (up to 5 days per year) at firms with 25 to 99 employees; and
- One hour for every 37 hours worked (up to 7 days per year) at firms with 100 or more employees.
- Sick leave can be rolled over from one calendar year to the next.

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee’s own or a family member’s physical or mental illness, injury, or medical condition; or for reasons related to stalking, domestic violence, or sexual abuse.

Financing: Employer-financed.

Accountability: Employers must maintain accurate time and payroll records that reflect the use of paid leave for no less than three years.

FLORIDA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

GEORGIA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

HAWAII

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

IDAHO

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

ILLINOIS

HAZARD PAY

Specialty Care Incentive

Description: Hourly wage increase for nursing home workers in over 100 nursing homes across the state as stipulated in a Memorandum of Understanding between the Illinois Association of Health Care Facilities and the SEIU Healthcare Illinois and Indiana.

Eligibility: All nursing home workers covered by the existing collective bargaining agreement between the Illinois Association of Health Care Facilities and the SEIU Healthcare Illinois and Indiana.

Amount: \$2 per hour minimum increase over new base rates.

Duration: Memorandum of Understanding signed on May 7, 2020; wage increase covered a 45-day period for each eligible worker, and for an additional 45 days for those working in nursing homes with COVID-19 outbreaks.

Financing: Not stated.

Accountability: Not stated.

PAID SICK LEAVE

No policy implemented.

INDIANA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

IOWA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

KANSAS

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

KENTUCKY

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

LOUISIANA

HAZARD PAY

Policy 1: Frontline Workers COVID-19 Hazard Pay Rebate Program

Description: One-time hazard pay rebate paid to “essential critical infrastructure workers” through a first-come-first-served online application process.

Eligibility: Nursing assistants, long-term care facility personnel, home care workers, personal assistance providers, and other relevant direct care workers, among other eligible occupational groups. Applicants must have worked at least 200 hours from March 22 to May 14, 2020 and have an adjusted gross income of ≤\$50,000. Rebates were limited to 20,000 applicants.

Amount: \$250 per applicant.

Duration: Application window open from July 15 through October 31, 2020.

Financing: Louisiana Department of Revenue, Coronavirus Local Recovery Allocation Fund, and Louisiana Main Street Recovery.

Accountability: The rebates were issued directly to approved applicants; employers were not involved.

Policy 2: Office for Citizens with Developmental Disabilities (OCDD) Hazard Pay

Description: Hazard pay rate designed to ensure continuity of care for OCDD waiver participants following a positive COVID-19 test result.

Eligibility: Direct care workers providing in-home supports to OCDD waiver participants who either tested positive for COVID-19 or who were required to quarantine after another member of their household tested positive. No more than 40 days of hazard pay allowed per participant meeting those criteria.

Amount: A minimum of \$0.50 per 15-minute unit paid directly to the worker.

Duration: From October 29, 2020 until six months after the end of the public health emergency period.

Financing: Louisiana Department of Health.

Accountability: Home and community-based service agencies employing eligible workers were required to complete a hazard pay request form. OCDD reserved the right to review and audit all records related to the hazard payments and to assess penalties/recoupment for non-compliance.

PAID SICK LEAVE

No policy implemented.

MAINE

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Earned Paid Leave Law

Description: Maine enacted an Earned Paid Leave Law in 2019 which could be used during the COVID-19 pandemic.

Eligibility: All employees working for employers that employ more than 10 employees in Maine, including part-time, temporary and per diem employees, and government employees. Seasonal industries exempted.

Amount: One hour for every 40 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Accrued leave may be used for any reason, but employees may be required to provide up to 4 weeks’ advance notice for any reason other than an emergency, illness, or sudden necessity.

Financing: Employer-financed.

Accountability: Bureau of Labor has enforcement over laws and sets out penalties for noncompliance. No requirements for employer documentation described.

MARYLAND

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Policy 1: Maryland Healthy Working Families Act, COVID-19 Guidance

Description: Guidance from the Attorney General briefly noted that employees may use paid sick time accrued under the state’s Healthy Working Families Act of 2018 for

COVID-19-related reasons. The details here pertain primarily to the existing paid sick leave law.

Eligibility: All those working for employers that employ fewer than 15 employees, except those who regularly work less than 12 hours per week, certain independent contractors, and some other occupational categories.

Amount: One hour for every 30 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: To care for or treat the employee's mental or physical illness, injury or condition; to obtain preventative medical care for the employee or the employee's family member; to care for a family member with a mental or physical illness, injury or condition; for maternity or paternity leave; or for an absence due to domestic violence, sexual assault, or stalking committed against the employee or the employee's family member under certain circumstances. The guidance confirmed that paid sick leave could be used for COVID-19-related reasons.

Financing: Employer-financed.

Accountability: Employers must maintain records of each covered employee's sick time accrual and use for at least three years.

Policy 2: Maryland Essential Workers' Protection Act

Description: The Maryland Essential Workers' Protection Act (HB 581), which passed on May 30, 2021, includes a new paid public health mandates up to 112 hours of paid leave for essential workers during a defined "emergency."

Eligibility: Essential workers who: perform a duty during an emergency that cannot be performed remotely; and who provide services that are determined to be essential or critical to their employers' operations.

Amount: Varies by hours of work:

- For those who work 40 hours per week or more, up to 112 hours of leave during an emergency period; and
- For those who work part-time, an equivalent number of hours of leave to the hours worked during a typical four-week period.

Duration: Paid leave entitlement in effect during declared emergency periods only.

Reasons: Essential workers may take paid leave if they have been diagnosed with the communicable disease that is the subject of the emergency; to obtain a medical diagnosis, preventive care, or treatment related to the disease; if they or their family members must self-isolate to prevent potentially infecting others; to care for a child or other family member; or if the child or family member's school or care center has been closed due to the emergency.

Financing: State or federal funding provided to employers during an emergency period. No funding stream for this Act has been specified during the COVID-19 pandemic, thus the paid leave provision is not currently in effect.

Accountability: Not specified, although the law stipulates a complaint process for individual employees that begins with mediation and may progress to civil penalties.

MASSACHUSETTS

HAZARD PAY

MassHealth COVID-19 Signing Bonus

Description: A signing bonus awarded to individuals who signed up through an online portal to work in nursing homes during the COVID-19 emergency period.

Eligibility: All individuals who registered through the Long-Term Care Staffing Portal to work in nursing homes in the state for a certain amount of time.

Duration: April 8 through May 15, 2020.

Amount: \$1000 per person.

Financing: MassHealth.

Accountability: Nursing facilities were required to submit documentation 30 days after the employee's start date to MassHealth to verify that the bonus was paid.

PAID SICK LEAVE

Policy 1: Earned Sick Time Act, COVID-19 Guidance

Description: Guidance from the Attorney General's Fair Labor Division clarified that employees may use paid sick time accrued under the state's

Earned Sick Time Law for COVID-19-related reasons. The details here pertain to both the existing sick leave law and the COVID-19 guidance, as relevant.

Eligibility: All those working for employers that employ 11 or more employees.

Amount: One hour for every 30 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for employee's own or a family member's physical or mental illness, injury, or medical condition; for routine medical appointments; or in cases of domestic violence. COVID-19 guidance states that paid sick leave may also be used if an employee or their family member is under a required or recommended quarantine order, as well as recommends that employers allow employees to use paid sick leave if their child's school is closed due to COVID-19.

Financing: Employer-financed.

Accountability: Employers must maintain records of each covered employee's sick time accrual and use for at least three years.

Policy 2: COVID-19 Emergency Paid Sick Leave Act

Description: Massachusetts enacted the COVID-19 Emergency Paid Sick Leave Act in May 2021 to reimburse employers that choose to provide additional paid sick leave during the COVID-19 emergency period.

Eligibility: All those employed by employers that provided COVID-19-related paid sick leave.

Amount: Up to 40 hours of paid sick leave related to COVID-19, not to exceed \$850 per employee.

Duration: June 7 through September 30, 2021, or when the funds ran out, whichever came first.

Reasons: If an employee or a family member must quarantine or seek diagnosis, medical treatment, or immunization for COVID-19; or if the employee was unable to telework due to a COVID-19 diagnosis.

Financing: American Rescue Plan Act funds administered through the Executive Office for Administration and Finance.

Accountability: Employers who provided COVID-19 emergency paid sick leave required to submit an application form for reimbursement.

MICHIGAN

HAZARD PAY

COVID-19 Premium Pay

Description: Hourly wage increase for direct care workers providing long-term services and supports.

Eligibility: Direct care workers employed under the Medicaid Home Help, MI Choice Waiver, MI Health Link and Behavioral Health programs, and directly by Area Agencies on Aging. Expanded to cover skilled nursing homes effective July 1, 2020.

Amount: \$2.00 per hour wage increase, raised to \$2.25 per hour as of March 1, 2021.

Duration: Renewed several times from April 1, 2020 through September 3, 2021 (then made permanent as a \$2.35 per hour increase through the 2022 state budget).

Financing: Michigan Department of Health and Human Services (MDHHS).

Accountability: Providers required to record the premium pay separately from base pay. Skilled nursing home providers required to submit a Nursing Home Direct Care Worker Wage Pass Through Reimbursement Form monthly or biweekly to MDHHS for reimbursement of the wage premium.

PAID SICK LEAVE

Paid Medical Leave Act, COVID-19 Executive Order

Description: Executive Order required that employers allow employees to take paid leave for COVID-19-related reasons under Michigan's Paid Medical Leave Act, and may not retaliate against them for quarantining due to COVID-19 exposure or infection. The details here pertain to both the existing sick leave law and the Executive Order, as relevant.

Eligibility: All workers employed by employers with 50 or more employees are eligible for paid medical leave, regardless of the number of hours they work. The Executive Order did not, however, pertain to "health care professionals" or "workers at a health care facility"; unclear whether this exemption covered home care workers.

Amount: One hour for every 35 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Preventative care or medical diagnosis, care, or treatment for an employee's own or a family member's physical or mental illness, injury, or health condition; for reasons related to domestic violence or sexual assault; or in the event of a public health emergency, including if employee's place of business or child's school or care center is closed, or if employee or a family member must quarantine to avoid the spread of infection. The Executive Order specified that paid leave may be used by anyone who has diagnosed COVID-19, who has one of the principal symptoms, or who has had close contact with someone with COVID-19 or a principal symptom.

Financing: Employer-financed.

Accountability: Employers must retain records of the hours worked and paid leave taken by employees for at least one year, and these records must be available to the Wage and Hour Division at any reasonable time.

MINNESOTA

HAZARD PAY

Temporary Rate Increase for Direct Support Services

Description: Service rate increase for personal care assistance service providers and for the consumer-directed community supports and consumer support grants programs, with a wage pass-through requirement.

Eligibility: Direct care workers assisting older adults and people with disabilities through these Medicaid-funded programs.

Duration: December 1, 2020 through February 7, 2021.

Amount: 8.4 percent service rate increase with at least 80 percent passed-through to direct care workers in the form of increased wages and benefits.

Financing: State general fund appropriation to the Commissioner of Human Services.

Accountability: Individual or agency employers required to prepare, post, and submit to the Commissioner (on request) a distribution plan specifying the anticipated amount and proposed uses of the enhanced funds.

PAID SICK LEAVE

No policy implemented.

MISSISSIPPI

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

MISSOURI

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

MONTANA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

NEBRASKA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

NEVADA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Paid Leave Law, COVID-19 Guidance

Description: Guidance from the Department of Business & Industry stated that employers could not require employees to use their accrued leave under the Paid Leave Act of 2019 to cover a mandated quarantine period, although employees could choose to use paid or other applicable leave. The guidance also encouraged employers to provide payment or offer alternative working arrangements to employees in quarantine. The details here pertain to the existing paid leave law.

Eligibility: Nevada's paid leave law covers those working for private employers with 50 or more employees in Nevada, not including temporary, seasonal, and on-call employees. Employers in the first two years of operation are exempt.

Amount: Eligible employees accrue 0.01923 hours of paid leave for every hour of work (~40 hours annually for full-time employees). Leave accrues immediately but may not be taken until 90 days after the date of hire.

Duration: Permanent law.

Reasons: Accrued leave may be used for any reason.

Financing: Employer-financed.

Accountability: Employers must notify employees on each payday of their accrued and unused paid leave, and retain these records for at least one year.

NEW HAMPSHIRE

HAZARD PAY

COVID-19 Long Term Care Stabilization Program

Description: Weekly stipends disbursed to direct care workers and other workers providing Medicaid-funded home and community-based services.

Eligibility: Employed and contracted workers who provide direct care, food service, maintenance or any other work that is vital to consumers and not able to be done remotely.

Duration: April 21 through December 31, 2020.

Amount: Varied by hours worked:

- \$150 weekly stipend for those working 8 to 29 hours per week; and
- \$300 weekly stipend for those working 30 or more hours per week.

Financing: New Hampshire Department of Employment Security (NHES).

Accountability: Participating providers required to submit a weekly certification form with details for each employee—including name, social security number, and employment status—receiving a stipend.

PAID SICK LEAVE

No policy implemented.

NEW JERSEY

HAZARD PAY

Policy 1: Temporary Wage Increases for Direct Support Professionals in Group Homes and Supervised Apartments

Description: Temporary hourly wage increase for direct support professionals supporting adult individuals with intellectual and developmental disabilities.

Eligibility: Direct support professionals providing supportive services in group homes and supervised apartments funded by the Division of Developmental Disabilities under the Department of Human Services.

Duration: May 1 through July 1, 2020; renewed from October 1 through December 31, 2020; renewed again from January 1 through March 31, 2021.

Amount: \$3 per hour increase.

Financing: Department of Human Services.

Accountability: Not stated.

Policy 2: Temporary Rate Adjustment for Certain Nursing Facilities

Description: Reimbursement rate increase for Medicaid-funded nursing homes with a wage pass-through requirement.

Eligibility: Certified nursing assistants (CNAs) in nursing homes.

Duration: October 1, 2020 through June 30, 2021.

Amount: 10 percent Medicaid rate increase with at least 60 percent passed through to CNAs in the form of increased wages or supplemental pay.

Financing: Department of Human Services.

Accountability: Nursing homes receiving the rate adjustment required to provide wage and cost data in a manner and form prescribed by the Commissioner of Human Services, and to adhere to specified infection control and testing policies.

PAID SICK LEAVE

Earned Sick Leave Law, Amendment

Description: New Jersey's Earned Sick Leave Law of 2019 was amended on March 25, 2020 to include allowable public health emergency reasons for using paid sick leave. The details here pertain to both the existing sick leave law and these amendments, as relevant.

Eligibility: The existing law covers all employees working in New Jersey except per diem health care employees.

Amount: One hour of leave for every 30 hours worked, up to 40 hours per year.

Duration: Permanent law, permanent amendment.

Reasons: Preventative medical care, diagnosis, care, or treatment for, or recovery from, an employee's own or a family member's mental or physical illness, injury or other adverse health condition; for reasons related to domestic or sexual violence; or to attend an event related to their child's health or education. According to the amendment, paid leave may also be used during a state of emergency or if the employee or their family member is required or recommended to quarantine or isolate to prevent the spread of infection.

Financing: Employer-financed.

Accountability: Employers must keep records of accrual, use, payment, payout and carryover for at least five years.

NEW MEXICO

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Healthy Workplaces Act

Description: New Mexico passed the Healthy Workplaces Act on April 8, 2021, but the law did not go into effect until July 1, 2022.

Eligibility: All employees working for private employers.

Amount: One hour for every 30 hours worked, up to 64 hours per year.

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's mental or physical illness, injury, or health condition; for meetings at the employee's child's school or daycare related to the child's health or disability; or for reasons related to domestic abuse, sexual assault, or stalking.

Financing: Employer-financed.

Accountability: Employers must maintain records of each covered employee's sick time accrual and use for at least four years.

NEW YORK

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

Policy 1: COVID-19 Paid Sick Leave

Description: Signed into law on March 18, 2020, New York's COVID-19 Paid Sick Leave Law authorized paid leave for employees who were subject to a mandatory or precautionary order of quarantine or isolation due to COVID-19.

Eligibility: Nearly all employees were entitled to some level of benefit (up to \$2,884.62 per week) and guaranteed job protection through the end of the quarantine/isolation order. Those working for employers with up to 10 employees and with a net income up to \$1 million in 2019 were not covered.

Amount: Varied by employer size:

- Up to 5 days of paid leave at firms with 1 to 10 employees and a net income of \$1 million or above in 2019, or at firms with 11 to 99 employees; and
- Up to 14 days of paid leave at firms with 100 or more employees, and for public employers of any kind. Up to three rounds of paid sick leave allowed.

Duration: No expiration date stated, but effectively replaced by New York's new state sick leave requirements (see below).

Reasons: Paid leave could be used by any employee who had COVID-19 (diagnosed or suspected), had been in close contact with someone with COVID-19 (diagnosed or suspected), or had been proximally exposed to COVID-19.

Financing: Employer-financed.

Accountability: Employers must keep payroll records for at least six years which include the amount of sick leave accrued and used by each employee on a weekly basis.

Policy 2: Sick Leave Requirements

Description: Established as part of the 2021 state budget, New York's Sick Leave Requirements were designed to take effect as the federal sick leave mandate through the Families First Coronavirus Response Act expired.

Eligibility: Nearly all employees are entitled to some level of benefit, with the exception of those working for employers with 4 employees or less and a net income of up to \$1 million (who are entitled to 40 hours of unpaid sick leave per calendar year only). Independent contractors also exempt.

Amount: Varies by employer size:

- Up to 40 hours per year for those working for employers with four or fewer employees and a net income of up to \$1 million, or working for employers with five to 99 employees; and
- Up to 56 hours per year for those working for employers with 100 or more employees (or for public employers of any size).

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's mental or physical illness, injury or health condition; or in the case of domestic violence, family offense, sexual offense, stalking, or human trafficking.

Financing: Employer-financed.

Accountability: At the request of an employee, employers must provide a summary of the paid sick leave accrued and used by that employee in the current calendar year and/or any previous calendar year.

NORTH CAROLINA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

NORTH DAKOTA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

OHIO

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

OKLAHOMA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

OREGON

HAZARD PAY

Policy 1: COVID-19 Emergency Response Incentive Program

Description: Rate increase provided to Medicaid-funded nursing homes that provided enhanced compensation to their employees in the case of COVID-19 exposures or outbreaks. Eligible nursing homes were also required to show that they had provided paid leave for workers who had to quarantine due to COVID-19 exposure or infection and that they had not terminated or disciplined any employee who took leave related to COVID-19.

Eligibility: All employees working in nursing homes that met the three criteria listed above.

Duration: The rate increase was provided to each eligible nursing home for a continuous 90-day period between May 1 and September 30, 2020.

Amount: Nursing homes received an additional 2.5 percent of their Medicaid Resident Revenue; no minimum compensation rate increase for employees stipulated.

Financing: Oregon Department of Human Services (ODHS).

Accountability: Nursing homes required to submit proof that they met the three criteria listed above in order to receive the increased rate.

Policy 2: Oregon Home Care Commission Pandemic Recognition Pay

Description: One-time recognition pay for home care workers established through a collective bargaining agreement between SEIU503 and the State of Oregon.

Eligibility: Home care workers, personal care attendants, and personal support workers employed between March 2020 and April 2021.

Duration: One-time payments issued to eligible workers on December 1, 2021.

Amount: \$1,410.35 for home care workers and personal care attendants employed through the ODHS Office of Aging & People with Disabilities and the Oregon Health Authority (OHA) Health Systems Division (taxes withheld); \$2,261.99 for personal support workers associated with the ODHS Office of Developmental Disabilities Services (taxes not withheld).

Financing: ODHS.

Accountability: Not stated.

PAID SICK LEAVE

Paid Sick Leave Law, COVID-19 Guidance

Description: Guidance from the Bureau of Labor & Industries emphasized that employees may use paid sick leave accrued under Oregon's Paid Sick Leave Law for COVID-19-related reasons. The details here pertain to both the existing sick leave law and the COVID-19 guidance, as relevant. (To note, this law does not pertain to home care workers and personal support workers, as their paid leave is covered by a collective bargaining agreement between SEIU503 and the State of Oregon.)

Eligibility: All those working for employers that employ up to 10 employees (or up to six employees in Portland). Employees must have worked for 90 days prior to taking sick leave.

Amount: One hour of paid sick leave for every 30 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Preventative medical care or medical diagnosis, care, or treatment for an employee's own or a family member's mental or physical illness, injury, or health condition; to care for an infant or newly adopted or fostered child; in the event of a death in the family; in the case of domestic violence, harassment, sexual assault or stalking; or if a public health emergency closes the employee's place of work or child's school or care center, or requires the employee to quarantine to prevent the spread of infection. The guidance confirmed that paid sick leave could be used for COVID-19-related reasons.

Financing: Funded jointly by employee and employer payroll contributions.

Accountability: Employers must inform employees at least quarterly of their accrued and unused sick leave balance.

PENNSYLVANIA

HAZARD PAY

COVID-19 Hazard Pay Grant Program

Description: Grant program to help employers provide hazard pay to employees working in "in life-sustaining occupations" during the COVID-19 pandemic. The program covered health care and social assistance, among other essential industries. Employers could apply for a grant to provide hazard pay for up to 500 eligible full-time equivalent employees per location.

Eligibility: All full-time and part-time employees earning less than \$20 per hour and working within eligible Pennsylvania-based industries.

Duration: August 16 through October 24, 2020.

Amount: \$3 per hour increase, not to exceed \$1,200 per person; total grants not to exceed \$600,000 per location.

Financing: Department of Community and Economic Development.

Accountability: Not stated.

PAID SICK LEAVE

No policy implemented.

RHODE ISLAND

HAZARD PAY

Workforce Stabilization Loan Program

Description: Short-term payroll support disbursed to nursing homes, assisted living facilities, and other congregate care providers through forgivable loans.

Eligibility: Direct care workers and other frontline workers earning less than \$20 per hour who support older adults, individuals with developmental disabilities, individuals with mental health and substance abuse disorders, and young people in Rhode Island's Department of Children, Youth, and Families congregate care facilities; not including state employees.

Duration: May 4 through June 30, 2020.

Amount: Varied by hours worked:

- \$100 weekly wage increase for those working 15 to 21 hours per week;
- \$150 weekly wage increase for those working 22 to 29 hours per week; and
- \$200 weekly increase for those working 30 or more hours per week.

Financing: Executive Office of Health and Human Services (EOHHS).

Accountability: Employers were required to sign a loan agreement before receiving funds stating they would comply with audit requirements, including biweekly submission of payroll documents. If funding was used for other purpose, employers were required to reimburse EOHHS.

PAID SICK LEAVE

Healthy and Safe Families and Workplaces Act, COVID-19 Guidance

Description: Guidance from the Department of Labor and Training clarified that employees may use paid sick leave accrued under the Healthy and Safe Families and Workplaces Act of 2018 for COVID-19-related reasons. The details here pertain to the existing sick leave law.

Eligibility: All those working for private employers with more than 18 employees, including part-time, full-time, seasonal, and temporary employees.

Amount: One hour for every 35 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Preventative care or medical diagnosis, care, or treatment for an employee's own or a family member's mental or physical illness, injury, or health condition; for reasons related to domestic violence, sexual assault, or stalking; or in the event of a public health emergency, including if an employee's place of business or child's school or care center is closed, or if an employee or a family member must quarantine to avoid the spread of infection.

Financing: Employer-financed.

Accountability: Employers must post notice to employees of paid sick leave policies and retain documentation of sick leave accrual and use in employee records for at least three years.

SOUTH CAROLINA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

SOUTH DAKOTA

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

TENNESSEE

HAZARD PAY

Division of TennCare COVID-19 Payment Flexibilities

Description: Wage enhancement for direct care workers providing in-home services for consumers diagnosed with COVID-19.

Eligibility: Direct care workers providing both agency-directed and consumer-directed services through CHOICES and Employment and Community First CHOICES TennCare Health Plans.

Duration: March 13 through July 24, 2020.

Amount: \$5 per hour, billable only for services provided during the period that a client required isolation due to a COVID-19 diagnosis (up to 30 days).

Financing: Division of TennCare.

Accountability: A provider's acceptance of payment for these temporary rate increases, after notification to the managed care organization (MCO), constituted the provider's attestation that all applicable conditions of payment would be met. Payments were subject to audit and recoupment if it was determined that conditions of payment were not met.

PAID SICK LEAVE

No policy implemented.

TEXAS

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

UTAH

HAZARD PAY

No policy implemented.

PAID SICK LEAVE

No policy implemented.

VERMONT

HAZARD PAY

Frontline Employees Hazard Pay Grant Program

Description: One-time bonus payments paid through a grant program available to "covered employers" whose employees were deemed to be substantially dedicated to responding to the COVID-19 public health emergency or providing essential services.

Eligibility: Employees who had an elevated risk of exposure to COVID-19 through their job; who were unable to perform their job remotely; who earned an hourly base wage of \$25 or less (home health agency and nursing home staff, among others, were exempt from this requirement); and who had worked at least 68 hours for a covered employer during the eligibility period.

Duration: Funds were disbursed retroactively in two rounds covering the period March 13 through May 15, 2020.

Amount: Varied by hours worked during the eligibility period:

- \$1,200 per person for those who worked 68 to 216 hours; and
- \$2,000 per person for those working more than 216 hours.

Financing: Department of Financial Regulation.

Accountability: Covered employers were required to complete a Grant Funds Spending Report and return any unspent grant funds. The State of Vermont retained the right to request back-up details to confirm that the bonus payments were disbursed, including but not limited to payroll reports.

PAID SICK LEAVE

Earned Sick Time Law, COVID-19 Guidance

Description: Guidance published by the Vermont Department of Labor clarified that employees must use paid sick leave accrued under Vermont's

Earned Sick Time Law (effective 2019 for all employers) for COVID-19-related reasons. The details here pertain to the existing sick leave law.

Eligibility: All employees whose primary place of work is in Vermont and who work 18 hours or more per week during the year on average, not including per diem health care employees.

Amount: One hour for every 52 hours worked, up to 40 hours per year.

Duration: Permanent law.

Reasons: Professional diagnostic, preventive, routine, or therapeutic health care for an employee or their family member; for reasons related to domestic violence, sexual assault, or stalking; or if an employee's or their family member's place of business or school or care center is closed for public health or safety reasons.

Financing: Employer-financed.

Accountability: Employers must provide sick time records within five days of an employee's request and must retain these records for at least three years.

VIRGINIA

HAZARD PAY

Hazard Pay for Home Health Workers

Description: One-time bonus payments to "home health personnel care attendants" who served high-risk populations during the early stages of the COVID-19 pandemic.

Eligibility: Direct care workers providing community-based personal care, respite, and/or companion care services to Medicaid beneficiaries.

Duration: Retroactively administered starting January 1, 2021 for the period March 12 through June 30, 2020.

Amount: \$1,500 per person.

Financing: Department of Medical Assistance Services (DMAS).

Accountability: Home care agencies were required to sign an attestation that they would provide the hazard pay bonus to eligible employees. After disbursing the payments, agencies had to enter the payment date on the Assigned Aide Payments spreadsheet and submit the spreadsheet with an invoice to DMAS.

PAID SICK LEAVE**Paid Sick Leave for Home Health Workers**

Description: Paid Sick Leave for Home Health Workers, which was signed into law in March 2021, mandates paid sick leave for home health workers effective July 1, 2021.

Eligibility: “Home health workers” are defined as those who provide personal care, respite, or companion services to individuals receiving consumer-directed services under Virginia’s Medicaid state plan. Eligible individuals must work at least 20 hours per week or 90 hours per month on average.

Amount: One hour of paid sick leave for every 30 hours worked, up to 40 hours per year.

Duration: Permanent.

Reasons: Preventative care or medical diagnosis, care, or treatment for an employee’s own or a family member’s mental or physical illness, injury, or health condition.

Financing: Employer-financed.

Accountability: Not specified, although the law stipulates that retaliatory action is prohibited.

WASHINGTON STATE**HAZARD PAY****COVID-19 Caregiver Hazard Pay**

Description: Hazard pay for independent providers and agency-employed home care workers established through a bargaining agreement between SEIU775 and the State of Washington.

Eligibility: Bargaining agreement covered independent providers (i.e., direct care workers employed directly by consumers through the state’s Medicaid-funded consumer-direction program), but due to the state’s parity statute, the agreement also pertained to direct care workers employed by Medicaid-funded home care agencies.

Amount: \$2.56 hourly raise from July 1 through December 31, 2020; \$2.54 hourly raise from January 1 through June 30, 2021.

Duration: July 1, 2020 through June 30, 2021.

Financing: Washington State Department of Social and Health Services (DSHS).

Accountability: Employers were accountable to enforcement and auditing requirements set by DSHS.

PAID SICK LEAVE**Paid Sick Leave Law, COVID-19 Guidance**

Description: Guidance from the Washington State Department of Labor & Industries clarified that employees may use paid sick leave accrued under Washington’s Paid Sick Leave Law for COVID-19-related reasons. The details here pertain to both the existing sick leave law and the COVID-19 guidance, as relevant.

Eligibility: Most full-time, part-time, and temporary workers employed in Washington, except for federal employees.

Amount: One hour for every 40 hours worked. Leave accrues immediately but may not be taken until 90 days after the date of hire.

Duration: Permanent law.

Reasons: Preventative care or medical diagnosis, care, or treatment for an employee’s own or a family member’s mental or physical illness, injury, or health condition; if employee’s workplace or child’s school or care center is closed for a health-related reason; or due to reasons specified under the state’s Domestic Violence Leave Act. The COVID-19-specified reasons include: if an employee’s place of business is closed by a public official in connection with COVID-19; if their child’s school or care center is temporarily closed due to COVID-19; if they feel ill or experience symptoms that may be COVID-19-related; due to possible COVID-19 exposure; or to seek diagnosis, care, treatment, or preventative medical care related to COVID-19.

Financing: Shared financing by employers and the state. Employers with fewer than 50 employees receive full coverage for the cost of premiums; those with 50 to 150 employees are eligible for state assistance with premiums.

Accountability: Employers must maintain monthly records for at least three years that detail paid sick leave accruals, unused and used paid sick leave, and paid sick leave donated or not carried over. Employers must also comply with any local paid sick leave ordinances with more generous requirements.

WEST VIRGINIA**HAZARD PAY**

No policy implemented.

PAID SICK LEAVE

No policy implemented.

WISCONSIN**HAZARD PAY**

No policy implemented.

PAID SICK LEAVE

No policy implemented.

WYOMING**HAZARD PAY**

No policy implemented.

PAID SICK LEAVE

No policy implemented.

APPENDIX B

Comparison of Direct Care Workforce Demographics in Michigan and Ohio

	MICHIGAN	OHIO
Gender		
Women	90%	93%
Men	10%	7%
Age Group		
16-24	11%	16%
25-34	24%	17%
35-44	10%	16%
45-54	22%	24%
55-64	18%	22%
65+	13%	5%
Race and Ethnicity		
White	67%	52%
People of Color	33%	48%
Black or African American	22%	37%
Hispanic or Latino (Any Race)	7%	4%
Asian and Pacific Islander	4%	6%
Another Race	0%	1%
Citizenship Status		
U.S. Citizen by Birth	91%	87%
Immigrant	9%	13%
U.S. Citizen by Naturalization	7%	13%
Not a Citizen of the U.S.	2%	0%

APPENDIX C

Comparison of Direct Care Workforce Demographics in States With and Without Paid Sick Leave Policies

	NO PAID LEAVE POLICIES	PAID LEAVE POLICIES	RAO-SCOTT CHI-SQUARE P-VALUE
Gender			
Women	89%	81%	<.01
Men	11%	19%	
Age Group			
16-24	17%	12%	<.01
25-34	19%	17%	
35-44	17%	17%	
45-54	19%	21%	
55-64	19%	22%	
65+	8%	10%	
Race and Ethnicity			
White	47%	36%	<.01
People of Color	53%	64%	
Black or African American	31%	26%	
Hispanic or Latino (Any Race)	15%	26%	
Asian and Pacific Islander	4%	10%	
Another Race	3%	2%	
Citizenship Status			
U.S. Citizen by Birth	83%	61%	<.01
Immigrant	17%	39%	
U.S. Citizen by Naturalization	10%	26%	
Not a Citizen of the U.S.	7%	14%	

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Phone: 718.402.7766
Fax: 718.585.6852
Email: info@PHInational.org

