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State Efforts to Improve Direct Care Workforce Wages: Final Report

Prepared for
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by
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STATE EFFORTS TO IMPROVE DIRECT CARE WORKFORCE WAGES: FINAL REPORT

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ARPA	American Rescue Plan Act
BLS	Bureau of Labor Statistics
CMS	HHS Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus
DC	District of Columbia
DCW	Direct Care Worker
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
LTSS	Long-Term Services and Supports
OEWS	Occupational Employment and Wage Statistics
VBR	Value-Based Reimbursement
WPT	Wage Pass-Through

EXECUTIVE SUMMARY

Direct care workers (DCWs) such as nursing assistants, home health aides, and personal care aides play an essential role in the health and well-being of over 20 million Americans. Yet wages for these workers are not enough to make jobs competitive with entry-level positions in other industries with similar job requirements. Some states have tried to address this issue by implementing policies aimed at improving DCW wages. The purpose of this study was to explore state policies for improving compensation for DCWs since 2009, the key elements of policies, and the results of those policies. We accomplished this through an environmental scan, wage trend analyses, expert interviews, and six state case studies.

ES.1 The Problem

DCWs often earn low wages, with almost one-half living below 200% of the federal poverty guidelines and about half relying on public assistance (Scales, 2021). In 2020, national median pay was $13.02 per hour ($27,080 per year) for home health and personal care aides and $14.82 per hour ($30,830 per year) for nursing assistants (BLS, 2021a, 2021b). Wages for DCWs are not enough to make jobs competitive with entry-level positions in other industries with similar requirements, such as janitors, retail salespersons, and customer service representatives.

Low wages among DCWs is a long-standing issue on which little or only incremental progress has been made in the last 20 years despite repeated policy efforts at the state and federal levels. While a few studies have suggested that wage pass-through policies do result in higher wages (Baughman & Smith, 2010); and may result in better staffing in nursing homes (Feng et al., 2010), by and large research in this area has not found much efficacy since a seminal study was conducted in 2002 (HHS, 2002).

Our wage trend analysis results show that, in 2019, home health and personal care aides earned lower wages than other entry-level workers in all states, and nursing assistants earned lower wages in 40 states and DC. We found that wages of home health and personal care aides were 78% of those of other entry-level jobs--DCWs made $0.78 for every $1.00 made by other entry-level workers. Similarly, nursing assistants made, on average 95% of wages of other entry-level workers.

ES.2 Potential Solutions

We found that since 2009 states have primarily used three methods to improve wages for DCWs: implementing wage pass-through policies, increasing the wage floor (minimum wage) for DCWs, and tying raises to workforce development and training.

Wage pass-through policies direct providers (such as nursing facilities and home care agencies) to use increases in state Medicaid reimbursement rates to increase DCW compensation.

Wage floor policies dictate the minimum allowable starting wage for DCWs. These policies have primarily targeted the wages of home health and personal care aides, and these are sometimes tied to the state's minimum wage.

Finally, a few states have tried tying increases in DCW wages to completion of various certifications or training programs by DCWs.

ES.3 Wage Trends

Our wage trend analyses found that the gap between DCW wages and the wages of other entry-level employees decreased in many of the states that implemented policies to improve the wages of DCWs. However, in most cases, DCWs--especially home health and personal care aides--still made far less per hour than other entry-level workers.

The experts and stakeholders we interviewed for this study noted two key elements of policies to successfully improve wages: (1) continuity in funding for wage increases; and (2) auditing processes that ensured state funds allocated to wages made it to DCWs.

ES.4 Barriers to Improving Wages and Suggestions for Improving Direct Care Work

Insufficient Medicaid reimbursement rates was the most mentioned barrier to improving DCW wages among the experts and stakeholders we spoke to. These experts and stakeholders noted that providers depend on Medicaid reimbursement as a major source of revenue, so when reimbursement rates are not adequate providers are unable to raise wages in a way that positively affects DCWs. Many said that this, in turn, also affects worker turnover and retention. As market forces have increased wages in other industries and Medicaid reimbursement and, subsequently, DCW wages have lagged further behind, DCWs leave the industry for positions that are often less stressful.

Experts and stakeholders suggested the need to professionalize the workforce in ways that improve opportunities for career advancement, such as through training opportunities and career ladders. Experts and stakeholders also noted that, in addition to increased wages, DCWs need to receive benefits, such as health insurance and paid leave. Many experts and stakeholders also suggested that direct care work needs to be better respected and that policymakers and the general public do not understand the important role these workers play in the health care system. Finally, many experts and stakeholders described the need for an increased supply of workers for direct care jobs and suggested that programs needed to be developed to funnel potential workers into this field.

ES.5 Conclusion

Despite state attempts since 2009 to improve DCW wages through wage pass-through and other policies, wages for DCW are not enough to make jobs competitive with other entry-level jobs. This is especially true for home health and personal care aides. The experts and stakeholders we spoke to repeatedly cited consistent funding of wage policies through Medicaid reimbursement rate increases as important to effectively increasing wages. They recommended that funding increases be continual, rather than requiring re-authorization year after year and noted it was particularly challenging when funds were not adequate to continually support annual wage increases. They described Medicaid reimbursement rates as a barrier to DCW recruitment, retention, and job satisfaction when rates did not keep pace with market trends. Many also recommended professionalizing the field, increasing the respect afforded these workers, and developing ways to increase the pipeline of workers as additional ways to improve direct care work. Until there is meaningful policy change, we will continue to struggle with barriers to improved compensation for DCWs which results in a disproportionate number of DCWs receiving public benefits, difficulties with recruitment and retention, and competition from other higher paying entry-level occupations.

SECTION 1.
THE PROBLEM

Direct care workers (DCWs) such as nursing assistants, home health aides, and personal care aides play an essential role in the health and well-being of over 20 million Americans who receive long-term services and supports (LTSS). It is estimated that from 2018 to 2028 this workforce will add 1.3 million new jobs to meet rising demand (PHI, 2020a). Despite the rising demand for services, DCWs continue to earn low wages. Almost one-half (45%) of the direct care workforce lives below 200% of the federal 200% poverty guidelines and about one-half (47%) rely on public assistance (Scales, 2021). In 2020, national median pay was $13.02 per hour ($27,080 per year) for home health and personal care aides, and $14.82 per hour ($30,830 per year) for nursing assistants (BLS, 2021a, 2021b).

Wages for DCWs are not enough to make jobs competitive with entry-level positions in other industries with similar entry-level requirements--such as janitors, retail salespersons, and customer service representatives--which worsens the challenges in recruitment and retention of DCWs (Ong et al., 2002; PHI, 2020b; HHS, 2002). Many DCWs are lost to other sectors that offer similar wages but more flexible schedules, more hours, and other benefits (Campbell et al., 2021). For example, a study of home health aides found that 40-60% leave after less than one year, and 80-90% leave within the first two years (New York Association of Homes and Services for the Aging, 2000). Although states have used a variety of methods to meet the growing demand for and to retain DCWs, limited investment in workers' wages across settings remains a major contributor to workforce shortages, high turnover, and poor quality of care (Gandhi et al., 2021; PHI, 2015; Ruffini, 2020).

Low wages for DCWs is a long-standing problem and repeated efforts at the state and federal levels in the past 30 years have resulted in little or only incremental progress. For example, a study conducted in 2002 found that while multiple states had used Medicaid wage pass-throughs and other policies to try to improve wages, there was little evidence supporting their efficacy (HHS, 2002). Yet, another study conducted several years later suggested that wage pass-through policies do result in higher wages (Baughman & Smith, 2010). And another study found that wage pass-throughs also result in better staffing in nursing homes (Feng et al., 2010).

In 2006 the Centers for Medicare & Medicaid Services (CMS) created the Direct Service Workforce Resource Center, which provided information and technical assistance to state and local governments as well as a comprehensive online resource database. In 2008, the Institute of Medicine report entitled *Retooling for an Aging America* included a chapter on the direct care workforce to highlight a range of approaches to improve the quality of direct care occupations, including needed increases in pay and benefits (Institute of Medicine, 2008). However, there is little evidence that either of these efforts had any real effect on DCW wages.

Progress toward improving wages and benefits for DCWs was made between 2010 and 2014 when the Affordable Care Act allowed a million DCWs to gain access to health care

coverage. In 2013 an update to the Fair Labor Standards Act extended minimum wage and overtime protections to most home care workers (Doty, Squillace & Kako, 2019).

More recently, the American Rescue Plan Act (ARPA) of 2021 provided a temporary 10% increase in the federal medical assistance percentage (FMAP) received by states for home and community-based services (HCBS). It is unclear how much of this additional funding will be used to improve wages for DCWs (Bodas et al., 2021), but many state plans include improving DCW wages, training, and recruitment efforts.

This report presents findings from a project that examined state policies aimed at increasing DCW wages implemented since 2009. An environmental scan, wage trend analysis, expert interviews, and state case studies were conducted to address the following policy research questions:

- What policies have been implemented to improve DCW wages and what is known about their key elements and effects?
    - Which approaches have had the biggest effect on wages?
    - Which policies were ineffective and why?
    - Which policies can perpetuate systemic barriers to improved wages?
    - What are the most promising next steps in research for informing policy to improve compensation for DCWs?
- What model Medicaid rate-setting approaches exist that successfully target direct care workforce compensation?

1.1 Methods

This report presents overall findings from an environmental scan, a wage trend analysis, interviews with subject matter experts, and state case studies. We focused on the paid direct care workers, not including unpaid family caregivers.

We first conducted an environmental scan (which included grey and peer-reviewed literature) to identify past, and current state policies and programs aimed at improving DCW wages and what is known about their effect. Through a scan of university, foundation, federal, and state websites, we systematically reviewed 239 grey literature documents for relevance and summarized 70 of them. We extracted details about the state, policy type, policy implementation dates, type of workers affected, key elements, and policy effect and data were organized by state in an Excel spreadsheet. For the peer-reviewed literature, we conducted searches of PubMed, Web of Science, and CINAHL for peer-reviewed articles published after 2009 that included terms for DCWs, their work settings, wages, and common policy terminology (e.g., wage pass-through). This yielded 75 article abstracts. We reviewed the abstracts for relevance and ten

articles were included in the full text review. We categorized information extracted from each article and organized it into key themes by topic area.

RTI conducted a wage trend analysis to assess state-level DCW wages relative to other entry-level jobs (for the reference period of May 2019) and assess the relationship between wage policy implementation and change in the wage gap between DCWs and other entry-level workers (from 2009 to 2019). We obtained information about state policies and programs to improve DCW compensation implemented in each state between 2010 and 2018 from the environmental scan. The analysis used state-level wage data from the U.S. Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) program for home health and personal care aides and nursing assistants. We also obtained hourly median wages from BLS for other entry-level jobs as defined by the U.S. Department of Labor Occupational Information Network (O*NET) OnLine.

RTI conducted interviews with nine subject matter experts including LTSS policy experts, provider associations, worker advocates, and researchers to gain more insight into policies that may influence the wages of DCWs and to gather recommendations for states to include in our case studies. We summarized each interview transcript and organized them into key themes.

Finally, we conducted case studies in six states (California, Michigan, New York, South Dakota, Tennessee, Washington) to further explore and better understand states with policies aimed at improving DCW wages. State selection was informed by the previously conducted environmental scan and subject matter expert interviews. We conducted up to five interviews in each case study state with a variety of stakeholders, including state Medicaid and LTSS representatives, representatives from provider groups (including HCBS and residential care) and worker associations. We summarized each state case study by highlighting the state policies or practices identified, the effectiveness of these policies and practices for improving DCW wages, and the key factors related to effectiveness.

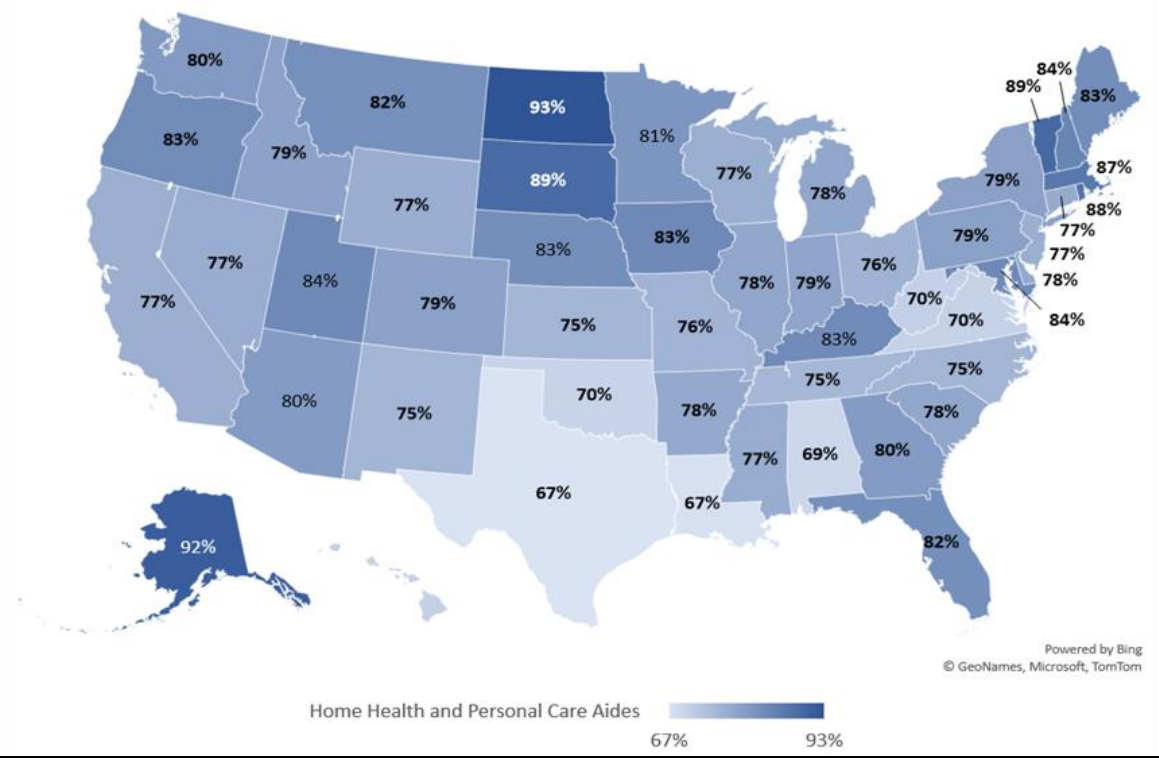
1.2 Wage Gaps Between Direct Care Workers and Other Entry-Level Jobs

Results of our quantitative analysis of DCW wages show that, in 2019, home health and personal care aides earned lower wages than other entry-level workers in all states and nursing assistants earned lower wages in 40 states and the District of Columbia (DC). We also found great variation across states in the gap between DCW wages and the wages of other entry-level workers. Specifically, in 2019, average state-level median wages were $12.01 per hour for home health and personal care aides and $14.39 per hour for nursing assistants. Wages for these occupations and for other entry-level jobs varied across states. Louisiana had the lowest hourly wages for DCWs ($9.03 for home health and personal care aides and $10.90 for nursing assistants) and Alaska had the highest hourly wages for DCWs ($16.43 for home health and

personal care aides and $18.66 for nursing assistants). Workers in other entry-level jobs had an average median wage of $15.16 per hour, ranging from $12.80 in Mississippi to $18.55 in DC.

On average, median wages of home health and personal care aides were $3.15 per hour lower than the wages of other entry-level jobs in all states and DC. Home health and personal care aides earned 78% of wages ($0.78 for every $1.00) made by other entry-level workers. As shown in ***Figure 1***, as a percentage of wages of other entry-level jobs, the wages of home health and personal care aides varied widely across states with the lowest (67%) in Texas and Louisiana and the highest (93%) in North Dakota. In dollar terms, the largest gap between wages of home health and personal care aides and other entry-level jobs was $5.45 per hour in Hawaii, and the smallest gap was $1.15 per hour in North Dakota.

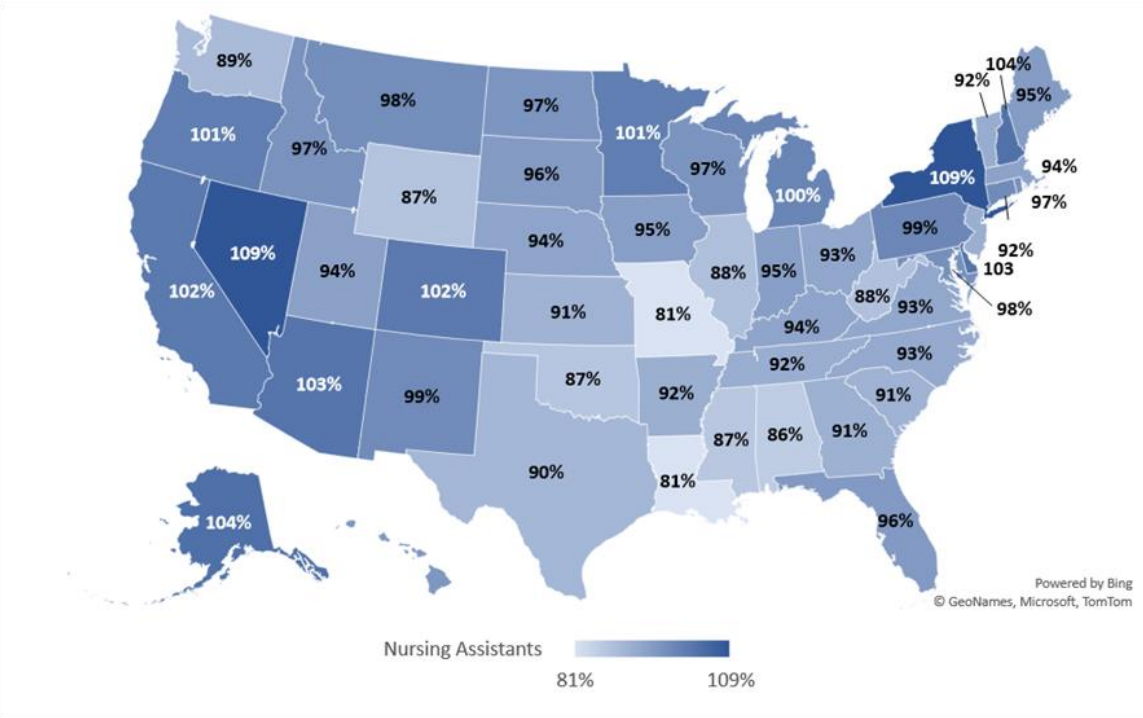
Figure 1. Wages of Home Health and Personal Care Aides as Percentage of Wages of Other Entry-Level Jobs (2019)



Notes: State-level median wages were obtained from the BLS OEWS program for the May 2019 reference period. Percentage reflect the fraction of the wages of other entry-level jobs made by DCWs. For example, a value 80% indicates that DCWs made 80% of wages made by other entry-level jobs or, in other words, DCWs make $0.80 for every $1.00 made by other entry-level workers.

Similarly, nursing assistants earned median wages that were 95% ($0.76 less per hour) than the wages of other entry-level jobs in 40 states and DC. As shown in ***Figure 2***, as a percentage of wages of other entry-level jobs, the wages of nursing assistants in 2019 were the lowest (81%) in Missouri and Louisiana and the highest (109%, indicating that nursing assistants had higher wages than other entry-level workers) in Nevada and New York.

Figure 2. Wages of Nursing Assistants as Percentage of Wages of Other Entry-level Jobs (2019)



Notes: State-level median wages were obtained from the BLS OEWS program for the May 2019 reference period. Percentage reflect the fraction of the wages of other entry-level jobs made by DCWs. For example, a value 80% indicates that DCWs made 80% of wages made by other entry-level jobs or, in other words, DCWs make $0.80 for every $1.00 made by other entry-level workers.

1.3 Expert Input

Despite being interviewed separately, the experts unanimously stated that DCW wages are too low, largely because of historic and chronic underinvestment in the workforce and insufficient state Medicaid budgets. This underinvestment has created workforce challenges that will be exacerbated by growing demands for LTSS. Experts noted that these challenges limit the ability for providers to improve and sustain wages for DCWs.

Experts also noted that low wages are a reflection of societal values related to caregiving and the populations in need of care. One labor union representative noted that elected officials and members of the general public often think people should not be well compensated for taking care of an older adult or person with a disability, because this type of work is just glorified babysitting. Experts agreed direct care work gets undervalued compared to workers in the rest of the health care system, and that as a society we do not understand, or adequately value, the importance of providing care to older adults and people with disabilities. Related to this idea, one expert noted they do not think we value the populations DCWs provide care to, and that this contributes to low wages.

Experts also noted that low DCW wages can interact with, and potentially exacerbate, other recruitment challenges. One expert attributed some of the difficulty in recruiting these staff to the physical difficulty and high risk of injury associated with these jobs. The healthcare industry shares a general view that DCWs are unskilled, which may also contribute to undervaluing this work and, in turn, lower wages. Experts note that job applicants themselves may also see DCW jobs as an inferior option compared to competing industries that offer equal or greater pay such as retail or fast food. One expert also attributed DCW pay issues to discrimination, noting that the workforce is comprised primarily of women of color.

Because of this stigmatization of DCWs as unskilled, agencies find the only people they can hire are people who either love the work and will accept low wages to do work they love, providing an opportunity for exploitation, or people who may struggle to get a job elsewhere. Other experts confirmed this dichotomy in the DCW workforce between highly capable workers who have a passion for the job versus workers who do not have many alternative employment opportunities.

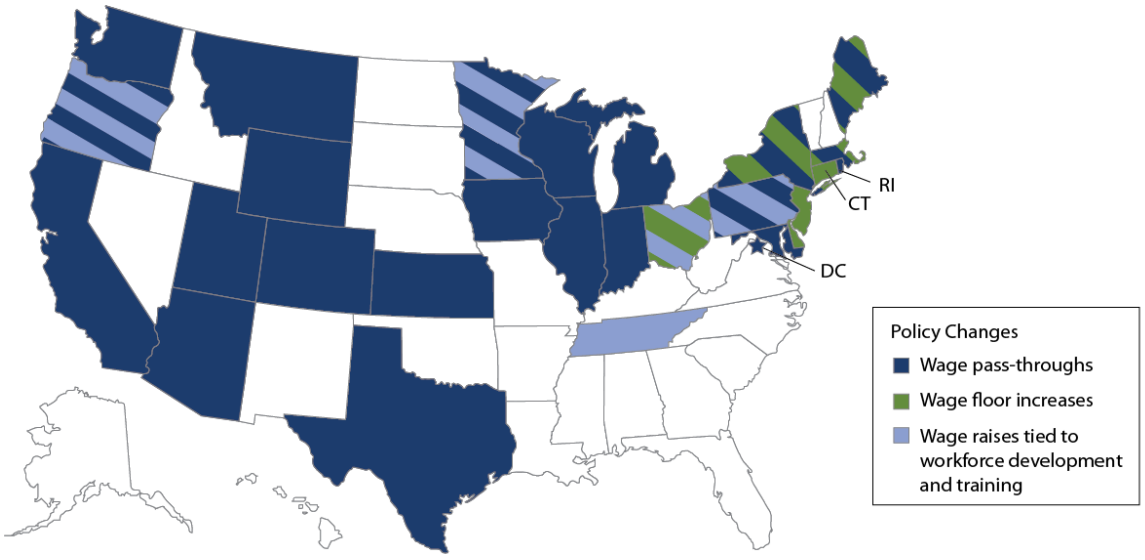
SECTION 2.
POTENTIAL SOLUTIONS

Our environmental scan found three prominent methods used by states to improve wages for DCWs since 2009. These include wage pass-through policies, increasing the wage floor for DCWs, and tying raises to workforce development and training.

2.1 Wage Pass-Through Policies

Since 2009, the most common policy states use to improve the wages of DCWs was a wage pass-through (***Figure 3***). There are three main ways that states implement wage pass-through laws. These include: (1) requiring a certain dollar amount be added to the wages or benefits of DCWs; (2) requiring a certain percentage of the Medicaid reimbursement rate providers receive be used to compensate DCWs; and (3) creating state trust funds that can be used to increase worker wages (Yearby et al., 2020). States most commonly choose to pass a percentage of Medicaid reimbursement on to DCWs.

Figure 3. State Policies Aimed at Improving DCW Wages (since 2009)



Our scan found that 22 states and DC have had wage pass-through policies in place since 2009. Not all wage pass-through policies were continuous, in that they were not repeatedly funded through annual legislation or appropriations, and some started prior to 2009. Most of these policies have been targeted at HCBS, including home health and personal care aides, as well as direct support providers in the intellectual and developmental disability service community. Four policies have been targeted at nursing assistants in nursing homes, and six have been targeted at all types of DCWs. Some states specify the ability for the state to dissolve the policy or not increase wages if they do not get additional funding from the Federal Government

(Yearby et al., 2020). Twelve states have implemented new wage pass-through policies in the past five years, suggesting that this is still a highly utilized method for states hoping to improve wages for DCWs.

2.2 Wage Floor Policies

Wage floor policies are also known as minimum wage policies. In October 2015, the U.S. Department of Labor established a final rule extending the application of the minimum wage and overtime regulations under the Fair Labor and Standards Act to DCWs providing services in the home setting (Morgan, 2016). This rule means that all home care aides must be paid the federal minimum wage and overtime, with a few exceptions. Some states require that their DCWs be paid a certain percentage above the state minimum wage, whereas others increase the minimum dollar amount DCWs must be paid.

For this scan, we looked for states that had implemented policies explicitly meant to raise the minimum wage for DCWs through various legislative means. Seven states have implemented wage floor policies, which may require wages of a certain percentage or dollar amount over minimum wage One state (New Jersey) targets its policy toward DCWs working in nursing facilities, and the policy in one state (Maine) covers all DCWs. Policies in the other five states are specific to home health aides.

2.3 Workforce Development Policies

Our scan found that five states (Minnesota, Ohio, Oregon, Pennsylvania, Tennessee) have provided increased wages for DCWs after completion of various certifications or training programs since 2009. Workforce development policies are defined as certifications or training programs that lead to an increase in DCW wages. In some cases, training is tied to an explicit increase in wages (e.g., $1/hour wage increase for completing a training) and in other cases there is an expectation that wages will increase based on the worker's new skill set without benchmarks or enforcement of wage increases. Three states (Minnesota, Ohio, Oregon) implemented workforce development policies tied to wage increases specifically for home health and personal care aides. Although our scan did not identify any workforce development policies tied to wage increases explicitly for nursing assistants, it did identify a policy from Pennsylvania that is applicable to both groups, and a policy in Tennessee that did not specify the type of DCW.

2.4 Other Policies

Two states have used other methods for improving wages--Minnesota has used value-based reimbursement (VBR) and South Dakota implemented one-time wage enhancement. We also found 41 states implemented policies to increase recruitment and retention during the COVID-19 public health emergency. These measures were often temporary, and in some cases, the money may not have been designated specifically to DCWs.

2.5 Key Elements of Policies

The key elements of policies to successfully improve wages noted by experts and stakeholders were: (1) funding for wage increases, including continuity in reimbursement rates or funds for wages; and (2) audit processes that ensured state funds allocated to wages made it to DCWs.

Stakeholders from California, Michigan, and South Dakota discussed the importance of state policies that were implemented to continue wage increases over longer periods of time. In Michigan, a worker group stakeholder described being pleased with the recent addition of a permanent annual wage add-on in their fiscal year 2022 state Medicaid budget that removed the need to re-authorize the add-on every quarter. A South Dakota state representative added that increases in Medicaid reimbursement are a long-term solution because raising Medicaid rates can be more sustainable than one-time wage increases.

Stakeholders from New York, Michigan, and Washington described monitoring and auditing processes as a key element to ensure the wage pass-through (New York) and wage add-on (Michigan, Washington) made it to the workers and increased their pay. At the outset of the COVID-19 pandemic, Michigan implemented a wage add-on and monitored it to ensure that the money goes to the DCWs by requiring providers to submit documentation of wage increases. Stakeholders in Washington similarly noted that their add-on wages require auditing and tracking that ensure workers receive the increased wages.

2.6 Expert Suggestions

Interviewed experts offered a range of potential policy solutions to address low wages for DCWs.

- **Increase Medicaid funding**. At the broadest level, experts agree states could increase Medicaid reimbursement rates to providers, allowing them to have more funding to invest in DCW wages.

- **Implement Medicaid reimbursement for training and certification**. In many states, Medicaid does not provide funding for training of DCWs who provide HCBS. Multiple experts suggested that reimbursing home care agencies for training and certification programs--and attaching a certification or license to completion of these trainings that comes with an enhanced base salary--would increase wages and improve the competency of the workforce.

- **Implement medical loss ratio approach**. New Jersey and New York have imposed a medical loss ratio approach in which a certain percentage of revenue that agencies receive must be spent on the direct care of residents, to include DCW wages. The New Jersey policy sets a 90% ratio that must be spent on the direct care of residents but does not further specify what percentage should be directed towards DCW wages (LegiScan, n.d.).. The New York policy requires nursing facilities to spend 70% of their revenue on resident care, and further specifies that 40% of that amount must be used for DCW wages

and benefits (New York State Senate, 2022). Because these are new policies, implemented in New Jersey in 2020 and not yet implemented in New York due to legal challenges, their impacts on DCW wages are not yet known.

- **Create value-based approaches**. Experts suggested using a value-based approach to HCBS whereby providers would get increased reimbursement rates if they met certain quality metrics such as hospital readmission, or pressure and skin ulcers. The increased reimbursement would be used for higher wages. In this arrangement, providers could also receive an increase in their Medicaid reimbursement rate if they demonstrate certain activities such as better compensation, health insurance for employees, and support for frontline staff.

- **Establish a career ladder**. Experts suggested the need for a clearly defined pathway for career advancement and accompanying wage increases. Providers could tie career advancement opportunities to training and certification completion.

SECTION 3.
WAGE TRENDS

As detailed in ***Section 2***, states have used several types of policies since 2009 to try to increase the wages of DCWs. We conducted wage trend analyses to determine the effect of these policies on the change in the gap between the wages of other entry-level workers and the wages of home health and personal care aides and nursing assistants.

3.1 Home Health and Personal Care Aides

Fifteen states implemented wage pass-through policies between 2010 and 2018 to improve compensation of home health and personal care aides. In these states, the median hourly wages in 2009 (adjusted for inflation to 2019$) were $11.98 for home health and personal care aides and $15.52 for other entry-level workers (see ***Table B-1*** in ***Appendix B***). By 2019, the average hourly median wages increased to $12.49 for home health and personal care aides and to $15.74 for workers in other entry-level jobs; and the wage gap in these states decreased by $0.29 to $3.25 per hour (***Figure 4***). In five states, the wage gap between home health and personal care aides and other entry-level workers increased between 2009 and 2019; the largest hourly increase was $0.81 in Arizona. The wage gap decreased the most ($1.67) in DC. Even then, the DC wage gap remained the second highest, at $3.89 per hour.

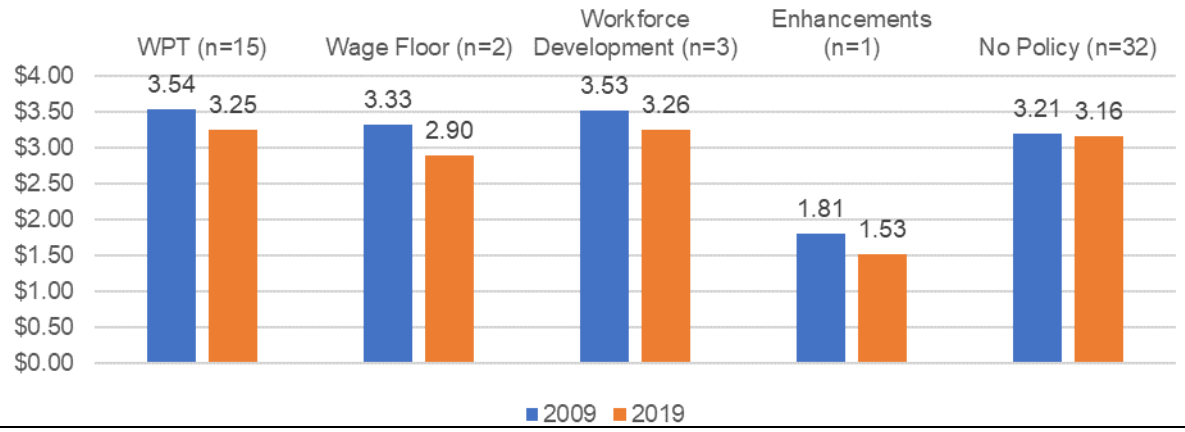
Two states implemented policies to increase the wage floor for home health and personal care aides. The wage gap between these DCWs and other entry-level workers in these states decreased by $0.43 per hour (from $3.30 to $2.90) from 2009 to 2019.

Three states implemented wage increases for home health and personal care aides tied to workforce development and training. Between 2009 and 2019, the wage gap between home health and personal care aides and workers in other entry-level jobs decreased by $0.08 per hour in Ohio and by $0.95 in Oregon; but increased by $0.23 in Tennessee. The average gap was $3.26 in 2019.

One-time DCW wage enhancements were implemented in South Dakota twice (in 2015 and 2018). The wage gap in this state decreased by $0.28 per hour between 2009 and 2019, shrinking to $1.53 by 2019.

In the 32 states that did not implement any of the policies examined here, the wage gap between home health and personal care aides and other entry-level workers decreased by only $0.05, from $3.21 in 2009 to $3.16 in 2019.

Figure 4. Wage Gap between Home Health and Personal Care Aides and Other Entry-Level Workers, 2009 and 2019, by Policy Type (adjusted to 2019$)



Notes: State-level median wages were obtained from the BLS OEWS program for reference periods of May 2009 and May 2019. Wages were adjusted for inflation to 2019 dollars using the Consumer Price Index. The wage gap represents the difference in median wages of DCWs and other entry-level workers. A positive (negative) value indicates that the wages of nursing assistants were lower (higher) than the median wages of other entry-level workers. Analysis is restricted to policies implemented between 2010 and 2018. The number in parentheses for each policy indicates the number of states that implemented the policy during this period.

3.2 Nursing Assistants

Eight states implemented wage pass-through policies aimed at improving compensation of nursing assistants between 2010 and 2018. These states' median hourly wages in 2009 were $14.19 for nursing assistants and $15.18 for other entry-level workers (see ***Table B-2*** in ***Appendix B***). By 2019, the average hourly median wages increased to $15.03 for nursing assistants and to $15.41 for other entry-level workers, with the hourly wage gap decreasing from $0.98 to $0.39 (***Figure 5***). The largest wage gap reduction occurred in California ($1.36 per hour) where, by 2019, the wages of nursing assistants were higher than the wages of other entry-level jobs. The hourly wage gap increased in Massachusetts by $0.36 from $0.68 to $1.04.

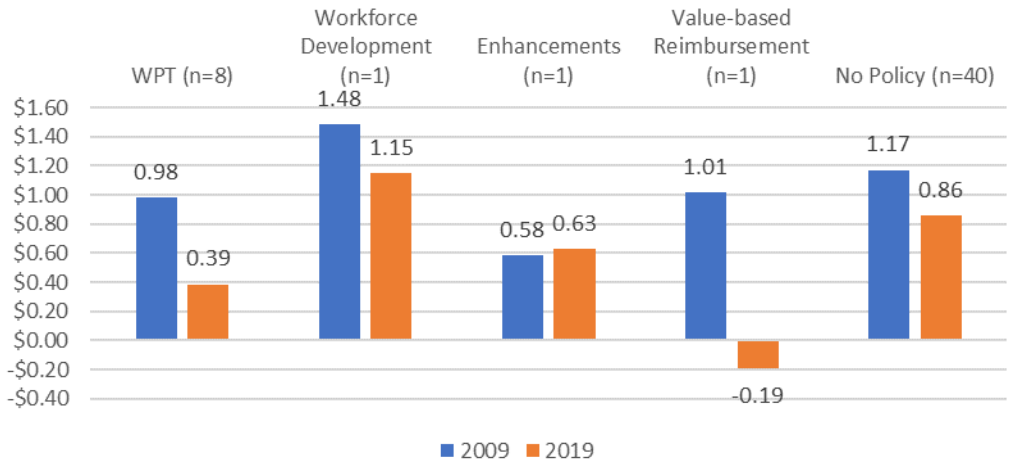
Tennessee implemented a wage increase for DCWs tied to workforce development and training and the wage gap for nursing assistants in this state decreased by $0.34, from $1.48 in 2009 to $1.15 in 2019.

South Dakota implemented DCW wage enhancements twice and experienced a widening of the wage gap between nursing assistants and other entry-level workers from $0.58 to $0.63 per hour.

Lastly, in Minnesota, which implemented a VBR program, the wage gap decreased by $1.20. By 2019, nursing assistants had higher hourly wages than workers in other entry-level jobs ($16.82 vs $16.63, respectively).

In the 40 states that did not implement any of the policies examined here, the wage gap between nursing assistants and other entry-level workers decreased by $0.31.

Figure 5. Wage Gap between Nursing Assistants and Workers in Other Entry-Level Jobs, 2009 and 2019, by Policy Type (adjusted to 2019$)



Notes: State-level median wages were obtained from the BLS OEWS program for reference periods of May 2009 and May 2019. Wages were adjusted for inflation to 2019 dollars using the Consumer Price Index. The wage gap represents the difference in median wages of DCWs and other entry-level workers. A positive (negative) value indicates that the wages of nursing assistants were lower (higher) than the median wages of other entry-level workers. Analysis is restricted to policies implemented between 2010 and 2018. The number in parentheses for each policy indicates the number of states that implemented the policy during this period.

3.3 Policy Effects on Wages

Stakeholders interviewed as part of the case studies agreed that wages had improved over time, but also noted that they were still too low to retain existing DCWs or recruit new workers. All stakeholders across all states agreed that recruitment and retention of DCWs has become even more difficult during the COVID-19 pandemic given competition from other industries.

According to stakeholders, evidence demonstrating this success of wage increases is largely anecdotal. Stakeholders from most case study states agreed that relatively more substantial wage increases have occurred recently, due primarily to market forces and competition for workers. South Dakota described increases of about $4 per hour over the past three years as result of one-time appropriations in response to a spate of nursing home closures. In Michigan and Washington, COVID-19 add-on wage increases provided an additional $2.35 per hour and $2.40 per hour, respectively. One Tennessee provider group stakeholder noted they have increased DCW wages by about 10% as a result of the FMAP funding available to the state from COVID-19 relief funding.

Stakeholders from California and South Dakota commented that, though wages have increased, they have not increased at a rate that significantly effects workers due to commensurate increases in cost of living. Provider group stakeholders in Tennessee described the limited effect the state's training program has had on DCW wages, noting that "the incentive

to participate, it's just not compelling enough," and that "… it's like a 50 cent pay increase [tied to] completion of a number of [training] modules."

3.4 Policy Effects on Recruitment, Retention, and Job Satisfaction

Stakeholders across case study states described the difficulty they have competing with other industries that are offering higher starting hourly wages. In California, provider group stakeholders noted that their members pay well over the minimum wage but still have challenges with turnover. However, provider and worker group stakeholders in California also commented that benefits like paid sick time, overtime, meal and rest periods, and health insurance help to reduce attrition and attract new workers. A Michigan provider group stakeholder stated that the COVID-19 add-on wage helped members pay DCWs and assisted with retention, but recruitment challenges remain.

In New York, the recent minimum wage increase for all workers in the state increased competition to recruit new workers and retain current DCWs, according to stakeholders. The one-time appropriations in South Dakota helped with staff retention in the short term because they often went towards bonuses for DCWs. Multiple stakeholders in Washington State mentioned state minimum wage laws enacted in 2017 and the higher Seattle minimum wage law have had a positive effect on DCW wages, recruitment, and retention.

3.5 Expert Interview Findings

Experts cited the merits of payment policies that improve wages, along with areas for improvement and lessons learned. In general, however, experts report challenges in determining the cause and effect of DCW wage policies because these have not been formally evaluated in most states.

> *"I think that's often the case with the laws is that we pass laws and feel like that's enough. But don't do the appropriate evaluation to see if it's making a change and whether we need to revise either the statute or the fund to make sure it's actually resulting in the change that we want it to."*
>
> ─ Academic Researcher

Policies rarely get systematically evaluated in a robust manner, making knowledge of the precise effect on workers difficult to ascertain. Contributing to this problem, experts stressed that it is difficult to evaluate many of these wage policies because of data challenges, specifically getting providers to share wage information. Experts have specifically had trouble finding information regarding what portion of wage pass-through funds actually get to DCWs. This makes it difficult to build the case for sustaining policies or replicating them on a wider scale.

Within state Medicaid programs, there are often multiple waivers with multiple funding streams serving different populations, which can create inequities in how funding gets dispersed and make it difficult to implement wage pass through policies equitably In general, administrative difficulties are a main drawback of wage pass-through laws, in particular when small wage increases approximate the change in cost-of-living, when funds are not specifically

targeted to workers, and when policies require annual legislative actions. Experts agreed that setting an explicit wage floor for DCW wages is the most effective way to increase wages, primarily because of the accountability mechanisms built in to ensure wages are at intended levels. Experts also praised DCW wage-floor policies designed to rise in accordance with minimum wage increases. This prevents future minimum wage increases from wiping out wage gains made by DCWs in previous time periods.

Some experts reported that states with large collective bargaining agreements tend to have the highest wages nationwide, providing evidence for the value of unionization in increased DCW wages. And although training and certification programs that lead to higher reimbursement rates for providers show efficacy in terms of increasing worker wages, robust training programs are not widespread. Additional training, especially with associated costs or time commitments, can also create barriers for DCWs who may not have funds or time available.

Experts identified legislature-passed funding as a problematic policy design. Funding appropriated by state legislatures is often time limited. Employers find it difficult to hire staff at higher wages when they are unsure about whether they can continue to pay these wages the following year. Without long-term funding solutions, building lasting policies can be challenging. Legislation can get removed or altered the next year.

SECTION 4.
BARRIERS TO IMPROVING WAGES AND SUGGESTIONS FOR IMPROVING DIRECT CARE WORK

We asked experts and stakeholders about barriers to improving wages and other aspects of direct care work during case study interviews. Several barriers came up repeatedly among stakeholders and experts.

> *"If Medicaid reimbursement is woefully inadequate, how do you offer a wage that's going to compete with hospitals and clinics and doctor's offices? You can't."*
>
> — Washington Provider Group Stakeholder

Medicaid reimbursement rates were the most commonly mentioned barrier to improving DCW wages among the experts and stakeholders we spoke to. These experts and stakeholders noted that providers depend on Medicaid reimbursement as a major source of revenue, so when reimbursement rates are not adequate, providers are unable to raise wages in a way that positively impacts DCWs. Many said that this, in turn, also affects worker turnover and retention. As market forces have increased wages in other industries and Medicaid reimbursement and, subsequently, DCW wages have lagged further behind, DCWs leave the industry for positions that are often less stressful.

Several stakeholders noted complexities in their policymaking at the state level, including the need to gain buy-in from multiple stakeholder groups who are competing to attract clients with long-term care needs (e.g., HCBS providers, nursing home industry). Experts also discussed how state policies are rarely systematically evaluated, leading to gaps in data across most states and an inability to determine if policies are working as intended or how they may be improved.

Finally, experts and stakeholders noted the lack of perceived value of DCWs and the need to professionalize the field and provide education to the public about the value of direct care work.

4.1 Suggestions for Improving Direct Care Work

Experts and stakeholders suggested other aspects of direct care work that need improvement. Many discussed the need to professionalize the workforce in ways that improve opportunities for career advancement, such as through career ladders or training and credentialing.

Many also suggested that direct care work needs to be better respected and that policymakers and the general public do not understand the important role these workers play in the health care system or how difficult the work is. Some suggested that marketing campaigns around these issues were needed.

Experts and stakeholders also noted that, in addition to increased wages, DCWs need to receive benefits such as health insurance and paid leave. In some cases, lack of these benefits was due to the inability to achieve full-time work because many direct care jobs are part-time

positions. Relatedly, many DCWs have little control over their work hours and may lose hours when providers lose clients.

Finally, many experts and stakeholders described the need to grow the potential labor force for direct care jobs and suggested that programs need to be developed to funnel potential workers into this field.

SECTION 5.
DISCUSSION

This study examined state policies aimed at increasing DCW wages since 2009. We conducted an environmental scan, wage trend analysis, expert interviews, and state case studies to determine the types of policies implemented by states, the key elements of policies, and the results of those policies. We found that states primarily used three approaches to improve wages: implementing wage pass-through policies, increasing the wage floor for DCWs, and tying raises to workforce development and training. Many states also implemented temporary policies during the COVID-19 pandemic aimed at DCW wages, such as hazard pay and bonuses.

Our wage trend analyses, which compared the wages of DCWs to the wages of other entry-level workers over time, found that the gap between DCW wages and the wages of other entry-level employees decreased in many of the states that implemented policies to improve the wages of DCWs from 2009-2019. However, in most cases, DCWs--especially home health and personal care aides--still made far less per hour than other entry-level workers. This is consistent with previous research on the effects of wage pass-through polices that found these policies increase wages (Baughman & Smith, 2010). However, previous research did not examine the effect of policies on the gap between DCW wages and the wages of other entry-level workers. Our findings show that even after wage improvements, these gaps are still quite substantial.

The experts we interviewed and stakeholders across our case study states agreed that policies have not done enough to improve wages, which remain too low to retain existing staff and recruit new DCWs. Although most agreed that wages had improved over time (especially recently because of pandemic-related pay increases), most also agreed that there was a long way to go. Experts and stakeholders across all states also agreed that recruitment and retention of DCWs was difficult given competition from other industries.

5.1 Changes Following Policy Implementation of Policies and What More Could be Done

Although we observed that wage pass-through policies were associated with improvements in wages the wages of these workers are still below the wages of other entry-level workers--far below, in the case of home health and personal care aides. Our wage trend analyses found that wage pass-through policies reduced the wage gap between home health and personal care aides and other entry-level workers in ten of the 15 states that implemented these policies. The average reduction in the wage gap was $0.29, but the average wage gap across all states was still $3.15 in 2019. Results for nursing assistants were similar, with reductions in the wage gap in seven of the eight states that implemented these policies. The average reduction in the wage gap was $0.60, bringing the average wage gap in these states down to $0.39.

Most experts and stakeholders we interviewed cited Medicaid reimbursement rates as key to improving DCW wages and said that wage pass-through policies were more successful when

Medicaid funding increases were continual, rather than requiring re-authorization year after year. Medicaid reimbursement rates were described as a challenge when funds were not adequate to continually support wage increases year over year. Many experts and stakeholders noted this was especially an issue in the wake of the pandemic, with wages in other industries increasing and DCW wages unable to compete. However, it should be noted that there is no literature to support the contention that increasing Medicaid rates results in increased DCW wages in the absence of policies aimed specifically at wages. Future research should examine the relationship between Medicaid reimbursement rates, and changes in these, and DCW wages.

Experts and stakeholders in a few states reported that increases to the minimum wage for all workers contributed to the wage gap because increases in Medicaid reimbursement rates often did not keep pace with the minimum wage increase. A few wage floor policies addressed this issue by tying the DCW wage floor to the minimum wage so that DCW wages were always a set amount above the minimum wage. However, wage floor policies have been implemented in very few states.

Experts and stakeholders said that as wages have increased for workers across many industries, there is little financial reason for people to choose to enter or remain in direct care. Many stakeholders thought that increases in the minimum wage among all workers was making direct care work a less attractive option because similar wages could now be earned in other (possibly less-demanding) industries. This suggests that policies should be used to increase DCW wages commensurate with minimum wage increases and even changes in the market rate for entry-level workers. However, this would likely require increases to Medicaid reimbursement rates, and many state representatives reported being constrained due to the budget implications this would have.

5.2 Limited Role of Medicaid Reimbursement Methodology

We anticipated that some states would attempt to improve DCW wages through their Medicaid reimbursement methodology by, for example, tying reimbursement rates to staffing measures or other measures of quality. However, we found that only Minnesota took this approach, with their VBR system for nursing facilities. Under VBR, care-related costs, including DCW wages, are reimbursed at actual costs subject to a quality limit. This means that nursing facilities achieving certain quality goals are reimbursed by the state for the total costs of these wages rather than the usual portion of those costs. This incentivizes facilities to invest in DCW wages as a way of improving their quality. Though the VBR system was not designed specifically to improve the wages of DCWs, early reporting by facilities suggested that it did so (Minnesota Department of Human Services, 2017). In April 2022, Illinois also passed legislation that will tie nursing facility Medicaid reimbursement rates to staffing and quality, but this has not yet been implemented (Hensel, 2022).

Other states are in the process of tying specific proportions of their Medicaid reimbursement to DCW wages. In late 2020, New Jersey became the first state to implement a

medical loss ratio for nursing facilities, wherein nursing facilities are required to put 90% of their revenue toward direct care, including DCW wages. This legislation also instituted a wage floor for DCWs that is $3.00 above New Jersey's minimum wage (LegiScan, n.d.). In late 2021, New York passed legislation that would require nursing facilities to utilize 70% of their revenue on resident care, and 40% of that amount must be used for DCW wages and benefits. This policy has not yet been implemented and is being challenged in court (mcknights.com, n.d.). Ohio also set a requirement that 70% of new funds from a Medicaid reimbursement rate increase implemented in 2021 be used for direct care, including DCW wages (Wu, 2021). These programs are all too new to determine their effect on DCW wages and future research should explore this.

5.3 Little Progress in 20 Years

Our findings confirm and reinforce findings of other studies conducted in the past 20 years and suggest that, despite state and federal efforts, little progress has been made toward improving wages for DCWs or other aspects of direct care jobs. This is likely because progress to address the problem in the past two decades has been driven by temporary solutions and limited policy actions with intermittent state-specific success stories. For example, further national efforts to highlight policy options and technical assistance, such as CMS's Direct Service Workforce Resource Center and the Institute of Medicine *Retooling for an Aging America* report (Institute of Medicine, 2008) which highlighted a range of approaches to improve DCW jobs helped to provide policy options but were not positioned to drive state action.

Incremental progress toward improving wages and benefits for DCWs was made between 2010 and 2014 when the Affordable Care Act allowed a million DCWs to gain access to health care coverage, and in 2013 when an update to the Fair Labor Standards Act extended minimum wage and overtime protections to most home care workers (Doty, Squillace & Kako, 2019). The effect of ARPA 2021, which provided a temporary 10% increase in the FMAP received by states for HCBS, is yet unknown.

Our results reaffirm those of a study conducted by AARP in 2006 which found that temporary Medicaid wage pass-throughs were the most common policies used by states to improve wages (Seavey & Salter, 2006) and previous research by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation which found that these policies are largely ineffective in producing sustained wage increases for DCWs (HHS, 2002). However, another study conducted several years later suggested that wage pass-through policies do result in higher wages (Baughman & Smith, 2010). And another study found that wage pass-throughs also result in better staffing in nursing homes (Feng et al., 2010).

The AARP report also noted that collective bargaining has been used by DCWs (primarily personal care aides) in some states to increase wages (Seavey & Salter, 2006). Some of the experts we spoke to also suggested that unions and collective bargaining would help improve DCW wages. A 2016 survey of home care workers found that unionized workers were: (1) more likely to expect to still be a home care worker a year from now; (2) less likely to be

looking for a job other than home care; (3) more likely to say they would benefit from training; (4) less likely to say they are never paid overtime when they work over 40 hours in a week; (5) more likely to receive an array of benefits; and (6) have higher wages on average (Christman & Connolly, 2017).

Other issues we heard about from experts also reflect the literature over the past 20 years. This includes that there has been chronic underinvestment in the direct care workforce and that these workers are undervalued compared to workers in the rest of the health care system (Scales & Lepore, 2020); low DCW wages exacerbate recruitment and retention issues (Kemper et al., 2008); and there is great need to professionalize DCWs in ways that improve opportunities for career advancement, such as through career ladders or training and credentialing (Randall Wilson et al., 2002). In addition to improved wages, experts confirmed that DCWs need to receive benefits such as health insurance and paid leave, and states need to design ways to increase the pool of applicants by developing programs to funnel potential workers into this field (HHS, 2020).

5.4 Limitations

Our environmental scan was limited to information that is publicly available about state policies aimed at improving DCW wages and did not include a formal analysis of state legislation. This may have limited the information we were able to find about state wage policies and biased which states were selected for the case studies. Our expert and case study stakeholder interviews are not generalizable, and the case studies included only six states. Experts and stakeholders who agreed to participate in these interviews may have been different from those who did not participate. In addition, some stakeholders we spoke to were not in their positions when policies were implemented or were unable to provide details about older policies that were no longer influencing wages.

As for our wage trend analyses, results presented are descriptive and did not account for other types of policies that may have affected DCW wages besides policies aimed explicitly at wages. In addition, the analysis was based on BLS OEWS data for reference periods of May 2009 and May 2019. BLS OEWS estimates for a given reference period are based on a survey of six semiannual panels for three consecutive years. For example, the May 2019 employment and wage estimates were calculated using data collected in the May 2019, November 2018, May 2018, November 2017, May 2017, and November 2016 semiannual panels. Given that the data from each reference period span a three-year period, changes in wages that may follow implementation of a compensation policy will be reflected in the OEWS estimates gradually rather than immediately. As a result, the changes following policy implementation of a policy that was implemented in 2018 or even 2017 may not yet be fully reflected in the BLS OEWS wage data from the May 2019 reference period. Thus, this study is limited by wage increases that may have occurred more gradually and for policies that required more time to have an effect on wages. Finally, due to limitations in data availability, our analysis only looked at policies implemented before 2018. Since then, more states have implemented additional policies to raise DCW wages. For example, about one-half of the states reported raising (or planning to raise) wages for DCWs through Medicaid reimbursement rate changes in fiscal years 2019 and 2020, a

notable increase from prior years (Gifford et al., 2019) with additional efforts undertaken since the COVID-19 pandemic began in early 2020 (PHI, 2021).

5.5 Future Research

Future research could build on the wage trend analyses we conducted and further explore the effects of Medicaid wage pass-through policies. Previous research and the general perception of experts and stakeholders suggests that wage pass-through legislation helps increase wages. Our descriptive analysis found that these policies did improve wages in most states that implemented them; however, they often had only a small change following policy implementation on the gap between DCW wages and the wages of other entry-level workers. Yet, some states with these policies greatly reduced or eliminated the wage gap. Additional quantitative analyses could be conducted to further examine the impact of these policies. For example, cross-state comparisons could identify the most effective versions of these policies (that produced larger reductions in the wage gap) and policy analysis could explain the elements common to the most effective policies. This would provide valuable information to states wanting to replicate the most successful policies.

Future research could also explore the effect of improved wages on other DCW, provider, and care recipient outcomes. Experts and stakeholders noted that low wages may be related to other important outcomes for workers (e.g., job satisfaction and turnover), providers (e.g., care quality), and care recipients (e.g., health outcomes, satisfaction, and gaps in service). Previous research has linked direct care workforce turnover and staffing shortages with poorer care quality and found that high turnover rates, low staffing levels, low stability levels, and high use of agency staff were negatively related to quality (Castle & Engberg, 2005). Additional research could determine if policies that successfully improved wages also affected these other outcomes. Such improvements would provide a strong argument for the return on investment that can be achieved through improving DCW wages. Some stakeholders suggested that improved quality could save the health care system enough money to cover DCW wage increases, but that these connections had not been made by policymakers.

Finally, several experts and stakeholders we spoke to noted that improving DCW wages was not the only thing that would need to be done to increase availability of DCWs and address current worker shortages and the expected increased need for DCWs in the future. They suggested that career ladder opportunities are needed and the pipeline of workers needs to be improved. Future research could, therefore, examine the policies and programs states are using to increase the availability of DCWs. For example, some states make funding available to reimburse DCWs for the cost of training and other states have created partnerships with community colleges or apprenticeship programs. However, little research has been conducted to determine the success of these types of policies and programs in increasing the supply of DCWs.

SECTION 6.
CONCLUSION

DCWs play an essential role by providing services and supports to nearly 20 million people. Yet, most DCWs earn wages lower than other entry-level workers with similar job requirements. Many states have implemented policies to improve wages for this workforce. This study sought to explore state policies for improving compensation for DCWs, the key elements of those policies, and the results of those policies.

Despite state efforts to implement wage pass-through policies, wage floor policies, and increased wages tied to worker training, DCW wages still lag woefully behind the wages of other entry-level workers in most states. This is especially true for home health and personal care aides, who we found made on average $3.15 less per hour in 2019 than other entry-level workers.

Many of the experts and stakeholders we spoke to suggested low or inconsistent Medicaid reimbursement rates for low DCW wages. They stated that even in states that had implemented policies to improve wages, that policies were not continuous or needed re-authorization year after year, or that funding had simply not kept pace with market trends, making direct care work less attractive compared to other jobs. On the other hand, state representatives we spoke to noted that even small increases to Medicaid reimbursement rates for DCW wages could have huge implications for state budgets.

Experts and stakeholders suggested the need to professionalize the workforce in ways that improve opportunities for career advancement. Experts and stakeholders also noted that, in addition to increased wages, DCWs need to receive benefits such as health insurance and paid leave. Many interviewees suggested that direct care work needs to be better respected and that policymakers and the general public do not understand the important role these workers play in the health care system. Finally, many experts and stakeholders described the need for a pool of applicants for direct care jobs and suggested that programs need to be developed to funnel potential workers into this field.

While the evidence on what could be done to improve DCW wages and jobs continues to grow, until there is meaningful policy change, we will continue to struggle with barriers to improved compensation for DCWs which results in a disproportionate number of DCWs receiving public benefits, difficulties with recruitment and retention, and competition from other higher paying entry-level occupations.

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APPENDIX A:
TABLES

Table B-1. Median Wages of Home Health and Personal Care Aides and Workers in Other Entry-Level Jobs by Compensation Policy and State, 2009 and 2019 (adjusted to 2019$)

Policy by State	Policy Implementation Year	Median Wages in 2009			Median Wages in 2019			Change in Wage Gap from 2009 to 2019	
		Home Health and Personal Care Aides	Other Entry-Level Jobs	Wage Gap (Other Entry-level jobs – Home Health and Personal Care Aides)	Home Health and Personal Care Aides	Other Entry-Level Jobs	Wage Gap (Other Entry-level jobs – Home Health and Personal Care Aides)		
Wage Pass-Through									
Arizona	2017	12.46	14.63	2.17	12.02	15.00	2.98	0.81	
California	2016	12.14	15.80	3.66	12.58	16.42	3.84	0.18	
Colorado	2018	12.02	15.61	3.59	12.54	15.88	3.34	-0.25	
District of Columbia	2014	12.79	18.34	5.56	14.66	18.55	3.89	-1.67	
Indiana	2017	11.56	14.90	3.34	11.31	14.41	3.10	-0.25	
Maine	2015, 2018	12.02	15.01	2.99	12.66	15.30	2.64	-0.35	
Maryland	2016	13.12	15.84	2.72	12.87	15.41	2.54	-0.18	
Michigan	2017	11.27	15.25	3.99	11.58	14.83	3.25	-0.74	
Montana	2017	11.72	14.02	2.30	12.12	14.73	2.61	0.32	
New York	2016	12.57	16.39	3.82	13.42	16.95	3.53	-0.29	
Oregon	2015	12.04	15.78	3.74	13.47	16.25	2.78	-0.95	
Texas	2014, 2015, 2016	9.38	14.02	4.64	9.68	14.44	4.76	0.12	
Utah	2015	11.67	14.56	2.89	12.22	14.63	2.41	-0.48	
Washington	2017	12.95	17.17	4.22	14.41	17.92	3.51	-0.71	
Wisconsin	2017	11.98	15.47	3.48	11.80	15.39	3.59	0.11	
Average		**11.98**	**15.52**	**3.54**	**12.49**	**15.74**	**3.25**	**-0.29**	
Increases in Wage Floor									
Massachusetts	2015	14.14	16.98	2.84	15.01	17.29	2.28	-0.56	
New York	2018	12.57	16.39	3.82	13.42	16.95	3.53	-0.29	
Average		**13.36**	**16.69**	**3.33**	**14.22**	**17.12**	**2.90**	**-0.43**	

Policy by State	Policy Implementation Year	Median Wages in 2009			Median Wages in 2019			
		Home Health and Personal Care Aides	Other Entry-Level Jobs	Wage Gap (Other Entry-level jobs – Home Health and Personal Care Aides)	Home Health and Personal Care Aides	Other Entry-Level Jobs	Wage Gap (Other Entry-level jobs – Home Health and Personal Care Aides)	Change in Wage Gap from 2009 to 2019
Wage Increases Tied to Workforce Development								
Ohio	2017	11.25	14.85	3.60	11.08	14.60	3.52	-0.08
Oregon	2018	12.04	15.78	3.74	13.47	16.25	2.78	-0.95
Tennessee	2018	10.88	14.13	3.25	10.45	13.93	3.48	0.23
Average		**11.39**	**14.92**	**3.53**	**11.67**	**14.93**	**3.26**	**-0.27**
Wage Enhancements								
South Dakota	2015, 2018	11.44	13.25	1.81	12.49	14.02	1.53	-0.28
No Policy (n=32)								
Average	**n/a**	**11.70**	**14.91**	**3.21**	**11.76**	**14.92**	**3.16**	**-0.05**

Notes: State-level median wages were obtained from the BLS OEWS program for reference periods of May 2009 and May 2019. Wages for 2009 were adjusted for inflation to 2019 dollars using the Consumer Price Index for All Urban Consumers (current series, not seasonally adjusted). Analysis was restricted to policies implemented between 2010 and 2018. A positive value in the "Wage Gap" columns indicates that wages in a given year and state were lower for home health and personal care aides than for other entry-level workers. A positive value or the symbol in the last column indicate that the wage gap between home health and personal care aides and other entry-level workers increased between 2009 and 2019 (an unfavorable result). A negative value or the symbol in the last column indicate that the wage gap decreased (a favorable result).

Table B-2. Median Wages of Nursing Assistants and Workers in Other Entry-Level Jobs by Compensation Policy and State, 2009 and 2019 (Adjusted to 2019$)

Policy by State	Policy Implementation Year	Median Wages in 2009			Median Wages in 2019			Change in Wage Gap from 2009 to 2019	
		Nursing Assistants	Other Entry-Level Jobs	Wage Gap (Other Entry-level jobs – Nursing Assistants)	Nursing Assistants	Other Entry-Level Jobs	Wage Gap (Other Entry-level jobs – Nursing Assistants)		
Wage Pass-Through									
Arizona	2017	14.16	14.63	0.47	15.47	15.00	-0.47	-0.94	
California	2016	14.80	15.80	1.00	16.78	16.42	-0.36	-1.36	
Kansas	2011, 2014	12.64	14.25	1.61	13.02	14.36	1.34	-0.27	
Maine	2015, 2018	13.51	15.01	1.49	14.59	15.30	0.71	-0.78	
Massachusetts	2018	16.30	16.98	0.68	16.25	17.29	1.04	0.36	
Michigan	2010	14.69	15.25	0.56	14.79	14.83	0.04	-0.52	
Montana	2017	13.00	14.02	1.02	14.44	14.73	0.29	-0.72	
Wisconsin	2017	14.43	15.47	1.04	14.89	15.39	0.50	-0.54	
Average		14.19	15.18	0.98	15.03	15.41	0.39	-0.60	
Wages Increases Tied to Workforce Development									
Tennessee	2018	12.64	14.13	1.48	12.78	13.93	1.15	-0.34	
Wage Enhancements									
South Dakota	2015, 2018	12.67	13.25	0.58	13.39	14.02	0.63	0.05	
Value-Based Reimbursement									
Minnesota	2015	14.91	15.92	1.01	16.82	16.63	-0.19	-1.20	
No Policy (N=40)									
Average	n/a	13.94	15.11	1.17	14.27	15.13	0.86	-0.31	