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Study of Maine's Direct Care Workforce : Wages, Health Coverage, and a Worker Registry

Maine Department of Health and Human Services

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Wages, Health Coverage, and a Worker Registry

Report to the 123rd Maine Legislature
Submitted by the
Maine Department of
Health and Human Services

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Executive Summary

Direct care workers – the CNAs and personal attendants on the frontline of long-term care – comprise a much needed workforce with over 22,000 Maine workers. These jobs include four of the top 11 fastest growing occupations in Maine. The demand for direct care workers to fill these jobs is already outpacing supply. Demographic trends indicate a serious and growing workforce shortage over the next 20 years, making this a critical issue for Maine lawmakers to address.

A growing body of empirical evidence indicates that adequate wages and affordable, accessible health insurance play a critical role in recruiting and retaining a competent and stable direct care workforce. But median wages for Maine's direct care workers are just over the federal poverty level and have not kept pace with inflation, making them uncompetitive with other entry level jobs. In fact, Maine lags behind all other New England states in their median wages for frontline direct care occupations.

In addition, many Maine direct care workers are uninsured, either because health coverage is not offered by their employers (particularly in home care) or because their income is too low to enroll in their employers' plan if there are copays.

The Maine Departments of Health and Human Services and Labor estimate that it would cost $3 million in state dollars to raise to $8.50 per hour all direct care workers' wages in MaineCare and state funded long-term care programs, and $6 million to raise them to $10.00. These estimates include a 2% increase for workers currently making above these two wage floors, plus associated employer cost increases in FICA, unemployment insurance, and workers compensation.

Based on a review of other states' insurance models addressing this workforce, several options emerge that could cover more direct care workers and build on Maine's existing programs. These include offering DirigoChoice to MaineCare providers with over 50 workers; offering a part-time employee pool in DirigoChoice for employers of part-time workers; extending the state employee health benefit plan to employers who receive MaineCare funds; establishing a select group plan in DirigoChoice for direct care workers employed by MaineCare providers; extending the state employee health benefit plan to individual direct care workers employed by MaineCare registered providers and provide discounts; or expanding MaineCare eligibility guidelines to cover all individuals employed as direct care workers.

In recent years, many states have recognized the need for monitoring the full range of direct care workers and are updating their federally mandated CNA registries to adjust to the changes in the direct care workforce. Based on a review of other states' registry models, a vision and plan for a comprehensive Maine Direct Care Worker Registry will be carefully considered by the Maine Department of Health and Human Services. This plan upgrades the current CNA registry to provide 24 hour on-line Internet access and basic website information on direct care employment, adds unlicensed direct care workers to the registry, and creates features to assist with recruitment and retention.

Legislative Charge and Study Process

Resolves and Appropriations Provision

The 122nd Maine Legislature enacted two resolves (Chapters 194 and 199) and an appropriations provision (Chapter 519 EEEE) that provide the basis for this study of the direct care workforce. (See Appendices A, B, C)

Chapter 194 (Resolve, To Improve Retention, Quality, and Benefits for Direct Care Health Workers) requires the Maine Department of Health and Human Services (DHHS) to conduct a study of direct care workers in state funded and MaineCare funded programs in conjunction with the Maine Department of Labor (DOL). DHHS was directed to do this within existing resources and to work with interested parties involved in long-term care or home health care, including direct support and personal assistance workers. Finally, DHHS was required to carry out the following tasks:

- Examine the wage, benefit and reimbursement structures for direct care workers in all long-term care settings, including, but not limited to, nursing facilities, residential care facilities, mental retardation waiver homes and home care.
- Determine the cost of a wage floor of $8.50 per hour and the cost of a wage floor of $10 per hour for entry-level direct care workers, including certified nursing assistants, personal support specialists, home health aides, homemakers and direct support professionals. The study must include determination of the cost of proportional increases in current wage scales for more experienced workers and employer-related costs such as FICA.
- Develop options to extend MaineCare or other health insurance coverage for direct care workers.
- Evaluate the need for a direct care worker registry, including the desired objectives of such a registry and a cost estimate.
- Survey persons formerly employed as direct care workers in long-term care settings to determine whether they would return to work as direct care workers if the pay were increased to $10 per hour.
- Survey organizations that provide services to senior citizens through paid workers and through volunteers to determine the level of interest among older persons in becoming direct care workers, either full-time or part-time and within their physical capabilities, to assist persons who are elderly or persons with disabilities.

Chapter 199 (Resolve, To Ensure the Availability of Consumer-Directed Personal Assistance Services) specifies a number of steps relating to consumer-directed personal assistance services provided by DHHS and DOL:

- DHHS: Submit to the federal Centers for Medicare and Medicaid Services a MaineCare state plan amendment to establish a new state plan program for personal assistance services for persons with physical disabilities, providing services through the self-directed program model authorized in the federal Deficit Reduction Act and transferring some participants in the current physical disabilities waiver to the new state plan program.
- DHHS and DOL: Increase reimbursement for providers of consumer-directed personal assistance services to $10/hour, after approval of the state plan amendment by CMS and provided that savings to the General Fund generated from the transfer of participants from the current physical disabilities waiver to the new state plan program cover the cost.
- DHHS and DOL: Initiate a competitive bidding process to solicit bids from prospective providers of consumer-directed personal care assistance services.
- DHHS and DOL: Develop and submit a plan and timeline to the Joint Standing Committees on Health and Human Services and Labor to:
    - Expand the availability of consumer-directed alternatives across the range of long-term care services;
    - Enhance the intake process to provide consumers with information about the range of services including consumer-directed services; and
    - Provide consumers the opportunity to participate in consumer-directed services with the use of an unpaid surrogate to assist with the management tasks associated with these services.
- DHHS and DOL: Perform a survey of wages and benefits to determine the wages paid to personal care assistants across the state, including all programs for which funds are provided by the State.

Chapter 519, EEE (appropriations bill) requires DHHS to report to the Joint Standing Committee on Health and Human Services on efforts to increase the availability of workers for homemaker and home-based care programs administered by the Office of Elder Services.

Study Process

The Maine Direct Care Worker Coalition served as the stakeholder group for this study. Formed in 2002, the Coalition is comprised of 27 member groups as well as interested individuals representing long-term care consumers, workers and providers. The Coalition suggested to the DHHS Commissioner that the Coalition representatives listed below participate in the study group.

Stakeholder Study Group Participants

Home Care Alliance of Maine	Vicki Purgavie, Lisa Harvey McPherson
Maine Health Care Association	Richard Erb
MSEA/SEIU	Matt McDonald
Maine Long Term Care Ombudsman	Brenda Gallant
Maine Personal Assistance Services Association	Roy Gedat, Sky Hall, Joyce Gagnon
Maine Center for Economic Policy	Lisa Pohlmann
Home Care for ME	Susan Rovillard
Maine Assoc. of Community Service Providers	Mary Lou Dyer
Maine Alzheimers Association	Kathryn Pears

Numerous administrative staff from both DHHS and DOL also participated in the study. (See Appendix D for a list of all study participants). Diana Scully, Director, DHHS Office of Elder Services, chaired the study group meetings. Particular support was provided by Mollie Baldwin, DHHS Office of Elder Services, and John Dorrer, Merrill Huhtala, and David Welch, DOL Labor Market Information Services. Dyan Villeneuve, a student intern from the University of Maine's School of Social Work, also contributed to the study.

Catherine McGuire and Elise Scala from the University of Southern Maine's Muskie School of Public Service and Lisa Pohlmann from the Maine Center for Economic Policy provided significant assistance. Technical assistance also was provided by Dorie Seavey and Carol Regan of the Paraprofessional Healthcare Institute, a national nonprofit organization. Their assistance was made available through a grant awarded to DHHS by the CMS National Direct Service Workforce Resource Center.

The study group met monthly from July through December 2006. In addition, two subcommittees met at least monthly—one focused on the calculation of wage floors and one on the direct care registry options. The Maine Long Term Care Ombudsman Program provided substantial support to the work of the registry subcommittee, which was chaired by Brenda Gallant.

The final report was written by Lisa Pohlmann with assistance from Elise Scala and Craig Freshley of Good Group Decisions. Romaine Turyn served as liaison from the DHHS Office of Elder Services

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Background

Key Points

- Direct care workers in long-term care comprise a significant and much needed workforce. Maine employed over 22,000 direct care workers in 2005.
- Direct care occupations will be among the top 11 fastest growing jobs in the state. Home care positions will grow the fastest.
- Demand for direct care workers is outpacing supply and demographic trends indicate a serious and growing workforce shortage over the next 20 years.
- Median wages for direct care workers with families are just over the federal poverty level and have not kept pace with inflation, making them uncompetitive with other entry level jobs such as food prep and retail sales.
- Maine's median wages for direct care workers are less than those of all other New England states.
- Nationally, as many as one out of four nursing home workers and two out of five home care workers lack health insurance coverage.
- A growing body of empirical evidence indicates that adequate wages and affordable, accessible health insurance play a critical role in recruiting and retaining a competent and stable direct care workforce.
- Changes in the direct care workforce call for a new vision of a worker registry to enhance consumer safety, cost efficiency, and workforce adequacy.

Supply of Direct Care Workers

Across Maine, thousands of workers, predominantly women, provide personal assistance and hands-on health care for elderly people and adults and children with disabilities. These paraprofessionals include certified nursing assistants (CNAs), personal support specialists (PSSs), home health aides (HHAs), direct support professionals (DSPs) and others. They work in hospitals, nursing homes, residential and assisted living facilities, and in people's homes. Together they provide eight out of every ten hours of paid care received by long-term care consumers.[1]

Consumers report that workforce quality and consistency is critical to their experience of quality care. Research indicates that the size, stability, and training of the direct-care workforce all play a profound role in determining the quality of care and quality of life for people receiving long-term care services in home and community-based settings.[2]

Constant staff turnover and shortages reduce quality of care significantly. The ultimate quality of the long-term care services in Maine depends on the availability and stability of the direct care workforce.

The Maine Department of Labor estimates that there were over 22,350 direct care workers employed in 2005.[3] This does not include self-employed workers in private pay arrangements that are not tracked. As baby boomers retire over the next 20 years, the demand for direct care and personal assistance services will continue to grow, making direct care occupations some of the highest demand jobs in the state.

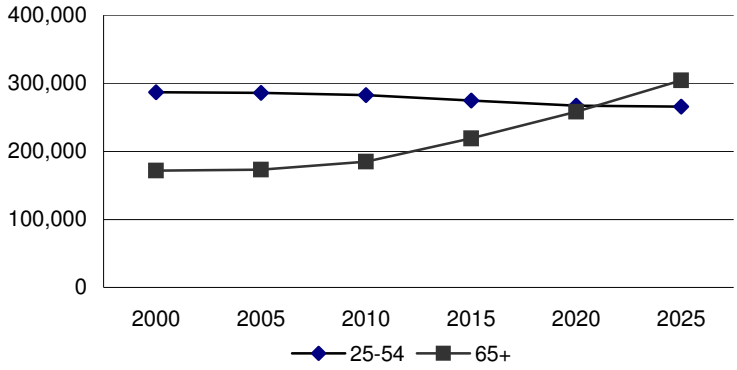
Growing "Care Gap"

The proportion of Maine's elderly population relative to the whole population is increasing by the decade and is projected to increase from 13.9% in 1995 to 21.4% in 2025.[4] The population most likely to require long-term care – those over 85 - will grow 26% from 2000 to 2015.[5]

The long-term care industry has relied on a large supply of traditional long-term caregivers – women aged 25-54 – that was entering the workforce for the first time. More recently, welfare-to-work policies and lay-offs from traditional manufacturing plants have also brought new female workers into direct care positions.

But despite this influx, demographics will likely create a worker shortage, since the number of women in this age cohort will fall behind the number needing the services over the long-term (Figure 1). This "care gap", which providers have already been experiencing for several years, will worsen with time.

Figure 1: Women of Caregiving Age and Elderly in Maine - 2000-2025
(Females aged 25-54 and elderly 65 and older)



Source: U.S. Census Bureau Population Projections

The competition for entry-level workers makes the situation even more difficult. From 2002-2012, all four of the direct care worker occupations are projected to be among the top 11 fastest growing jobs in the state (Table 1). Personal and home care aide positions, for example, are expected to increase by 55% from 2002-2012. Other high demand, entry-level jobs will be cashiers, food servers, waitpersons, and retail salespersons. Many of these jobs are less demanding and some offer better compensation.

Table 1: Occupations with the Largest Projected Net Job Growth in Maine between 2002 and 2012

	Occupation	Average Employment		Net Growth
		2002	2012	
1	Registered Nurses	13,000	16,469	3,469
2	**Personal and Home Care Aides**	4,853	7,502	2,649
3	Cashiers	17,616	20,017	2,401
4	Food Prep, Serving Workers, Including Fast Food	10,726	13,000	2,274
5	**Social and Human Service Assistants**	3,249	5,295	2,046
6	**Home Health Aides**	4,991	7,018	2,027
7	General and Operations Managers	11,288	12,918	1,630
8	Waiters and Waitresses	10,121	11,707	1,586
9	First-Line Supervisors/Mngrs of Retail Sales Workers	9,519	10,950	1,431
10	Retail Salespersons	19,240	20,669	1,429
11	**Nursing Aides, Orderlies, and Attendants**	9,061	10,482	1,421

Source: Maine Department of Labor, Labor Market Information Services

Low Wages

The relatively low compensation for these direct care jobs often makes them uncompetitive with other service industry jobs, particularly given the difficult nature of the work and the added pressures brought on by understaffing. The median hourly wage for personal and home care aides in 2005 ($8.58), for example, was about 110% of the federal poverty level wage for a family of three ($7.74). By contrast, an estimated "livable" wage in Maine, which would actually cover the costs of child care, transportation, housing, and health care for a family with one parent and two children, has been estimated at $18.15/hour in 2004.[6]

Median wages in direct care occupations have also not kept pace with inflation. Personal and home care aides saw a 6% decline in the real value of their wages from 2001 - 2005 and social and human service assistants a 12% decline. Meanwhile, food prep and retail sales workers saw median wage increases of over 6%, which is more reflective of Maine's overall economic growth for this period (Table 2).

Table 2: Direct Care Worker Median Wages from 2001 to 2005

	2001 Median	2005 Median	% Change from 2001-2005 (inflation adjusted)
Nurses Aides, Orderlies, Attendants	$9.35	$10.08	-2.3%
Home Health Aides	$8.43	$9.61	3.3%
Personal and Home Care Aides	$8.28	$8.58	-6.1%
Social Service Assistants	$11.04	$10.76	-11.7%
Food Preparation	$6.93	$8.75	14.4%
Retail sales	$8.41	$9.84	6.0%

Source: Maine Center for Economic Policy analysis using U.S. Bureau of Labor Statistics data and the CPI calculator at http://minneapolisfed.org/research/data/us/calc/

A regional comparison indicates that Maine's median wages for direct care workers are less than those of other New England states in all occupational categories. Additionally, in most other New England states, median wages for personal and home care aides are higher than they are for retail sales and food prep workers, making these high-demand jobs more competitive than they are in Maine (Table 3).

Table 3: New England Regional Comparison of Direct Care and Other Hourly Wages, 2005

	Maine	Vermont	New Hamp.	Mass.	Rhode Island	Conn.
Human and Social Service Assistants	$10.76	$12.87	$10.81	$13.26	$12.30	$17.94
Nurses Aides, Orderlies, Attendants	$10.08	$10.28	$12.03	$12.51	$12.06	$13.03
Home Health Aides	$9.61	N/A	$10.41	$11.16	$10.88	$11.87
Personal and Home Care Aides	$8.58	$9.63	$9.33	$10.46	$10.34	$9.55
Food Preparation	$8.75	$8.77	$8.93	$9.45	$8.57	$9.92
Retail Sales	$9.84	$10.30	$9.70	$9.83	$9.94	$10.46

Source: U.S. Bureau of Labor Statistics; N/A = not available

Cost of Turnover

The cost of turnover for providers is also a financial drain. One study estimates that direct costs for turnover are around $2,500 each time a direct care worker position is vacated and must be refilled.[7] Constant turnover impacts quality of care and drives up the cost of long-term care.

Lack of Health Benefits

National worker surveys have indicated that as many as one out of four nursing home workers and two out of five home care workers lack health insurance coverage.[8] Nearly 10% of all nursing home aides and more than 11% of all home health care aides rely on Medicaid to provide health insurance as compared to 3.9% of all workers in the U.S.[9] While nursing home and residential care facilities generally offer health insurance to frontline direct care workers, some of these workers cannot participate because their premium co-payments are too high given their income. Home care agencies generally do not offer health insurance at all, in part because home care is set up as a system of per diem workers who do not have guaranteed hours, and therefore, do not have paid time off or other benefits.

Recruitment and Retention

A recent comprehensive study[10] cited a growing body of empirical evidence indicating that adequate wages and affordable and accessible health insurance play

a critical role in recruiting and retaining a competent and stable direct-care workforce.[11] The author states that, "A negative correlation is consistently found between higher wages and job turnover and a positive correlation between employer-provided health insurance benefits and average tenure (retention).[12] Before and after studies of actual interventions that have improved wages and benefits for direct-care workers have found that investments in better compensation have reduced turnover and increased retention.[13] Some research also suggests that, for direct-care workers, health insurance is even more important than wages in reducing turnover.[14]

Maine's CNA Registry

Maine's CNA registry, mandated by federal law, has been in operation since 1989. A small directory staff within DHHS keeps a database of all registered CNAs in Maine, including training, employment history, and a listing of substantiated complaints for abuse, neglect, or misappropriation of property in a health care setting. Criminal history record checks on all registrants are conducted by the registry about every two years through the State Bureau of Identification (SBI). Provider agencies contact the registry to get this information, although most also request and pay for their own criminal history records checks through SBI to provide more up-to-date information. No other direct care workers are tracked on this registry.

The direct care workforce has changed considerably since 1989. As a result, some states have expanded their CNA registries to include unlicensed direct care workers, (e.g. personal attendants and homemakers). Other systems for conducting criminal history records checks for these workers exist and some states have increased access for registry users by improving Internet and telephone services. Some have added features that help connect workers with consumers and provider agencies to promote recruitment. It is time for Maine to reevaluate its current CNA registry and consider improvements to enhance consumer safety, cost efficiency, and workforce adequacy. [See Section 7 of this report]

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State Reimbursement to Long-term Care Settings

Key Points

Legislative Charge:

*Examine the…**reimbursement** structures for direct care workers in all long-term care settings, including, but not limited to, nursing facilities, residential care facilities, mental retardation waiver homes and home care…(Chapter 194)*

Findings:

- There are no standardized cost-of-living increases in any long-term care provider reimbursement rates.
- The fee-for-service reimbursement in home care has created a situation in which direct care workers generally must work per diem, with no guaranteed hours. Also as a result of the reimbursement structure, home care providers are generally unable to afford paid time off or health benefits for their direct care workers if they serve a predominantly MaineCare-funded population.
- Consumer-directed workers paid through Alpha One have one legislated wage rate. In 2006, they received their first hourly wage increase in eight years – from $7.71 to $9.00 per hour, and there is a legislative effort underway to raise their wages to $10.00 in 2007.

Table 4 shows a basic summary of the differences in MaineCare reimbursement rate setting across long-term care setting. Brief narrative descriptions follow.

Table 4: Maine State Reimbursement Structure in Long-term Care Settings

	Nursing homes/res care/assisted living	**MR waiver programs & community care**	**Consumer-directed care**	**Traditional home care**	**Homemaker**
Scope of work	Assist with activities of daily living and some health maint. e.g. range of motion, exercise, feeding. CNAs deliver personal care	Direct assistance w/daily living and self-management activities, teaching personal development , promoting well-being	Assist with activities of daily living (ADL), instrumental activities of daily living (IADLs), and health maintenance activities	Personal care delivered by PSS or CNA - Assist with ADL & IADLs and health maintenance activities	Routine housework, grocery shopping, laundry
Training & credentials	At least 150 hours of training and certified as a CNA	DHHS competency based training	Trained by consumer	50 hours of training using DHHS curriculum	Trained by agency; majority have completed 50 hour DHHS curriculum
Type of reimburse-ment	Cost reimbursed	Fee for service	Fee for service	Fee for service	Fee for service
Hourly rate of reimburse-ment	Direct care component of cost reimbursed formula	AVG $24.00/hour up to $43.25	$10.44/ hour reimbursement	$14.98 /hour	$17.00/hour
Reimb. for taxes, benefits & workers comp	Taxes, health insurance & worker's comp	Taxes, health insurance & worker's comp	Taxes & worker's comp	Taxes & worker's comp	Taxes & worker's comp
Program related reimb.	Separate amount incorporated as line item in rate calculations	Separate amount incorporated as line item in rate calculations	NO	Included in reimbursement rate YES	Included in reimbursement rate YES
Agency admin. reimb.	Separate amount incorporated as line item in rate calculations	Separate amount incorporated as line item in rate calculations	NO	Included in reimbursement rate	Included in reimbursement rate
Median direct care wages, 2005	$10.08	$10.76	$9.00	$8.58	$8.58

* Program costs include items such as training, employee travel, universal precaution items (gloves, etc)

** Administration costs include human resource costs, payroll costs; MR reimbursement includes a percentage for employee costs that includes mandated fringe costs and health insurance.

The ways in which Maine pays for long term care services through MaineCare and state-funded programs impact providers' ability to pay direct care workers competitive wages and affordable health benefits. There are no standardized cost-of-living increases in any long-term care provider reimbursement rates.

Nursing Homes, Residential Care and Assisted Living

The payment rate for nursing facilities is based on costs incurred in a specified base year, (currently 1998). Inflation adjustments are determined by DHHS.[15] Allowable costs are categorized as direct, routine, and fixed costs[16] and there are certain expenditure ceilings per cost category.[17]

The system takes into account that some residents are more costly to care for than others. Reimbursement for direct care costs is based on a classification system that groups residents according to their functional capacity and the resources required to care for them. This is the facility's "case mix."

DHHS determines an upper limit cost per day for three "peer groups" of facilities (hospital based facilities, non-hospital based facilities with less than or equal to 60 beds, and non-hospital facilities with greater than 60 beds). The upper limit cost is a percentage (varying by peer group) above the median of the base year mix adjusted cost. Each facility's direct care rate is the lesser of the limit, or the facility's base year adjusted cost per day, all based on case mix. If there are less direct care costs at the time of audit, the facility is required to reimburse DHHS for the difference.

Residential care facility reimbursement works similarly to nursing facilities as of 2001, and is based on case mix and a base year (1998). However, residential care's direct component is based on a case mix adjusted price that is not settled at audit. Personal care services have been added for these facilities, including dietary and housekeeping services, which were previously considered part of routine costs. Inflation adjustments for residential care are determined by DHHS.

Home Care

Home care providers are reimbursed under Medicaid and the General Fund on a fee-for-service basis. The fee-for-service reimbursement in home care has created a situation in which direct care workers generally must work per diem, with no guaranteed hours. Also as a result of the reimbursement structure, home care providers are generally unable to afford paid time off or health benefits for their direct care workers if they serve a predominantly MaineCare-funded population.

Table 4 shows the 2006 provider reimbursement rates. Agencies are reimbursed per hour of time in the home, based on a standard assessment of the number of hours of service a client needs. The administrative and capital costs must be subsumed

within that direct care hourly rate, so wage rates are generally much lower than the reimbursement rate.

Currently, the rate for PCAs is $14.98 per hour and $17.00 for homemakers. The homemaker rate is higher because homemaker services have additional administrative and training requirements. Medicare-covered home health aide services are paid as part of an all-inclusive payment that covers a 60-day episode of care. This payment, based upon patient acuity, covers all in home services and medical suppliers related to the plan of care.

Consumer-directed workers paid through Alpha One have one legislated wage rate. In 2006, they received their first hourly wage increase in 8 years – from $7.71 to $9.00 per hour.

MR Waiver Programs

The mental retardation waiver program is a negotiated rate system based on individual needs for services. The system is grounded in person-centered planning and annual budget allotments. DHHS has adopted rules that describe allowable costs for this program. The payment system is in the design stage of a fee-for-service, published rate system, established by the federal Centers for Medicare and Medicaid Services that is scheduled to go into effect on July 1, 2007.

3

Maine's Direct Care Workforce Wage Structure

Key Points

Legislative Charge:

*Examine the **wage**…structures for direct care workers in all long-term care settings, including, but not limited to, nursing facilities, residential care facilities, mental retardation waiver homes and home care... (Chapter 194)*

Perform a survey… to determine the wages paid to personal care assistants across the state. The survey must include all programs for which funds are provided by the state (Chapter 191)

Findings:

- The average median wage across direct care occupations in 2005 was $9.75 per hour.
- There appears to be a hierarchy of direct care worker wages across long-term care settings. Earning less than a median of $10.00 per hour are:
  - 34% of direct support professionals in mental retardation (MR) waiver homes.
  - 48% of the CNAs working in facility-based care.
  - 58% of home health aides.
  - 77% of personal care attendants in home care.
- A survey performed by the Maine Center for Economic Policy found that median wages in southern and coastal Maine tend to be higher than in central or rim counties.

This section includes an analysis of Maine Department of Labor occupational wage data to determine the basic wage structure of the direct care workforce. (See detailed methodology in Appendix E.) Further data on wage structure are provided from a survey of direct care workers in four Maine long-term care settings conducted for this study. (See detailed methodology in Appendix G.)

DOL Occupational Wage Data Analysis

The Maine Department of Labor collects occupational wage data through an annual employer survey. These data are collected using Standard Occupational Classifications (SOC) established for use across the states. Using survey data and standardized statistical methods, estimates are made for the number of workers employed and the wage distribution in each occupation.

Four classifications were selected that are most likely to represent the direct care workforce: Human and Social Service Assistants; Nurses Aides, Orderlies and Attendants; Home Health Aides; and Personal and Home Care Aides. As shown in Table 5, Human and Social Service Assistants, which tend to be those working in residential settings for adults and children with developmental disabilities, have the highest median hourly wage at $10.76. Nursing Aides, Orderlies and Attendants are the classification with the highest number of workers – over 9,000 in 2005 – and tend to work in nursing homes, hospitals, and other residential settings. They have a median hourly wage of $10.08. Home Health Aides are CNAs working in home care settings under the direction of a registered nurse and have a median hourly wage of $9.61. Personal and Home Care Aides generally assist with activities of daily living and do minimal or no medical care. They have a median hourly wage of $8.58. The average of these four median wages is $9.75 per hour.

A statistical filter was used to estimate the number of workers making less than $8.50 and $10.00 per hour – the two wage floors proposed by the study. Similar to the wage differentials cited above, there was a range of workers making below $10.00/hour:

- One out of three (34%) Human and Social Service Assistants (mostly direct support professionals)
- One half (48%) of the Nurses Aides, Orderlies and Attendants (mostly CNAs in facility-based care)
- Over half (58%) of the Home Health Aides.
- Three-quarters (77%) of the Personal and Home Care Aides.

Table 5: Maine Direct Care Workers Above and Below the Proposed Wage Floors, 2005

	No. Workers	Mean Hourly Wage	Median Hourly Wage	Pct. Earning < $8.50	Pct. Earning < $10
Human and Social Service Assistants	4,680	$11.20	$10.76	10%	34%
Nurses Aides, Orderlies, Attendants	9,080	$10.27	$10.08	17%	48%
Home Health Aides	3,830	$9.81	$9.61	27%	58%
Personal and Home Care Aides	4,760	$8.75	$8.58	48%	77%

Source: U.S. Bureau of Labor Statistics; DOL analysis

Maine Direct Care Worker Survey Data

In addition to the occupational wage data, a survey of direct care workers in four settings was conducted by the Maine Center for Economic Policy with the assistance of individual employers and industry trade associations to check current wage rates and health insurance status. Because of the method of data collection, these data may not be generalized to the full population of direct care workers and the results cannot be combined to make an aggregate estimate of all direct care workers' wages in Maine.

The four settings are home care under the state's home and community based waiver, the consumer-directed waiver program for adults with disabilities, mental retardation (MR) waiver programs, and nursing home/residential care/assisted living facilities. They encompass the major categories of direct care workers, including CNAs, direct support professionals, personal support specialists/personal care attendants in home care, and personal assistants. Each of these settings is either entirely or largely funded by MaineCare and state-funded programs. (See Appendix G for survey methodology and further descriptions of these settings.)

As shown in Table 6, the median wage was $9.00 for the two home care settings, $9.59 for direct support professionals in MR waiver programs and $10.23 for the direct care workers in nursing homes, assisted living and residential care facilities. These wages are slightly higher than those reported in the occupational wage data, perhaps because they are more current data or because the surveys are biased upward by higher-paying employers who chose to participate in the survey.

Table 6: Direct Care Worker Wages in Some Maine Long-term Care Settings, 2006

	Alpha One/ Consumer-Directed N = 190	Home Care for ME N = 205	MR Waiver N = 589	Nursing Homes/Res Care/Assisted Living N= 155
Median Hours Worked/Week	28	20	36	40
Wages ($)				
Median	$9.00	$9.00	$9.95	$10.23
Min	$6.00	$6.75	$6.25	$7.00
Max	$18.00	$11.50	$18.75	$16.28
Median Wages by Region*				
South/Coastal Counties	$9.00	$9.28	$10.15	$11.59
Central Counties	$9.00	$8.76	$9.50	$10.09
Rim Counties	$9.00	$8.99	$9.50	$9.87

Source: Maine Center for Economic Policy Direct Care Worker Survey

* South/Coastal: York, Cumberland, Sagadahoc, Lincoln, Knox, Waldo, Hancock; Central: Androscoggin, Kennebec, Penobscot; Rim: Somerset, Oxford, Franklin, Piscataquis, Aroostook, Washington

There were workers making $7.00 or less in each setting. Since Maine's minimum wage at the time of the survey was $6.75 per hour, it is possible that the workers reporting wages lower than the minimum were not clear about their wage rate. It is also the case that 169 of the 190 Alpha One workers reported a wage of $9.00, coinciding with their legislated wage that was increased to $9.00 (from $7.71) as of October 2006. Those making more than $9.00 in the Alpha One sample likely represent workers employed by a few consumers who are able to supplement workers' wages.[18]

A regional analysis of wages (also in Table 6), using the State Planning Office designation of three Maine regions, indicates that the median wage in southern and coastal Maine (except at Alpha One) is noticeably higher than in central or rim counties. At Home Care for ME, the median is 3% higher than in the more rural rim counties; in MR waiver programs, it is 7% higher and in nursing homes and residential care facilities it is 17% higher.

4

The State Cost of Raising Direct Care Wages

Key Points

Legislative Charge:

Determine the cost of a wage floor of $8.50 per hour and the cost of a wage floor of $10 per hour for entry-level direct care workers, including certified nursing assistants, personal support specialists, home health aides, homemakers and direct support professionals. The study must include determination of the cost of proportional increases in current wage scales for more experienced workers and employer-related costs such as FICA. (Chapter 194)

Findings:

- It is estimated that it will cost the state $3 million to raise to $8.50 per hour all direct care workers' wages in MaineCare and state funded long-term care programs. This cost rises to $6 million to reach $10.00 per hour. This includes the state share of MaineCare and state-only funded programs, and does not include the federal MaineCare match.
- These estimates include a 2% increase for workers currently making above these two wage floors, plus associated employer cost increases in FICA, unemployment insurance, and workers compensation.
- With 2.5% escalating annual cost-of-living increases, in five years it would cost $3.3 million for the $8.50 wage floor, and $6.6 million for the $10.00 wage floor.

This section briefly summarizes the methodology developed to estimate the cost of raising all of Maine's direct care workers up to two wage floors—$8.50 and $10.00—as well as the results (See Appendix F for detailed methodology).

Methodology

DHHS Office of Elder Services and the Muskie School of Public Service provided the Maine Department of Labor with a list of MaineCare and state-funded agencies who employ direct care workers. This list was crosschecked with the DOL Occupational Employment Statistics (OES) data, a biennial survey of a representative sample of Maine employers that are covered by the Maine Employment Security Law. The agencies that matched included approximately 5,424 direct care workers (certain employers were omitted for reasons explained in Appendix F). The wage ranges for these workers are shown in Table 7. All four occupations were totaled and the proportion of workers in each range was calculated: 3.2% of direct-care workers were earning less than $6.75 per hour; 18.3% were earning between $6.75 and $8.49; 52.4% were earning between $8.50 and $10.74 and so on.

Table 7: Direct Care Workers' Wages in Surveyed MaineCare and State-funded Long-term Care Agencies (n = 5,424)

	< $6.75	**$6.75 - $8.49**	**$8.50 – $10.74**	**$10.75 – $13.49**	**$13.50 – $16.99**	**$17.00 – $21.49**	**$21.50 – $27.24**
Social & Human Service Assistants	62	173	1,024	422	213	20	2
Nursing Aides, Orderlies, & Attendants	42	171	702	354	79	0	0
Personal & Home Care Aides	42	434	612	127	13	0	0
Home Health Aides	28	215	505	168	16	0	0
Total in Each Wage Range	174	993	2,843	1,071	321	20	2
Percent of Total in Each Wage Range	3.2%	18.3%	52.4%	19.7%	5.9%	0.4%	0.0%
Midpoint Hourly Wage	$6.55	$7.63	$9.62	$12.12	$15.25	$19.25	$24.37

Source: Maine Department of Labor and Maine Department of Health and Human Services

In addition to current employee numbers and wage ranges, an estimate of how many hours direct care workers are actually employed is needed in order to quantify the cost of their current and potentially increased wages. MaineCare and state-funded program service units were used as a proxy for workers' hours.

DHHS Office of Elder Services and the Muskie School of Public Service compiled data on service units corresponding to services provided by direct care workers for the period 2/1/05 to 1/31/06 (paid by July 2006). These units were converted to hours in two categories – Community Care (4,031,321 hours) and Facility-based Care (10,881,605 hours), for a total of 14,912,926 hours of service provided by direct care workers in the MaineCare and state funded programs in that 12-month period.

For Community Care, the percent of total workers in the relevant wage ranges was then applied to the total number of hours of this service (the proxy for hours worked), giving total number of hours worked in each pay range. For Facility-based Care, only the percent of nurse aides against total nurses aides was applied to the total number of hours of facility-based service. Multiplying the total number of hours worked in each pay range by the difference between the midpoint of each range and the $8.50 and $10 wage floors provides an estimate of the cost of bringing all state and MaineCare funded workers up to the two wage floors. (See Tables 17 and 20 in Appendix F).

Next, a 2% increase was added for all workers already earning above the midpoint hourly wage. This is a modest but important addition because creating too much wage compression can be a disincentive for those workers who already earn more than the new wage floors. In fact, providing only a 2% increase may result in a greater shortage in direct care occupations requiring more training, such as CNAs, if their wages do not rise accordingly. This has already been indicated in declining enrollment in CNA training over the last few years.[19]

These costs were adjusted by the 2007 federal Medicaid matching rate for Maine and prorated to reflect a 58/42 split between state-only and MaineCare funded services. This provided the state portion of the costs.

As wages increase, there are mandatory employer-related costs that rise proportionately. To incorporate these costs, the totals were multiplied by the employer Social Security rate (7.65%), the 2007 average Unemployment Insurance contribution rate for the long-term care and home heath care industries (1.71%), and a Workers Compensation rate (6.64%). Finally, these total costs were projected over five years with a 2.5% escalated annual rate of increase (Table 8).

Table 8: Five-year 2.5% Escalating Wage Cost (State Share)

	Community Care		Facility-based Care		Total	
	$8.50 Wage Floor	**$10.00 Wage Floor**	**$8.50 Wage Floor**	**$10.00 Wage Floor**	**$8.50 Wage Floor**	**$10.00 Wage Floor**
Year 1	$1,339,786	$2,785,579	$1,635,911	$3,187,750	$2,975,698	$5,973,329
Year 2	$1,373,281	$2,855,219	$1,676,809	$3,267,443	$3,050,090	$6,122,662
Year 3	$1,407,613	$2,926,599	$1,718,729	$3,349,129	$3,126,342	$6,275,729
Year 4	$1,442,803	$2,999,764	$1,761,698	$3,432,858	$3,204,501	$6,432,622
Year 5	$1,478,873	$3,074,758	$1,805,740	$3,518,679	$3,284,613	$6,593,437

Source: Maine Department of Labor and Maine Department of Health and Human Services

Estimated Cost of Increasing Wages

Thus, it is estimated to cost the state approximately $3 million in the first year to raise wages for all direct care workers in MaineCare and state-funded programs to $8.50 with the additional 2% for workers above the floor and associated employer costs. This rises to around $6 million for a wage floor of $10.00. At five years, the $8.50 wage floor costs about $3.3 million and the $10 wage floor costs about $6.6 million.

5

Health Insurance Status of Maine's Direct Care Workers

Key Points

Legislative Charge:

*Examine the … **benefit** … structures for direct care workers in all long-term care settings, including, but not limited to, nursing facilities, residential care facilities, mental retardation waiver homes and home care. (Chapter 194)*

Findings: (based on survey of workers in 4 settings)

- The large majority of direct care workers in facility-based agencies are offered health insurance by their employers: 92% of mental retardation waiver programs and 93% of nursing homes and residential care and assisted living facilities. Neither of the two surveyed home care providers--Alpha One or Home Care for ME—offers their direct care workers health insurance.

- Among those surveyed, the following were uninsured:
  - 10% of workers in MR waiver programs.
  - 16% of workers in nursing/residential care facilities.
  - 32% of Alpha One workers.
  - 34% of Home Care for ME workers.

- Many of the surveyed workers were on MaineCare:
  - 8% of workers in MR waiver programs.
  - 13% in nursing homes and residential care facilities.
  - 26% Alpha One consumer-directed workers.
  - 18% of Home Care for ME direct care workers.

- Nearly one in ten of the surveyed direct care workers who were offered health coverage in nursing/residential care facilities declined the coverage and remained uninsured because they cannot afford the premium co-payments.

This section describes the results of a survey of direct care workers in four settings conducted by the Maine Center for Economic Policy with the assistance of individual employers and industry trade associations to further verify wage rates and health insurance status. Because of the method of collecting these data, they may not be generalized to the full population of direct care workers and the results cannot be combined to make an aggregate estimate of all direct care workers' health insurance status.

Four Settings

The four settings are home care under the state's home and community based waiver, consumer-directed waiver program for adults with disabilities, mental retardation (MR) waiver programs, and nursing home/residential care/assisted living facilities. They encompass the major categories of direct care workers, including CNAs, direct support professionals, personal support specialists/personal care attendants in home care, and personal assistants. Each of these settings is either entirely or largely funded by MaineCare and state-funded programs. (See Appendix G for sample methodology and further descriptions of these settings.)

Demographics

Table 9 shows basic demographics about the workers in each setting. The direct care workers at Home Care for ME and in nursing homes and residential care facilities were nearly all women -- 96% and 95% respectively. Alpha One and MR waiver program direct care workers had a slightly lower proportion of women at 80% and 82% respectively. The median age was around 50 in the two home care settings and around 40 in residential care. When asked about their health status, one in five home care workers in both settings said their health was only fair while closer to one in ten in residential settings said their health was only fair. This differential in health status may be due to age.

Table 9: Demographics of Maine Direct Care Worker Survey Respondents

	Alpha One/ Consumer-Directed (n=199)	**Home Care for ME (n=220)**	**MR Waiver (n=630)**	**Nursing Homes/Res Care/Assisted Living (n=166)**
Gender/Female	80%	96%	82%	95%
Median Age	46	52	39	42
Self-Reported Health Status				
Excellent	26%	19%	25%	21%
Good	52%	63%	62%	68%
Fair	20%	18%	13%	10%
Poor	2%	0%	1%	1%

Source: Survey conducted by the Maine Center for Economic Policy

Health Insurance Status

Table 10 indicates a variation in direct care workers' health insurance status across these settings. Two settings do not offer health insurance to their workers: consumer-directed through Alpha One and Home Care for ME, Thus, the few workers in each of these settings that reported getting health insurance from their direct care employer were also working for some other employer. Among Alpha One workers, over one quarter of the workers were on MaineCare, one in eight were on Medicare, and one in three were uninsured. Nearly one in five workers at Home Care for ME was on MaineCare, one out of ten was on Medicare and one in three was uninsured.

In the MR waiver programs, two-thirds of the direct support professionals were insured by their direct care employer. One out of twelve was on MaineCare and nearly one out of ten was uninsured. In nursing homes, residential care and assisted living facilities about half of the direct care workers were insured by the facility. One out of eight was on MaineCare and one out of six was uninsured.

Table 10: Health Insurance Status among Direct Care Workers in Some Maine Long-Term Care Settings, 2006

	Alpha One/ Consumer-directed n = 199	Home Care for ME n = 220	MR Waiver Programs n = 630	Nursing Homes/Res Care/Assisted Living n= 166
Health Insurance Status				
Uninsured	31.5%	34.4%	9.8%	15.7%
Direct Care Employer*	1.0%	1.4%	64.8%	53.0%
Other Employer	12.5%	2.8%	2.4%	.6%
MaineCare	26.0%	18.3%	8.1%	12.7%
Medicare	13.0%	9.2%	1.1%	1.2%
Military	2.0%	.9%	.8%	1.2%
Spouse's Health Plan	9.0%	27.0%	10.8%	12.7%
Privately Purchased Plan	3.5%	2.3%	.8%	1.8%
Other	1.5%	3.7%	1.4%	1.1%
	100%	100%	100%	100%

Source: Survey conducted by the Maine Center for Economic Policy
* May be a direct care employer other than the agency distributing the survey.

Table 11 shows the co-payments for employee health insurance. About half of the MR waiver programs offer employee health insurance with no premium co-pays, while only 18% of nursing and residential care facilities do so. Copay rates run as high as $568 per month in the MR waiver homes and $317 in nursing and residential care facilities. About 9% of those direct care workers in nursing homes and residential care facilities who decline coverage do so because they can't afford the premium copayments and remain uninsured.

Table 11: Premium Co-pays for Employee Health Insurance among Direct Care Workers in Two Long-term Care Settings

	MR Waiver Programs	Nursing Homes/Res Care/Assisted Living
% working in agencies offering coverage to direct care workers	92%	93%
% with no premium co-payment	49%	18%
Median monthly co-pay (for those who pay)	$73	$95
Min/Max monthly co-pay	$20/$568	$26/$317
% who decline coverage and are uninsured because they can't afford the co-payment	3%	9%

Source: Survey conducted by the Maine Center for Economic Policy

Table 12 shows that 85% of these workers in MR waiver programs were offered insurance for their families. However, of the 241 workers whose families were not covered elsewhere or were single with no dependents, only 41 participated in the family coverage. The other 200 could not afford the co-payments. Ninety-two percent of the workers in nursing home and other residential facilities were offered health coverage for their families. Of the 66 whose families were not covered elsewhere or were single with no dependents, only 23 took up the coverage and the rest could not afford the co-payments.

Table 12: Family Health Insurance Take-up Rates among Direct Care Workers in Two Long-term Care Settings

	MR Waiver Programs	Nursing Homes/Res Care/Assisted Living
% working in agencies offering coverage to direct care workers' families	85%	92%
Take-up rate for family coverage	**(n=546)**	**(n=149)**
%/No. who take up family coverage	8% (41)	15% (23)
%/No. who decline because they would pay the full premium	19% (106)	9% (14)
%/No. who decline because they can't afford the co-pay	17% (94)	20% (29)
%/No. whose families are covered elsewhere	26% (140)	31% (46)
%/No. single with no dependents	30% (165)	25% (37)

Source: Survey conducted by the Maine Center for Economic Policy

6

Health Benefit Options for Direct Care Workers

Key Points

Legislative Charge:

Develop options to extend MaineCare or other health insurance coverage for direct care workers. (Chapter 194)

Findings: Based on a national review of states' efforts to insure direct care workers, the following options are suggested:

Discounted Employer-Sponsored Programs

- Offer DirigoChoice for MaineCare providers with over 50 workers.
- Offer a part-time employee pool in DirigoChoice for employers of part-time workers.
- Extend the state employee health benefit plan to employers who receive MaineCare funds.
- Form a new administrator/program plan for MaineCare service providers with low-income worker discounts.

State-Sponsored Individual Plans

- Target direct care workers in the DirigoChoice individual program.
- Establish a select group plan in DirigoChoice for direct care workers employed by MaineCare providers.
- Extend the state employee health benefit plan to individual direct care workers employed by MaineCare registered providers and provide discounts.
- Expand MaineCare eligibility guidelines to cover all individuals employed as direct care workers.

This section of the report summarizes research[20] collected by the study group to identify state approaches for insuring direct care workers and offers options for Maine. As indicated by the data in the health insurance survey described above, significant numbers of direct care workers who provide health care and personal assistance to elderly and disabled citizens are not insured themselves. In every state this issue is becoming more prominent. In fact, Maine was one of five recipients of a multi-year grant from the Centers for Medicare and Medicaid Services to increase health insurance coverage among direct care workers.[21]

Research across the country has shown that workers' access to affordable health insurance benefits can improve recruitment and retention of direct care workers, thereby improving overall quality of care. Maine's goal of universal access to health coverage for all must also address the particular circumstances of this workforce.

Types of Health Care Coverage

In general, there are three sources of health insurance coverage in the United States:

Publicly funded plans/programs for individuals based on age and/or income level, including Medicare, Medicaid (including State Children's Health Insurance Programs [SCHIP] for children and some parents), and state or county subsidized and/or operated health systems and coverage plans.

Employer-sponsored insurance plans with purchase options for employees, which are generally purchased through the private insurance market. Some states have limited options for discounts/subsidies, such as Maine's DirigoChoice for low income employees in small businesses.

Individual plans which are generally purchased through the private insurance market. There are also tax credits available for premiums and uncovered medical expenses, with some states offering subsidies/discounts for qualified individuals, generally based on low income, such as Maine's Dirigo Health for individuals, which has capped enrollment.

Sector Specific Characteristics in Long-Term Care

To increase access to health coverage, specific characteristics of direct care workers and their employers must be taken into account. There are several employer types, including agency-based home care, consumer-directed home care, nursing homes, residential and assisted living facilities, and MR waiver programs. There are variations in agency size. For example, there are home care providers with as few as 2-3 employees and home care agencies offering statewide coverage with 400 or more employees. There are also differences in sources of agency funding, predominantly MaineCare, Medicare, and private pay, with many agencies having a mix.

Direct care workers also have a range of circumstances, depending on where they work. Workers in nursing homes, residential care facilities, and MR waiver programs tend to work full-time and are offered health coverage, although not all can afford the premium copayments. Home care workers tend to be employed on a part-time, per diem basis, without guaranteed hours, and most are offered no employer-based

coverage. Many workers are MaineCare eligible, but others are just above the eligibility threshold, without enough income to afford privately purchased health coverage. Some direct care workers are over 65 and eligible for Medicare.

Coverage Options across the States

Across the states, it appears that the three general program options best targeted for direct care workers are a discounted employer-sponsored program, a discounted individual program, or a combination of the two. Table 13 shows multiple examples of such models, which are described in more detail below.

Table 13: Options for Increasing Health Coverage among Direct Care Workers

A. Discounted Employer Products
A1. Shared premiums
"Third Share Plans"
State premium subsidies
Discounted employer products ▪ Dirigo Choice ▪ Access to state employee health plan ▪ Purchasing pools
A2. State/private jointly-administered health funds
Pooled funds
Professional employer organization
Reinsurance
B. State Sponsored Individual Plans
State employee health plan buy-in
Expansion of public coverage
Discounted plans to low-income individuals

A. Discounted Employer Products

Discounted employer-sponsored programs offer assistance and/or incentives from public funding sources to individual provider agencies, or offer eligibility for participation in a very large group plan in order to provide coverage benefits that are affordable to the business and all of their employees, including part-time employees.

A1. Shared Premiums

"Third Share Plan": This option is a public/private partnership model, providing access to care in communities through a local provider network. It is called "third share" because premiums are divided three ways—the employer pays a third, the employee pays a third, and a third-party (usually a governmental entity) pays the rest. This is being implemented in states such as Florida, Michigan, West Virginia, Texas, Ohio, and North Carolina.

State premium subsidies for workers or employers: States choose to subsidize selected workers' or employers' premiums for private employer-sponsored plans rather than enrolling low-income workers into public insurance programs. Premium subsidies can be provided through Medicaid or through a state-only program. There are 14 states with such programs, for example Maine's Dirigo Health Plan, Rhode Island's RIteCare program[22] for child care providers, and Pennsylvania's Adult Basic Coverage.[23]

Discounted employer products: There are several examples of state-funded discounts for employer-based plans. The employer discounts are funded directly through publicly funded payments, the savings based on participation in a group purchasing pool, or indirectly through savings from central administration of the program.

DirigoChoice: In Maine's case, the employer premium is not discounted, but the Dirigo Health Agency -- a public-private partnership -- works to keep the cost and product competitive.

Access to state employee health benefit plan: In Utah, employers that provide services for state and federally funded programs may offer their employees access to enrollment in the state employees' health benefit plan.

Purchasing pools: Small businesses or organized workforce groups establish a private or public purchasing coalition. California, Oregon and Washington have organized public authorities that pool consumer-directed home care workers and serve as purchasing agents. Two successful public pools are the Federal Employees Health Benefit Plan and CalPERS, the plan for California public employees. These groups are successful because of their large size, which allows them to diminish adverse selection, recruit many health plans, and use market share to influence the levels of services they provide.[24]

A2. State/Private Jointly-Administered Health Funds

Pooled funds: Such models exist in private industry sectors such as building/ construction, janitorial, nursing home, food and food service, entertainment and trucking. This model offers advantages such as portability for workers across the sector, administrative efficiencies, and a predictable cost per hour contribution rate set across either the region or sector. Forty-four home attendant agencies in New York City collaborate with SEIU 1199NY. Each contributes a negotiated cents-per-hour into the 1199 National Benefit Fund, a Taft-Hartley fund,[25] covering 39,000 home care workers, 15,500 spouses and 22,500 children.

Professional employer organization: This is a pilot program in Milwaukee, Wisconsin whereby the Wisconsin Regional Training Partnership is serving as a vehicle for providing health insurance to direct care workers and other worker employment support functions. This model is also under consideration by the southwest Pennsylvania Regional Collaborative Direct Care Workforce Center.

Reinsurance: In this model, the state covers a portion of private insurers' claims. This "stop-loss" mechanism may cover catastrophic claims above a certain dollar amount or it may cover claims within a designated corridor. Such pilot projects are being implemented for New York City garment workers under the state's Healthy New York Plan for the UNITE HERE labor union's benefit fund.

B. State-Sponsored Individual Plans

Some states are targeting plans to individuals or worker groups.

State employee health plan buy-in: In Connecticut, legislation allowed members of the personal assistant worker association to purchase benefits through the state health benefit plan. No discounts are offered.

Expansion of public coverage: Some states have created a new categorical eligibility group for Medicaid coverage for a specific workforce group, based on income guidelines. This has been done in Pennsylvania's Adult Basic Coverage and for Rhode Island's child care workers.

Discounted plans to low-income individuals: Maine's DirigoChoice allows low-income individuals up to 300% of the federal poverty level as well as individuals who meet standard MaineCare household income guidelines to enroll in MaineCare and qualify for discounts on premium and service copayments. Enrollment is not specific to any worker group and annual enrollment caps have been instituted to control costs.

Options to Consider for Maine

Based on this review of state options, the study group identified the following as primary options for Maine policymakers' consideration to increase access to health coverage for currently uninsured direct care workers. The legislative charge for this study (see Appendix A) did not require DHHS to develop cost estimates for various health insurance options for direct care workers. The study group and DHHS were not able develop such estimates, given the limited time and resources for the study.

A. Discounted Employer-Sponsored Programs

A 'Third Share' plan that provides publicly funded discounts for eligible employers and scaled-discount rates for workers, with premium costs being shared three ways, though not necessarily in equal portions. The program must address the unique characteristics of direct care workers (part-time, low-wage, intermittent hours) while requiring employers to share the responsibility for coverage policies and payments. Such a requirement would also require examining and updating reimbursement rates to ensure that employers are able to contribute without sacrificing quality of care.

Offer DirigoChoice for MaineCare providers with over 50 workers to expand employer and worker access to this program. While it may not currently be feasible for all employers to enroll, those who can would thereby enable their workers to receive DirigoChoice discounts.

Offer a part-time employee pool in DirigoChoice for employers of part-time workers, such as those in direct care, construction, tourism, and other small businesses.

Extend the state employee health benefit plan to employers who receive MaineCare funds.

Form a new administrator/program plan for MaineCare service providers with low-income worker discounts.

B. State-Sponsored Individual Plans

Target direct care workers in DirigoChoice by allowing direct care workers to enroll regardless of the enrollment cap.

Establish a select group plan in DirigoChoice for direct care workers employed by MaineCare providers.

Extend state employee health benefit plan to individual direct care workers employed by MaineCare registered providers and offer low-income discounts.

Expand MaineCare eligibility guidelines to cover all individuals employed as direct care workers.

7

A Maine Direct Care Worker Registry

Key Points

Legislative Charge:

Evaluate the need for a direct care worker registry, including desired objectives of such a registry and a cost estimate. (Chapter 194)

Findings:

- Many states are making changes to their federally mandated CNA registries including increasing access to information, adding unlicensed workers, and providing worker recruitment functions.
- Such changes would meet many of the currently unmet needs of Maine long-term care providers and workers.

This section describes a study of options to create a more expansive and effective Maine direct care worker registry that was initiated in May 2006 by the Maine Long Term Care Ombudsman. The effort was intended to build on the current CNA registry's capacity to address consumer safety and long term care quality. This group joined with the legislated study group and the work continued in a Registry Subcommittee. Through the course of monthly meetings the subcommittee reviewed Maine's CNA Registry and registry models in other states, and formulated a vision, objectives, and a proposed three-phase plan for an expanded Maine direct care worker registry to serve Maine's growing demand for safety and efficiency in its long term care services.

Registry Functions and Characteristics

CNA registries were established to meet federal law requiring all states to train and register nurses' aides (Federal Nursing Home Reform Act, Subtitle C of OBRA 1987). This ruling requires the registry to list individuals who have been found competent to function as nurse aides through the successful completion of approved training and testing. The registry also must list individuals barred from serving as nurse's aides due to substantiated claims of abuse, neglect or misappropriation of property in a health care setting. The rule bars states from charging CNAs any fees for being listed on the registry. A CNA in Maine must be listed on the registry to work as a CNA and re-registration is required every two years. Criminal history records checks are conducted about every two years. Employers are required to check the registry prior to hiring a CNA.

A 2004 assessment by the U.S. Department of Health and Human Services[26] found that many states have expanded their registries beyond the original mandate to add other paraprofessionals and/or add additional information to the database. For the purposes of this Maine study, five states' registry officials were interviewed in the fall of 2007 to provide up-to-date information: Illinois, Indiana, Iowa, Kansas and Missouri. (See Appendix I for chart of interview findings)

Across the states, registry functions include:[27]

- Collecting and managing worker information in searchable databases.
- Creating and maintaining lists of workers who have received training or certification.
- Maintaining lists of workers who have problematic criminal backgrounds and substantiated complaints of abuse, neglect or misappropriation of personal property.
- Providing information for employers, workers and consumers about direct care/support activities, trainings, and resources.
- Providing web-based search tools to match worker qualifications with consumer needs.

- Collecting common data on direct care workers.
- Administering training.

The design characteristics of these registries also vary. Here are some of the elements:

- Most are operated or administered by state-based agencies/departments, although eight are outsourced.
- Some states have multiple registries based on the type of worker. Some have separate registries for offenders.
- Most CNA registries are limited to CNAs, but some have expanded to include other direct care paraprofessionals with certified titles and a few have added unlicensed assistive personnel.
- Many states use it as a clearinghouse for criminal history records checks; some actively perform criminal checks. (An Iowa survey[28] of 40 states lists 24 states where employers conduct the checks and 14 where departments within state government perform the checks. A few do not require any checks).
- Access to the registry information ranges from direct calls and mail to registry staff to self-directed Internet and automated phone access to the selected databases.
- A few function as a data source for workforce planning.
- Most are funded by the Centers for Medicare and Medicaid Services (federal) and state funds.

Overall, it appears that most states are making changes to their registries to adjust to the changes in the direct care workforce. For example, there are many more job titles that overlap and/or parallel the CNA; training requirements and standards are changing and may not be addressed by the OBRA 87 rules; the complexity and concern for safeguards against abuse and neglect by care providers is increasing; and, there is a range of technical advances that are available that can link databases and improve information access and efficiencies for employers and consumers of direct care services and registry staff.

The differences across the registries include the administration of criminal history records checks; the level of general information they have on their website, and the level of technical capability of their system to use the Internet as a tool for gathering and dispensing information. Most of the five registries contacted do not conduct the pre-employment criminal history records checks. Instead, the employers conduct the required check prior to hiring and some are asked to report this information back to the registry.

The use of the Internet, and in some states an automated telephone system, is a notable difference across the registries. The more developed systems allow

employers to access and report information directly to the registry database using Social Security and/or certificate number. The employer may also use a state-issued access code, and in Kansas and Iowa the employer access activity is tracked. Most states noted that Internet access has been invaluable, allowing them to manage as many as 80,000 records. Iowa has recently increased their technical capacity for managing more records in anticipation of other worker titles being added, including unlicensed assistive personnel. (Such legislation is pending.)

Maine's CNA Registry

Maine's CNA Registry is intended to help health care facilities (nursing homes and hospitals) hire only CNAs who meet federal and state training and competency requirements. The registry is also required to list any finding by the state survey agency of abuse, neglect or misappropriation of property in a health care setting. In addition to federal mandates, Maine's CNA registry operates under supplemental state law and regulation requirements.

The registry tracks workers' names and other information necessary to identify the individual, their training, and current and historical CNA employment. The registry lists any criminal convictions, except for most Class D and E crimes over 10 years old. Criminal history records checks are currently required as part of the training course and that information is provided to the registry as part of the registration process. To the extent funding allows, the registry updates the individual's criminal history records check at the time of re-registration.

Employers are required to check the registry prior to hiring a CNA. Employers in some health care settings are also required to check the registry prior to hiring an individual to work as a PCA. Federal and state law and regulation govern whether an individual may work as a CNA or a PCA in certain health care settings based on complaint and conviction information. Employers must access the registry by phoning the central office; there is no Internet access to the registry.

There are currently no comparable centralized registries for the growing number of other direct care and direct support workers employed in home care and residential care serving elders and people with disabilities. These are the unlicensed assistive personnel in Maine, such as personal attendants, personal support specialists, and direct support professionals. State administrators for mental health services are also exploring the need for a registry.

The Registry Subcommittee identified numerous concerns for consumer safety arising from changes in the direct care workforce—most notably the lack of information on the growing number of unlicensed workers—and discussed ways to build on the current CNA registry to address these concerns. State laws and regulations have been enacted to require certain providers to complete a criminal history records check on unlicensed direct care workers and to prohibit the hiring of

individuals with adverse backgrounds. The extent of these requirements differs based on the employment setting and service funding source.

The CNA Registry offers standardized services and information that are recognized by CNAs and their employers. Significant concerns were raised by both registry staff and users about the capacity of the current registry to meet its current obligations and to expand without additional resources. There was also consensus that ensuring safety and quality in long term care services would be enhanced by having a centralized direct care worker registry.

Other Maine Models

Three other relevant in-state worker directory models are worth noting. **Maine Roads to Quality**[29], sponsored by DHHS and operated by the University of Southern Maine, administers a Maine Roads Registry, which is a registry for the child care and early education provider system in Maine. Worker registration is voluntary and information includes work experience and ongoing training and educational accomplishments in early childhood education or related fields.

Maine PASA Connection is a website feature of the Maine Personal Assistance Services Association that connects people who need assistance in their homes due to disability and age with people looking for employment in direct care/direct support.[30]

The **Maine State Board of Nursing** serves as the licensing board for registered nurses (RNs) and licensed practical nurses (LPNs). The board oversees the licensing process, which includes reviewing and approving applications and processing complaints. Information on current nursing programs in Maine is also available on the Board of Nursing website. The DHHS Office of Data, Research and Vital Statistics compiles data from the survey nurses complete on-line at the Board of Nursing website when they renew their license. The survey is optional but has a very high response rate. Data from the workforce survey is aggregated by DHHS and provides information on the status of the RN workforce.[31]

Issues to Consider

Based on the above information, the Registry Subcommittee discussed priorities and issues related to the creation of a comprehensive direct care worker registry that would be useful to employers, workers, consumers and regulators, and which would result in improved consumer safety, worker opportunity, quality care giving, and consumer choice. The following is a summary of their discussion:

- **One registry vs. two**

A central registry containing information on both certified nursing assistants and other certified and unlicensed direct care workers would be preferable to creating and maintaining two or more separate registries. A central registry that would confirm suitability for employment and offer accessible information could better provide "one stop shopping" for consumers, providers and workers.

- **Contents of proposed registry**

In addition to managing standardized information, other functions were discussed. The proposed registry could include training and credentialing information for unlicensed direct care workers. This component would be very helpful to recruiting more people to the workforce. Workforce demographics plus data on workers' wages and benefits would provide essential information for ongoing monitoring of the workforce for public policy purposes.

- **Criminal history records checks**

There was not consensus about how and whether standard criminal history records checks through the State Bureau of Identification (SBI) should be centralized as a registry function. Some subcommittee members felt that the criminal history information must be part of the registry in order to provide employers with a central place to obtain criminal history records checks. Others believed it should be the employers' responsibility and that most were already requesting them at the time of hire for liability reasons because doing so was the only way to ensure currency of information.

Cost inefficiencies in Maine's current practices were noted. Currently, the registry conducts criminal history record checks through the SBI about every two years. The registry pays for these checks since federal law prohibits a CNA being charged a fee for listing on the registry. Employers are paying to have criminal history records checks conducted by the SBI on the same workers, paying $15 per background check for every new hire and for any rechecks. When an employee changes jobs, each successive employer pays to repeat that check. Rather than the employers paying for multiple SBI checks, and the registry duplicating these checks to meet state biennial requirements, efficiencies could be identified that serve registry staff, workers and employers. Registries in other states have demonstrated that it is possible for a centralized registry to collect and maintain standardized, up-to-date background information that meets employer and consumer safety interests and is provided to employers through a secured access system.

The CNA registry uses name-based rather than fingerprint-based checks. It was noted that name-based checks can be inaccurate (due to name changes and aliases); information can be confusing because SBI sends providers information on all individuals with the same or similar name; there is no access to information on

workers from other states; and information is only current as of the date the check is completed. Fingerprint checks allow for a continual feed with updates provided automatically at no additional charge. However, setting up a fingerprinting system for all direct care workers is expensive and potentially controversial for the workers. Some subcommittee members felt such checks would be a deterrent for workers and that this category of workers should not be singled out when such checks are not required of most other health care professionals.

- **Complaint process**

The DHHS Division of Licensing and Regulatory Services investigates complaints against a CNA. If a complaint is substantiated by licensing personnel, the CNA has a right to appeal that finding. If DHHS is upheld on appeal, the CNA is annotated on the registry. Under federal and state law, that individual is prohibited from employment as a CNA. In some cases, the complaint is referred to law enforcement or to the Attorney General's Medicaid Healthcare Crimes Unit for criminal investigation.

It was noted that there is now no state agency directly responsible for overseeing complaint investigations of other categories of direct care workers and no standard method of substantiating complaints. Some complaints are forwarded to the Medicaid Healthcare Crimes Unit at the Attorney General's Office, but others fall outside the parameters of that unit or do not rise to the level of criminal prosecution. An expanded registry could establish a process for dealing with such complaints, including due process protections for workers, and maintaining annotations on the registry. Registry Subcommittee members also noted the lack of procedures that workers can use to file complaints about workplace conditions and care practices among service providers.

- **Voluntary vs. involuntary registry**

There was no consensus as to whether the proposed registration of unlicensed workers should be voluntary or mandatory for workers other than CNAs. Some subcommittee members felt that a mandatory registry is required for effectiveness and perceived legitimacy by the public. Others felt that a mandatory registry might deter workers from entering or continuing in this field, especially if there is no perceived benefit to workers for being listed on the registry. It was also suggested that the registry and associated rules be focused on those services provided through MaineCare, Medicare or other state funds, although others expressed concern for safety and the public need for information about private pay care providers too.

It was further noted that the registry requirement could be tied to the completion of required training courses, rather than employment. Both CNAs and personal support specialists have required training courses; however, this is not the case for all workers, such as consumer-directed personal assistants. All DHHS licensed

employers could also be mandated to register their direct care workers at the time of hire, although not all providers are licensed by DHHS.

- **Access to registry data**

It was agreed that information should be available on the Internet, to the extent confidentiality allows, for workers, providers and consumers.

Vision for an Expanded Direct Care Worker Registry

Appendix H includes the Registry Subcommittee's vision, objectives, characteristics, and proposed phased-in implementation plan for an expanded directory. DHHS will review and carefully consider this.

Estimated Cost

Chapter 194 requires DHHS to determine the cost of a direct care worker registry. The first priority of DHHS will be to make sure that the existing CNA registry receives the resources it needs to be fully operational. In the proposed biennial budget, there is an initiative to require the employers of certified nursing assistants to pay for the cost of criminal background checks by the State Bureau of Investigation. At present, the cost to the State of these background checks is $128,695 per year. Computer updates are needed to increase the functionality of the CNA Registry; DHHS has determined that this would cost less than $20,000.

The cost of expanding the registry to other direct care workers beyond CNAs is not known, because this will depend on the scope and functions of an expanded registry. DHHS will assemble a group of internal and external stakeholders and will charge them with a careful consideration of and recommendations regarding the vision, objectives and plan proposed by the Registry Subcommittee.

8

Other Legislative Specifications

Two Surveys under Chapter 194

Chapter 194 (Resolve, To Improve Retention, Quality and Benefits for Direct Care Health Workers) required DHHS, in conjunction with DOL, to survey persons formerly employed as direct care workers in long-term care settings to determine whether they would return to work as direct care workers if the pay were increased to $10 per hour. It also required a survey of organizations that provide services to senior citizens to determine the level of interest among older persons in becoming direct care workers to assist persons who are elderly or persons with disabilities. At the same time, Chapter 194 specified that the study of direct care workers must be carried out within existing financial resources.

Efforts were made to carry out these two surveys, but this was not possible for the following reasons:

- The study group pursued the possibility of surveying a sample from the only database of current or former direct care workers—the Maine CNA Registry—in order to ask about pay incentives for returning to the field. However, it was not technically possible to produce a random sample of worker addresses due to the limitations of the database system.
- The study group also pursued the possibility of surveying senior citizens through the Area Agencies on Aging (AAA) to determine their interest in becoming direct care workers. However, the necessary resources for the AAAs to conduct the survey were not available.

Consumer-Directed Provisions under Chapter 199

Chapter 199 (Resolve, To Ensure the Availability of Consumer-Directed Personal Assistance Services) outlined a number of steps foe DHHS and DOL to take relating to consumer-directed personal assistance services. The required study of salary and benefits for personal care assistants has been included in the previous sections of this report.

DHHS continues to explore the option under the federal Deficit Reduction Act of 2005 to move portions of Maine's Home and Community Based waiver services to the State Plan. However, CMS has yet to release the federal regulations necessary

for this implementation of this DRA option. Thus, DHHS has not yet submitted a state MaineCare plan amendment to the federal Centers for Medicare and Medicaid Services (CMS) as directed in Chapter 199.

Because it has not been possible to prepare and submit a plan amendment, participants have not transferred from the current physical disabilities waiver program to the new state plan program and there have been no savings to the state's General Fund to pay for a rate increase for consumer-directed personal care assistants to $10/hour.

DHHS and DOL discussed the provision in Chapter 199 that requires a competitive bidding process to solicit bids from prospective providers of consumer-directed personal care assistance services. DHHS agrees that language in MaineCare rules will be amended to ensure that more providers than the state's single Independent Living Center will be eligible to provide consumer-directed personal care assistance services.

With regard to providing information about available alternatives, DHHS already provides extensive information to applicants about the range of long term care services available, including consumer-directed services. DHHS does this in two ways:

- First, every applicant receives a face-to-face assessment to determine his/her long term care needs. During this process, the nurse who performs the assessment shares with each person the options for services based on needs.
- Second, Maine is participating in the federal Aging and Disability Resource Center (ADRC) grant program funded by the Administration on Aging and CMS. The purpose is to provide information and easy access to resources to Maine people with long term needs. Eastern Agency on Aging, SeniorsPlus, and Senior Spectrum are all operating ADRCs, which offer another venue for making sure that applicants for long term services and supports receive full information about consumer-directed and other services.

Availability of Workers under Chapter 519

Chapter 519, Part EEEE requires DHHS to report on efforts to increase the availability of workers for homemaker and home-based care programs administered by the Office of Elder Services. The Legislature made this request because both the homemaker and home-based care programs were having increasing difficulty finding direct care workers to provide care for individuals assessed as needing services to remain in their own homes. Direct care workforce shortages have resulted in consumer waiting lists and unspent appropriations for needed care. Because of the similarity of this topic with the work required by Resolves, Chapters 194 and 199, the Chapter 519 report has been incorporated into this larger study. Data on the wage structure, costs analyses, and health insurance options relating to home care workers are included in previous sections of this study.

Appendix A

RESOLVE, Chapter 194

Signed on 2006-04-19
122nd Legislature, Second Regular Session

Resolve, To Improve Retention, Quality and Benefits for Direct Care Health Workers

Sec. 1. **Long-term care direct care workers; study. Resolved:** That the Department of Health and Human Services, in conjunction with the Department of Labor, shall conduct a study of direct care workers in state-funded and MaineCare-funded programs to:

1. Examine the wage, benefit and reimbursement structures for direct care workers in all long-term care settings, including, but not limited to, nursing facilities, residential care facilities, mental retardation waiver homes and home care;

2. Determine the cost of a wage floor of $8.50 per hour and the cost of a wage floor of $10 per hour for entry-level direct care workers, including certified nursing assistants, personal support specialists, home health aides, homemakers and direct support professionals. The study must include determination of the cost of proportional increases in current wage scales for more experienced workers and employer-related costs such as FICA;

3. Develop options to extend MaineCare or other health insurance coverage for direct care workers;

4. Evaluate the need for a direct care worker registry, including desired objectives of such a registry and a cost estimate;

5. Survey persons formerly employed as direct care workers in long-term care settings to determine whether they would return to work as direct care workers if the pay were increased to $10 per hour; and

6. Survey organizations that provide services to senior citizens through paid workers and through volunteers to determine the level of interest among older persons in becoming direct care workers, either full-time or part-time and within their physical capabilities, to assist persons who are elderly or persons with disabilities.

The department shall invite participation of, and consultation with, interested parties involved in long-term care or home health care, including direct support and personal assistance workers from all settings during the course of the study. The departments shall conduct the study within existing financial resources. The department shall submit its report, including any necessary implementing legislation, to the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than January 1, 2007.

Appendix B

RESOLVE, Chapter 199

Signed on 2006-04-27
Second Regular Session, 122nd Legislature

Resolve, To Ensure the Availability of Consumer-directed Personal Assistance Services

Sec. 1. State plan amendment. Resolved: That the following provisions apply to consumer-directed personal assistance services provided by the Department of Health and Human Services and the Department of Labor.

1. The Department of Health and Human Services shall submit to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services a MaineCare state plan amendment to establish a new state plan program for personal assistance services for persons with physical disabilities. The program must provide services through the self-directed program model authorized in the federal Deficit Reduction Act of 2005, Section 6086. The state plan amendment must be designed to transfer some participants in the current physical disabilities waiver to the new state plan program for personal assistance services for persons with physical disabilities.

2. After approval of the state plan amendment by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services and no earlier than January 1, 2007, the Department of Health and Human Services may increase reimbursement for providers of consumer-directed personal assistance services in the 3 programs administered by the department up to a rate of $10 per hour as long as the conditions of this subsection are satisfied.

A. Savings to the General Fund must be generated from the transfer of participants from the current physical disabilities waiver program to the new state plan program for personal assistance for persons with physical disabilities and those savings must be sufficient, together with any federal matching funds, to fund any increase in reimbursement above $9 per hour.

B. This subsection does not authorize an increase in General Fund expenditures for reimbursement for providers of consumer-directed personal assistance services above the level budgeted for reimbursement of $9 per hour.

3. Beginning on the effective date of the new reimbursement level established under subsection 2 by the Department of Health and Human Services for the 3 programs of consumer-directed personal assistance services administered through that department, the Department of Labor may increase the reimbursement rate for consumer-directed personal assistance services in the program administered by the

Department of Labor by an amount equal to the increase granted by the Department of Health and Human Services; and be it further

Sec. 2. Competitive bidding process. Resolved: That the Commissioner of Health and Human Services and the Commissioner of Labor shall initiate a competitive bidding process to solicit bids from prospective providers of consumer-directed personal care assistance services; and be it further

Sec. 3. Implementation of recommendations. Resolved: That the Commissioner of Health and Human Services and the Commissioner of Labor shall develop a plan and timeline for the implementation of the following recommendations of the working group established pursuant to Public Law 2003, chapter 673 on consumer direction in Maine's long-term supportive services system, as outlined in the working group's January 1, 2005 report:

1. Expanding the availability of consumer-directed alternatives across the range of long-term care services;

2. Enhancing the intake process to provide consumers with information about the range of services available, including consumer-directed services; and

3. Providing consumers the opportunity to participate in consumer-directed services with the use of an unpaid agent, commonly referred to as a "surrogate," to assist with the management tasks associated with these services; and be it further

Sec. 4. Submission of plan; timeline. Resolved: That the Commissioner of Health and Human Services and the Commissioner of Labor shall submit the plan and timeline developed pursuant to section 4 to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over labor matters no later than 6 months after the effective date of this resolve. Following receipt and review of the plan and timeline, the committees may report out to the First Regular Session of the 123rd Legislature legislation necessary to implement the plan and the timeline; and be it further

Sec. 5. Salary and benefits survey and report. Resolved: That the Commissioner of Health and Human Services and the Commissioner of Labor shall perform a survey of wages and benefits to determine the wages paid to personal care assistants across the state. The survey must include all programs for which funds are provided by the State. By January 1, 2007, the Commissioner of Health and Human Services and the Commissioner of Labor shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters with the results of the survey and include any recommendations for legislative action or rulemaking by the Department of Health and Human Services and the Department of Labor; and be it further

Sec. 6. Major substantive rules. Resolved: That rules adopted pursuant to this resolve by the Department of Health and Human Services and the Department of Labor related to the expansion of availability of or participation in consumer-directed long-term care services are major substantive rules pursuant to the Maine Revised Statutes, Title 5, chapter 375, subchapter 2-A.

Appendix C

PUBLIC LAW, CHAPTER 519, PART EEEE

Second Regular Session, 122nd Legislature

Sec. EEEE-1. Report. The Commissioner of Health and Human Services shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 15, 2007 on the efforts of the Department of Health and Human Services to increase the availability of workers for homemaker and home-based care programs administered by the Office of Elder Services.

Appendix D

Study Group Participants

Mollie	Baldwin	DHHS, Office of Elder Services
Julia	Bell	DHHS Developmental Disabilities Council
Jim	Braddick	DHHS, Adult Mental Health
Steve	Butterfield	Maine State Employees Association/SEIU
Catherine	Cobb	DHHS, Licensing and Regulatory Services
Lou	Dorogi	DHHS, Licensing and Regulatory Services
John	Dorrer	DOL, Labor Market Information Services
Mary Lou	Dyer	Maine Association of Community Service Providers
Richard	Erb	Maine Health Care Association
Sally	Flesher	Maine CNA Registry
Deborah	Friedman	Office of Senate President
Joyce	Gagnon	Maine Personal Assistance Services Association
Brenda	Gallant	Maine Longterm Care Ombudsman
Jane	Gallivan	DHHS, Office of Adults with Cognitive & Physical Disabilities
Elizabeth	Gattine	DHHS, Office of Elder Services
Roy	Gedat	Maine Personal Assistance Services Association
David	Goddu	DHHS, Office of Adults with Cognitive & Physical Disabilities
Nadine	Grosso	Maine Health Care Association
Renee	Guignard	Office of Attorney General
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Lisa	Harvey-McPherson	Home Care Alliance of Maine
Merrill	Huhtala	DOL, Labor Market Information Services
Nancy	Kelleher	AARP Maine
Sharon	Kelly	DHHS, Office of Adult Mental Health Services
Dan	Koeler	Kennebec Valley Organization
Matt	McDonald	SEIU
Catherine	McGuire	Muskie School of Public Service
Vicki	Mihalik	Home Care for ME
Iya	Negra Lavessari	Maine Personal Assistance Services Association
Graham	Newson	Area Agencies on Aging
Kathryn	Pears	Maine Alzheimers Association
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Vanessa	Santarelli	Maine Department of Labor
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Christopher	St. John	Maine Center for Economic Policy
Mike	Sylvester	Maine State Employees Association/SEIU
Dyan	Villeneuve	University of Maine / DHHS, Office of Elder Services
Lisa	Wilson	DHHS, Financial Services

Appendix E

MaineCare and State Funded Long-Term Care Programs within Occupational Employment Statistics Data

The Maine Department of Labor (DOL), Division of Labor Market Information Services in conjunction with the Maine Department of Health and Human Services, Office of Elder Services, the University of Southern Maine Muskie School of Public Service, and the members of the study group to address Resolve 194 and parts of Resolve 199 passed by the 122nd Maine Legislature, have jointly developed this analysis of employment, wage rates and costs for jobs providing frontline direct care services to Maine citizens.

Determining Appropriate Occupational Classifications

The study participants chose to use already existing data for this analysis. Data relating to direct care jobs were collected through the Occupational Employment Statistics (OES) survey conducted nationwide and administered by the U.S. Bureau of Labor Statistics. This is a biennial survey of a representative sample of Maine employers that are covered by the Maine Employment Security Law. Estimates produced by the survey are straight-time, exclusive of overtime and benefits. Estimates of hours worked are beyond the scope of the OES survey. Self-employed, independent contractors, partners, and unpaid family members are excluded. OES coverage is limited to workers defined as employees and covered under the Maine Employment Security Law for unemployment insurance purposes.

Six initial Standard Occupational Classifications (SOC) were considered as potentially including direct care workers: Nursing Aides, Orderlies and Attendants; Home Health Aides; Home and Personal Care Attendants; Human and Social Service Assistants; Psychiatric Aides, and Psychiatric Technicians. After cross-checking with MaineCare and state-funded provider agency names provided to DOL by the Office of Elder Services, Psychiatric Aid and Psychiatric Technician were eliminated because they did not include direct workers in long-term care agencies funded by the state and MaineCare programs.

Occupational definitions for the four remaining occupations are provided in Table 14 with several illustrative examples. Job titles reported by employers and workers, to DOL data analysts are included to provide some insight into the occupational overlap that exists among these occupations. Also provided are numerous direct care job titles recognized by the Maine Department of Health and Human Services. These titles have been matched as best as possible to the SOCs.

There is considerable overlap in that some job titles are reported in two or more occupational categories. Job titles are often misleading however, and standards provided by O*NET[32] and the SOC represent an attempt to classify workers according to their skills as well as their job tasks. Considering the scope of job titles reported to the DOL analysts, it must be assumed that individual survey respondents are making relatively similar judgments as they distribute these job titles across the range of occupations surveyed by OES.

Table 15 contains OES estimates of employment and wages by industry for these four occupations, using the standard North American Industry Classification System (NAICS) codes.

Table 14: Standard Occupational Classification Descriptions for Direct Care Workers

21-1093 Social and Human Service Assistants	**Employers by NAICS Code**	**Sample of Job Titles**
Assist professionals from a wide variety of fields, such as psychology, rehabilitation, or social work, to provide client services, as well as support for families. May assist clients in identifying available benefits and social and community services and help clients obtain them. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or adult daycare."	· Social Assistance · Nursing and Residential Care Facilities · Ambulatory Health Care Services · Hospitals · Public Administration · Religious, Grantmaking, Civic, Prof., Organizations	· Advocate · Human Services Program Specialist · Mental Health Technician · Addictions Counselor Assistant · Caseworker · Independent Living Specialist · Activities of Daily Living Specialist · Case Manager · Family Development Specialist · Family Self-Sufficiency Specialist · Residential Advisor
31-1012 Nursing Aides, Orderlies, and Attendants	**Employers by NAICS Code**	**Sample of Job Titles**
Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens.	· Administrative and Support Services · Ambulatory Health Care Services · Hospitals · Nursing and Residential Care Facilities · Social Assistance · Public Administration	· Certified Nursing Assistant · Certified Nurse Aide · Nursing Assistant · Psychiatric Attendant · Nurse's Aide · Patient Care Technician · Resident Assistant · Caregiver · Patient Care Assistant · Certified Nursing Assistant-Medication (CNA-M), Certified Residential Care Medication Aide (CRMA) · Medication Technician

Table 14 cont.		
31-1011 Home Health Aides	**Employers by NAICS Code**	**Sample of Job Titles**
Provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility.	· Social Assistance · Ambulatory Health Care Services · Public Administration	· Home Health Aide · Residential Counselor · Certified Nursing Assistant · Home Health Provider · Habilitation Training Specialist · Caregiver · Direct Support Person · Personal Care Attendant · Residential Assistant · Residential Care Specialist
39-9021 Personal and Home Care Aides	**Employers by NAICS Code**	**Sample of Job Titles**
Assist elderly or disabled adults with daily living activities at the person's home or in a daytime non-residential facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide meals and supervised activities at non-residential care facilities. May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities.	· Social Assistance · Nursing and Residential Care Facilities · Ambulatory Health Care Services	· Certified Nursing Assistant · Personal Care Assistant · Community Living Specialist · Companion · Direct Service Provider · Habilitation Training Specialist · Individual Service Staff · Personal Care Provider · Personal Home Care Aide · Direct Support Staff · In-Home Support Specialist · Personal Support Specialist · Homemaker · Personal Care Assistant · Consumer-Directed Attendant · Informal and/or Paid Caregiver

Table 15: Industries, Occupational Classifications, and Wage Ranges for Direct Care Workers in Maine
Source: Maine Department of Labor

	NAICS Industry Description	SOC Occup. Title	No. Earn < $8.50 /hr	% Earn < $8.50 /hr	No. Earn < $10 /hr	% Earn < $10 /hr	Est. Total Empl. (2005)	% Relatv. Std. Error (Empl)	Mean	% Relatv. Std. Error (Mean)	p10	p25	p50	p75	p90
0000	**Combined**	**Social and Human Service Assistants 21-1093**	**456**	**9.7%**	**1,632**	**34.9%**	**4,680**	**1.4**	**$11.20**	**6.9**	**$8.52**	**$9.49**	**$10.76**	**$12.69**	**$14.70**
621	Ambulatory Health Care Services		9	1.4%	71	10.9%	650	7.2	$12.88	2.6	$9.87	$11.28	$12.65	$14.36	$16.50
622	Hospitals		2	2.2%	7	7.8%	90	19.3	$15.25	3.1	$10.71	$12.88	$15.23	$17.14	$20.25
623	Nursing and Residential Care Facilities		136	7.4%	624	33.9%	1,840	12.6	$10.84	1.3	$8.86	$9.60	$10.69	$12.12	$13.35
624	Social Assistance		246	16.3%	726	48.1%	1,510	13.1	$10.51	2.5	$7.85	$8.95	$10.08	$11.73	$13.99
813	Religious, Grantmaking, Civic, Professional, and Similar Organizations		7	5.0%	34	24.3%	140	33.3	$13.70	11.2	$9.13	$10.08	$12.24	$18.44	$21.16
999	Public Administration		1	0.50%	19	9.5%	200	2.5	$12.64	1.7	$10.09	$11.34	$12.45	$13.55	$16.09
0000	**Combined**	**Home Health Aides 31-1011**	**1,016**	**26.5%**	**2,232**	**58.3%**	**3,830**	**10.4**	**$9.81**	**2.3**	**$7.32**	**$8.38**	**$9.61**	**$10.76**	**$13.10**
621	Ambulatory Health Care Services		124	28.8%	245	57.0%	430	15.4	$9.69	3.6	$7.46	$8.27	$9.55	$11.05	$12.61
622	Hospitals		5	10.0%	20	40.0%	50	24.0	$10.76	4.1	$8.60	$9.42	$10.54	$12.26	$13.59
623	Nursing and Residential Care Facilities		581	22.9%	1,467	57.8%	2,540	14.0	$9.75	1.4	$7.32	$8.63	$9.68	$10.68	$12.53
624	Social Assistance		297	38.1%	481	61.7%	780	21.4	$10.01	7.3	$7.25	$7.92	$9.13	$11.04	$15.19
999	Public Administration		9	30.0%	19	63.3%	30	3.7	$9.80	5.4	$7.34	$8.11	$9.31	$10.48	$12.30

Table 15 cont.

	NAICS Industry Description	SOC Occup. Title	No. Earn < $8.50 /hr	% Earn < $8.50 /hr	No. Earn < $10 /hr	% Earn < $10 /hr	Est. Total Empl. (2005)	% Relatv. Std. Error (Empl)	Mean	% Relatv. Std. Error (Mean)	p10	p25	p50	p75	p90
		Nursing Aides, Orderlies, and Attendants													
0000	**Combined**	**31-1012**	**1,506**	**16.6%**	**4,372**	**48.2%**	**9,080**	**4.2**	**$10.27**	**0.8**	**$7.82**	**$8.94**	**$10.08**	**$11.60**	**$13.21**
561	Administrative and Support Services		6	3.2%	38	20.0%	190	40.0	$11.61	2.0	$9.21	$10.33	$11.75	$12.96	$13.69
621	Ambulatory Health Care Services		139	20.1%	405	58.7%	690	21.3	$9.80	2.3	$7.67	$8.77	$9.68	$10.56	$11.98
622	Hospitals		193	9.5%	835	40.9%	2,040	5.1	$10.68	1.2	$8.54	$9.29	$10.39	$12.11	$13.47
623	Nursing and Residential Care Facilities		1,019	18.2%	2,777	49.7%	5,590	5.9	$10.16	0.9	$7.71	$8.85	$10.01	$11.49	$13.09
624	Social Assistance		40	50.0%	64	80.0%	80	44.5	$8.58	6.8	$7.19	$7.66	$8.43	$9.58	$10.43
999	Public Administration		81	18.0%	215	47.8%	450	0.2	$10.47	2.3	$7.77	$8.88	$10.09	$11.81	$13.63
		Personal and Home Care Aides													
0000	**Combined**	**39-9021**	**2,266**	**47.6%**	**3,678**	**77.3%**	**4,760**	**9.0**	**$8.75**	**2.3**	**$7.11**	**$7.66**	**$8.58**	**$9.87**	**$10.66**
621	Ambulatory Health Care Services		170	44.7%	295	77.6%	380	23.3	$8.70	3.2	$7.07	$7.68	$8.77	$9.87	$10.54
623	Nursing and Residential Care Facilities		450	28.9%	1,044	66.9%	1,560	17.0	$9.29	2.4	$7.42	$8.27	$9.36	$10.30	$10.86
624	Social Assistance		1,624	58.4%	2,311	83.1%	2,780	11.7	$8.45	3.1	$7.04	$7.49	$8.24	$9.44	$10.46
TOTALS:			**5,253**	**21.0%**	**12,056**	**48.3%**	**24,980**								

Appendix F

Calculating the State Cost of Two Wage Floors

An estimate of how many hours direct care workers are actually employed is needed in order to quantify the cost of their current and potentially increased wages. Since Maine Department of Labor Occupational Employment Statistics survey data (described in Appendix E above) do not include hours, MaineCare and state-funded program service units, as reported to DHHS, were used as a proxy for workers' hours.

DHHS Office of Elder Services and the Muskie School of Public Service compiled data on service units corresponding to services provided by direct care workers for the period 2/1/05 to 1/31/06 (paid by July 2006). These data are from MaineCare Claims Management System (MECMS) extract and were pulled as of June 2006 and included MECMS claims with a request for remittance generated (application status=130) and paid status (business status = 71). The Office of MaineCare Services does not guarantee the completeness of these data. Claims data posted after January 2005 may be less accurate due to processing issues with the new claims management system, claims not yet processed, and claims requiring adjustment. The data and any related materials contained within are provided "as is" and should be used with appropriate caution.

These units were converted to hours, and were divided into two categories. One was the estimate of all **Facility-based** hours of service, including nursing homes, residential care, assisted living, and MR waiver homes. Facility-based hours were based on units of service for nursing facilities, Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR), and Private Nonmedical Institutions (PNMI). The units for these services are equivalent to resident days and totaled 3,510,195. An estimate of 3.1 CNA hours per resident per day was applied to these units, resulting in 10,881,806 hours. The 3.1 average CNA per resident day is based on information collected during the Center for Medicare and Medicaid Services (CMS) Survey and Certification process and reported on the CMS website for Maine nursing facilities.[33] While the level of care may be different in PNMI and ICF/MR facilities, at least for the medical and remedial PNMIs, this time was consistent with data collected in the DHHS time study to develop case mix reimbursement so it was applied this to all of the resident days to get an estimate.

The other was all **Community Care** (including home care and non-facility based MR waiver programs), which totaled 4,031,321 hours. These hours were then applied to the number of workers in MaineCare funded programs across the wage spectrum as described below.

MaineCare and State Funded Long-term Care Programs within Occupational Employment Statistics Data

The Maine Department of Human Services, Office of Elder Services and the Muskie School of Public Service provided names and locations for 1,245 MaineCare and state-funded long-term care service providers. The Federal Employer ID Number (FEIN) was used as a cross-reference to the Occupational Employment Statistics (OES) data set. Records without an FEIN identifier are not considered employers, and were deleted. (They may work as independent contractors, but no information is available for them in Maine Bureau of Employment Security databases.) Several other records were eliminated: agencies with duplicate FEINs (companies with more than one location but for which there would only be one survey); companies that operate businesses across several unrelated industries; and hospitals (which employ a large number of CNAs not working in long-term care.) There were 256 remaining records of MaineCare and state-only funded programs that could be cross-referenced with the OES survey – about one-quarter of the original list -- with a total of 5,424 workers.

These workers are categorized in standard wage ranges. Workers in all four occupations were totaled and the proportion of workers in each range was calculated. As shown in Table 16, 3.2% of direct-care workers earned less than $6.75 per hour; 18.3% earned between $6.75 and $8.49; 52.4% earned between $8.50 and $10.74 and so on.

Table 16: Direct Care Workers' Wages in MaineCare and State-funded Long-term Care Agencies Responding to the Occupational Employment Survey (n = 5,424)

	< $6.75	**$6.75-$8.49**	**$8.50-$10.74**	**$10.75-$13.49**	**$13.50-$16.99**	**$17.00-$21.49**	**$21.50 – $27.24**
Social & Human Service Assistants	62	173	1,024	422	213	20	2
Nursing Aides, Orderlies, & Attendants	42	171	702	354	79	0	0
Personal & Home Care Aides	42	434	612	127	13	0	0
Home Health Aides	28	215	505	168	16	0	0
Total in Each Wage Range	**174**	**993**	**2,843**	**1,071**	**321**	**20**	**2**
Percent in Each Wage Range	**3.2%**	**18.3%**	**52.4%**	**19.7%**	**5.9%**	**0.4%**	**0.0%**

Source: Maine Department of Labor and Maine Department of Health and Human Services

The Cost of Bringing Workers to Two Wage Floors Plus a 2% Increase for Those Above the Floor

Community Care and Facility-based costs of bringing workers to the two proposed wage floors were calculated slightly differently as follows. For Community Care, the proportion of total workers in each wage range below the two floors were multiplied by the total number of Community Care hours (the proxy for hours worked), giving an estimate of the total number of hours worked in each pay range. The midpoint of each range was then determined, with $6.55 selected as the midpoint between the 2005 minimum wage of $6.50 and $6.75 at the top of the range. Services in the community care programs include a variety of direct care workers including personal support specialists, homemakers, CNAs, etc. Since it is not possible to directly determine which workers provide which services, the proportional mix of all direct care workers was used, based on DOL survey data.

Multiplying the hours by the difference between the midpoint of each range and the $8.50 and $10 wage floors and adding across all three ranges provides an estimate of the cost of bringing all state and MaineCare funded workers in Community Care up to the two wage floors. These figures are shaded in Table 17. For example, it would cost $252,181 + $642,090 = $894,271 to bring all state funded direct care workers in Community Care up to $8.50. Likewise, it would cost $446,166 + $1,749,143 + $802,949 = $2,998,258 to bring them up to $10.00.

Table 17: Calculating the Cost of Raising Wages for Direct Care Workers in MaineCare and State Funded Community Care Programs

	< $6.75	**$6.75 - $8.49**	**$8.50 – $10.74**	**$10.75 – $13.49**	**$13.50 – $16.99**	**$17.00 – $21.49**	**$21.50 – $27.24**	**Totals**
Total workers in each wage range	174	993	2,843	1,071	321	20	2	5,424
Percent of workers in each wage range	3.2%	18.3%	52.4%	19.7%	5.9%	0.4%	0.0%	100%
Midpoint Hourly Wage	$6.55	$7.63	$9.62	$12.12	$15.25	$19.25	$24.37	
Hours of service (total hrs * % of workers)	129,323	738,035	2,113,025	796,008	238,579	14,865	1,486	4,031,321
Cost to reach $8.50 wage floor + 2% for all above	$252,181	$642,090	$406,546	$192,952	$72,767	$5,723	$725	$1,572,983
Cost to reach $10.00 wage floor + 2% for all above	$446,166	$1,749,143	$802,949	$192,952	$72,767	$5,723	$725	$3,270,424

Source: Maine Department of Labor and Maine Department of Health and Human Services

The remaining calculations (not in bold) also include a 2% increase for those already making above the midpoint. For example, 2% of $12.12 multiplied by 796,008 hours = $192,952 for a 2% raise for all workers already above $8.50 in that wage range. Totaling across the rows thus provides an estimate of the cost of bringing all state-funded direct workers up to the two wage floors plus providing a 2% increase for those above the floor.

This represents the full cost of MaineCare and state funded worker wage increases. However, nearly two-thirds of MaineCare expenditures are covered by federal funds. Thus, the final cost figures were adjusted by the 2007 federal Medicaid matching rate for Maine (FMAP), prorated to reflect a 58/42 split between state-only and MaineCare funded community services (Table 18).

Table 18: Adjusting for Federal MaineCare Match (Community Care)

	Total MaineCare/ State-Only Funded Programs	**State Portion of MaineCare + State-only Funded Programs**
$8.50 wage floor	$1,572,983	$1,154,988
$10.00 wage floor	$3,270,424	$2,401,361

Source: Maine Department of Labor and Maine Department of Health and Human Services

To incorporate the employer-related costs, the two totals were multiplied by the employer Social Security contribution rate (7.65%), the 2007 average Unemployment Insurance contribution rate for the long-term care and home health care industries (1.71%), and a Workers Compensation rate (6.64%) for a total of 16%. The total estimated cost for each of the two wage floors in Community Care programs, with increases of 2% for those above the floor, and employer related costs were $1,339,786 for the $8.50 floor and $2,785,579 for the $10.00 floor (Table 19).

Table 19: Adding Employer Related Costs to the Wage Floor Costs (Community Care)

$8.50 floor	FICA	7.65% * $1,154,988	$88,357
	UI	1.71% * $1,154,988	$19,750
	WC	6.64% * $1,154,988	$76,691
		TOTAL	$1,339,786
$10.00 floor	FICA	7.65% * $2,401,361	$183,704
	UI	1.71% * $2,401,361	$41,063
		6.64% * $2,401,361	$159,450
		TOTAL	$2,785,579

Source: Maine Department of Labor and Maine Department of Health and Human Services

This same methodology was repeated for Facility-based Care with one exception. Instead of taking the proportion of the total of all four worker groups times the hours of service, only the proportion of nurses aides was used (Table 20). This is because it was assumed that nurses' aides make up the vast majority of direct care workers in long-term care facilities.

Table 20: Calculating the Cost of Raising Wages for Direct Care Workers in MaineCare and State Funded Facility-Based Programs

	< $6.75	$6.75 - $8.49	$8.50 – $10.74	$10.75– $13.49	$13.50- $16.99	Totals	State Dollars	Employer Costs
Total nurses aides wage range	42	171	702	354	79	1,348		
Percent of workers in each wage range	3.1%	12.7%	52.1%	26.3%	5.9%	3.1%		
Midpoint Hourly Wage	$6.55	$7.63	$9.62	$12.12	$15.25			
Hours of service (total hrs * % of workers)	339,041	1,380,382	5,666,830	2,857,632	637,720	10,881,605		
Cost to reach $8.50 wage floor + 2% for all above	$661,130	$1,200,932	$1,090,298	$692,690	$194,505	$3,839,555	$1,410,268	$1,635,911
Cost to reach $10.00 wage floor + 2% for all above	$1,169,692	$3,271,504	$2,153,395	$692,690	$194,505	$7,481,786	$2,748,060	$3,187,750

Source: Maine Department of Labor and Maine Department of Health and Human Services

Finally, the total costs were projected over five years with a 2.5% escalated annual rate of increase (Table 21). In the first year, the estimated cost of bringing all direct care workers up to $8.50 with 2% for workers above the floor plus 16% of employer-related costs would be $2,975,698. It would cost about $5,973,329 for the $10.00 floor. In five years, these costs would rise to $3,284,613 for the $8.50 floor and $6,593,437 for the $10 floor.

Table 21: Five-year 2.5% Escalating Wage Cost

	Community Care		Facility-based Care		Total	
	$8.50 Wage Floor	**$10.00 Wage Floor**	**$8.50 Wage Floor**	**$10.00 Wage Floor**	**$8.50 Wage Floor**	**$10.00 Wage Floor**
Year 1	$1,339,786	$2,785,579	$1,635,911	$3,187,750	$2,975,698	$5,973,329
Year 2	$1,373,281	$2,855,219	$1,676,809	$3,267,443	$3,050,090	$6,122,662
Year 3	$1,407,613	$2,926,599	$1,718,729	$3,349,129	$3,126,342	$6,275,729
Year 4	$1,442,803	$2,999,764	$1,761,698	$3,432,858	$3,204,501	$6,432,622
Year 5	$1,478,873	$3,074,758	$1,805,740	$3,518,679	$3,284,613	$6,593,437

Source: Maine Department of Labor and Maine Department of Health and Human Services

Limitations of this Cost Analysis

In the absence of a costly survey of long-term care providers that are funded by MaineCare and other state funds, this analysis is limited by the nature of the data used. The OES survey is stratified in several manners to allow for aggregation of data, primarily by industry and geographic location. It is not stratified by the factor most relevant to this analysis -- whether a company receives MaineCare funds. Therefore, we must make the assumption that the wage range distribution throughout the universe of recipient companies of these public funds is similar to the distribution in this sample. The other main assumption being made is that wages are evenly distributed within each wage range. Based on these assumptions, DOL staff analysts have made an educated estimate for a margin of error for these cost estimates at +/- 15%.

Appendix G

Data Sources and Methodology for Wage and Health Insurance Survey

The Maine Center for Economic Policy (MECEP) in conjunction with study group members created the Direct Care Worker Survey instrument and organized its dissemination. MECEP also provided data input and analysis. Four long-term care settings were surveyed as follows.

Consumer-directed Personal Attendants at Alpha One: Alpha One is a nonprofit fiscal intermediary for the state's MaineCare funded consumer-directed program for adults with physical disabilities. The survey was included in a payroll mailing to all workers paid through Alpha One -- 790 Personal Attendants. There were 199 surveys received from this effort -- a 25% response rate. Alpha One does not offer health insurance and had a legislated wage rate of $9.00 as of October 2006 and there is a legislative initiative underway to increase it to $10.00 in 2007.

Homemakers and Personal Support Specialists in Home Care: Home Care for ME is one of Maine's largest statewide home care providers and has the MaineCare funded "Homemaker" contract with the state. About 95% of their funding comes from the MaineCare program and the remaining 5% comes from private pay, Veteran's Administration, and other services. The survey was mailed to all 440 direct care employees. There were 220 surveys received – a 50% response rate.

Direct Support Professionals at MR Waiver Programs: The Maine Association of Community Service Providers (MACSP) is a statewide association of 60 agencies providing services to adults and children with developmental disabilities. Almost all funding comes from the MaineCare program for these consumers. The survey was mailed to all member agencies and they were asked in a cover letter to survey every direct support professional. There were 630 workers who responded, out of approximately 5,000 direct support professionals.

Direct Care Workers at Nursing Homes, Residential Care, and Assisted Living Facilities: The Maine Health Care Association (MHCA) is a statewide association of approximately 200 member nursing homes, residential care and assisted living facilities. MHCA distributed the survey via email to every member, and requested that each facility select five frontline direct care staff members to complete the survey and fax it back to MHCA. There were 41 agencies that participated, generating 166 individual surveys including titles such as Certified Nursing Assistant, Personal Care Attendant, Certified Residential Medication Aide, Residential Care Specialist, and Mental Health Rehabilitation Technician. Typically these agencies receive about 70% of their funding from the MaineCare program. As a whole, MHCA members employ approximately 4,000 direct care workers.

In the case of Home Care for ME and Alpha One, these data are cite specific and may not be generalized to the full population of home care workers in Maine. In the case of the MACSP and MHCA member surveys, these are considered nonrandom, convenience samples and the results cannot be generalized to the rest of the member organizations' workers. These data cannot be combined to make an aggregate estimate of all direct care workers' wages or health insurance status.

Appendix H

Vision for an Expanded Direct Care Worker Registry

The following describes the Registry Subcommittee's vision, objectives, characteristics, and proposed phased-in implementation plan for an expanded directory. DHHS will review and carefully consider this.

Vision Statement

We envision a registry that serves as a central place where workers, consumers and employers can find information that will help promote professionalism, access and safety in the fields of personal care, direct support, and certified nursing assistance.

Objectives

The registry will help achieve the following objectives:

- Increase the number of direct care workers hired in Maine by expanding the functions of the current CNA registry.
- Improve consumer and worker safety and reduce the cost of criminal history records checks for employers.
- Improve general understanding and legitimacy of the direct care/support profession and improve consumer choice by using the on-line registry for public educational purposes.

Desired Registry Characteristics

- Accurate information
- Confidentiality safeguards
- 24 hour Internet access to information
- Easy navigation with reader-friendly language
- Easy sign-up for workers

Achieving the Long Term Vision

Based on research about other registries, current institutional capacities, needs, and economic and political realities, the subcommittee recommends a phased approach to establishing a Direct Care Worker Registry, as follows:

Phase I

1. Improve the current CNA Registry

- Ensure adequate funding to allow for efficient processing and updating of all registrants.
- Ensure that the registry meets all state/federal criteria or better.
    - Re-certification every two years
    - SBI checks every two years
- Provide up-to-date, 24/7 Internet access for provider agencies

2. Reduce duplication of cost and effort

- Form a committee of representatives from the state, CNA Registry, providers, and others to identify ways to reduce duplication of criminal history records checks and associated costs.

3. Add general information about direct care to the website

For Workers

- Job titles and responsibilities; the difference between certified, licensed and registered jobs, and career ladder opportunities.
- Job opportunities
    - Link to Maine's Career Center website for current direct care employment opportunities.
    - Encourage providers to use the Career Centers for job postings.
- Job training opportunities
    - Develop a crosswalk for existing job requirements and a current schedule of required direct care trainings.
    - Identify continuing education opportunities.
    - Identify train-the-trainer programs for personal support specialists and CNAs.

For Consumers

- A resource guide to assist consumers in understanding:
    - Categories of workers.
    - Types of agencies.
    - State funded programs that cover direct care services.
    - How to conduct a hiring process that helps to achieve quality care.

For the Public

- Collect data on workers through on-line surveys and provide analytic reports about the workforce.
- Provide links to organizations and coalitions working to improve quality care and the working conditions for direct care workers.

Phase II

1. Add Unlicensed Assistive Personnel to the CNA Registry

- Include the following workers in a phased approach, starting with those who work in licensed settings or publicly funded:
  - Mental Health Rehabilitation Technician (MHRT 1)
  - MHRT C
  - Peer Support Specialists
  - Direct Support Professionals
  - Behavioral Specialists (for children)
  - Personal Support Specialists/Personal Care Attendants
  - Certified Residential Medical Aides (CRMA)
  - Homemakers
  - Personal Assistants
- Include the following information about each worker:
  - All information currently on CNA registry
  - Education
  - Number of training hours
  - Dates of completion
  - Dates of background checks
  - Work history
  - Whatever is needed for state licensing
  - Substantiated complaints
  - Demographic information
  - Age, gender, wage and benefits

2. Improve Maine's complaint investigation process

- Create a process of substantiating and consolidating complaints about direct care workers.
- Create a process for processing complaints about provider agencies by workers.

Phase III

3. Create an on-line search and match service to help match employers and workers.

Appendix I

Samples of State Direct Care Worker Registries

State Registry	Workers listed	Info collected	Manda-tory for employers	Access for users	Operated by:	Who does criminal history checks?	Info provided on site	Sources of funding
Illinois www.idph.state.il.us/nar/home.htm Contact: Teri Berriman 217-785-5133	CNA + DD Aides, DSPs	Eligibility, training, employment site, crim. history check, demo-graphics	Yes	Internet access for limited data	Dept of Health	Employers	See S. Illinois University	Federal and state funds + grants
Indiana http://www.in.gov/isdh/regsvcs/acc/certhha/faq.htm Contact: Darlene Jones 317-233-7351	CNA + Med Aide, Registered Home Health Aide	Eligibility, training, employment site, positive complaint findings	Yes	Automated phone and internet access	Dept of Health	Employers	See website	Federal and state funds
Iowa https://dia-hfd.iowa.gov/DIA_HFD/Home. do Contact: Greg DeMos, Coordinator 515-281-4077	CNAs + developing options for other titles including unlicensed workers	Eligibility, training, employment site, demographics	Yes + must check separate abuse registry	Internet access; phone service, workers can update directly	Dept of Lic. & Appeals	Employers	Yes	Federal and state funds + grants
Kansas http://www.kdheks.gov/hoc/ Contact: Kathy Fritts 785-296-0059 Training info: Dolores Staab 785-296-6796	CNAs + certified home health and med aides	Eligibility, training, Employment site, crim history incl, date of last check	Yes	Internet access to request crim. history and track eligibility.	Dept of Health & Environ.	Registry	Yes	Info not provided
Maine Contact: Sally Flesher 207-287-9300	CNAs	Eligibility, training, employment site, criminal history w/date of last check, positive complaint findings	Yes	Direct calls to registry staff	DHHS, Div. of Licensing &Reg. Srvcs.	Registry and employers	No	Federal and state funds
Missouri http://www.dhss.mo.gov/CNARegistry/ Contact: Gail Sanbothe 573-526-8529	CNAs + others w/ plan to add PCAs and MH workers	Eligibility, training, employment site, positive complaint findings	No	Internet links to crim. history checks w/ employer access	Dept of Health & Senior Services	Employers check + links to multiple databases for checks	Links and limited general info.	Federal funds

Endnotes

[1] Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care.

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

[3] Including Nursing Aides, Orderlies and Attendants; Home Health Aides; Personal and Home Care Aides and Human and Social Service Assistants. Maine Occupational Wage Data. May 2005. www.bls.gov

[4] U.S. Bureau of the Census. Population Projections for States. http://www.census.gov/population/projections/state/9525rank/meprsrel.txt

[5] Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

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[8] Paraprofessional Healthcare Institute. Health Care for Health Care Workers. Policy Brief No. 1. Caregivers without Coverage: The Facts about a Critical Gap in Long-Term Care.

[9] GAO Testimony by William Scanlon, Director, Health Care Issues. Long Term Care-Baby Boom Generation Increases Challenge of Financing Needed Services. 3/27/01, p. 23.

[10] Dorie Seavey and Vera Slater. 2006. Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants. AARP.

[11] See, for example, K.C. Lakin and R. H. Bruinninks (1981) "Personnel Management and Quality of Residential Services for Developmentally Disabled People." In: T. C. Muzzio, J. J. Koshel, and V. Bradley, eds., Alternative Community Living Arrangement and Non-Vocational Social Services for Developmentally Disabled People. Washington, DC: The Urban Institute; D. Braddock and D. Mitchell (1992) Residential Services for Persons with Developmental Disabilities in the United States: A National Study of Staff Compensation, Turnover, and Related Issues. Washington, DC: American Association on Mental Retardation; and S. Larson and C. Lakin (1999) Longitudinal Study of Recruitment and Retention in Small Community Homes Supporting Persons with Developmental Disabilities. Mental Retardation 37(4): 267Œ280; L. Dresser, D. Lange, and A. Sirkus (March 1999) Improving retention of frontline caregivers in Dane County, Madison, WI: Center for Wisconsin Strategy, University of Wisconsin; E. Hatton and L. Dresser (2003) Caring About Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin, Center for Wisconsin Strategy, University of Wisconsin-Madison [available at: http://www.cows.org/pdf/rp-jwf-cna.pdf]. As cited in Dorie Seavey and Vera Slater. 2006. Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants. AARP.

[12] See, for example, Niev Duffy (September 2004) Job Tenure of Frontline Healthcare Workers: Do Health Benefits Reduce Turnover? Working Paper 102, New York, NY: City University of New York, JFK Jr. Institute for Worker Education; Niev Duffy (October 2004) Keeping Workers Covered: Employer-Provided Health Insurance Benefits in the Developmental Disabilities Field, New York, NY: City University of New York, JFK Jr. Institute for Worker Education; L. Dresser, D. Lange, and A. Sirkus (March 1999) Improving retention of frontline caregivers in Dane County, Madison, WI: Center for Wisconsin Strategy, University of Wisconsin. As cited in Dorie Seavey and Vera Slater. 2006. Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants. AARP.

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

University of Southern California University Affiliated Program. As cited in Dorie Seavey and Vera Slater. 2006. Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants. AARP.

[14] See RTZ Associates, Inc (2004) The Impact of Health Benefits on Retention of Homecare Workers: A Two-Year Study of the IHSS Health Benefits Program in Los Angeles Count, Prepared for the Los Angeles County Personal Assistance Services Council (PASC) [available at: http://www.rtzassociates.com/publications/benefits_retention_la2004.pdf]. As cited in Dorie Seavey and Vera Slater. 2006. Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants. AARP.

[15] Maine Department of Human Services. MaineCare Benefits Manual. Principles of Medicaid Reimbursement to Nursing Facilities. Chapter 101. Ch. III Section 67. http://www.state.me.us/sos/cec/rcn/apa/10/ch101.htm

[16] The direct care cost component includes salaries, wages and fringe benefits for registered nurses, licensed practical nurses, nurses' aides, patient activities personnel, and ward clerks, as well as contractual labor costs. Also included are medical supplies and medicine. Routine costs include salaries and benefits for personnel in management, dietary, housekeeping, and maintenance as well as all associated costs such as training. Fixed costs include the capital costs of buying and maintaining the facilities.

[17] Medicaid payments to nursing facilities in the aggregate may not exceed the upper limits of Medicare payments.

[18] Email communication with Dennis Fitzgibbons, Executive Director, Alpha One, January 16, 2007.

[19] Conversations with Rick Erb of the Maine Health Care Association in January 2007.

[20] Carol Regan from the Paraprofessional Healthcare Institute presented the study group with this national research.

[21] A Direct Service Worker Demonstration Grant from the Centers for Medicare and Medicaid Services was awarded to Maine in 2003 to implement and evaluate programs to recruit and retain direct care workers in home care. The Muskie School of Public Service has been coordinating the program and conducting surveys. The Employer of Choice for Health and Wellness for Retention Program was developed in 2006 to complete the fourth, and final, year of the grant.

[22] Rhode Island's Rite Care at http://www.dhs.state.ri.us/dhs/famchild/shcare.htm

[23] Pennsylvania's Adult Basic Coverage at http://www.ins.state.pa.us/ins/cwp/view.asp?a=1278&q=527068

[24] "Implementing a Health Plan Purchasing Pool," Massachusetts' Roadmap to Coverage, October 7, 2005. http://www.roadmaptocoverage.org/pdfs/RoadMap_PurchasingPool.pdf)

[25] Under federal labor law (the Taft-Hartley Act), a multiemployer fund must be governed by a joint board of trustees, with equal representation of labor and management. The Taft-Hartley Act is an amendment to the National Labor Relations Act, 29 USC §§141-197, enacted in 1947.

[26] Nursing Aides, Home Health Aides and Related Health Care Occupations – Workforce Shortages and Associated Data Needs. U.S. DHHS Health Resources & Services Admin. (HRSA) - Feb. 2004 (*Lists characteristics of the registries on p. 60)*. http://bhpr.hrsa.gov/healthworkforce/reports/nursinghomeaid/nursinghome.htm

[27] From presentation materials provided by Dorie Seavey, Paraprofessional Healthcare Institute.

[28] Survey of Nurse Aide Registries (Direct Care Worker) in the United States; Iowa Caregivers Association, November 2004 (http://www.iowacaregivers.org/uploads/pdf/99165ICGAFullBook.pdf)

[29] Maine Roads to Quality at http://muskie.usm.maine.edu/maineroads/Registry.html

[30] Maine PASA Connection at http://www.mainepasaconnections.org/Connections/index.htm

[31] Board of Nursing: www.maine.gov/bon

[32] These analysts work with the O*NET program, the nation's primary source of occupational information. Central to the project is the O*NET database, containing information on hundreds of standardized and occupation-specific descriptors. The database, which is available to the public at no cost, is continually updated by surveying a broad range of workers from each occupation.

[33] CMS Nursing Home Compare Website, http://www.medicare.gov/NHCompare, referenced Jan. 2006.