



# Fair Pay for Quality Care in North Carolina

Fair wages for home care workers ensure economic stability  
and increase continuity of care

By Sabine Schoenbach, WORKERS' RIGHTS PROJECT

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# Fair Pay for Quality Care in North Carolina

Fair wages for home care workers ensure economic stability, increase continuity of care, and strengthen the local economy

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## Executive Summary:

- North Carolina is rapidly aging – the population over 65 is projected to more than double by 2050. The aging of the state’s baby boomers will correspond with an increase in community members with functional and cognitive limitations, indicating a growing need for direct care that allows community members to continue to live with dignity.
- Direct care occupations, including home care jobs, are some of the fastest growing occupations. But, these jobs offer some of the lowest wages in the state. Median wages in the caregiving occupations pay less than \$10 an hour, compared to the state’s \$15 an hour median wage. That means that half of all home healthcare workers aren’t earning enough to rise above the federal poverty line despite working full-time.
- Moreover, despite the high occupational injury rates, almost half of home care workers remain uninsured and the majority of workers have no earned paid sick days to take time to recover from injuries or illness.
- Low wages increase worker turnover, increase long-run costs for providers, and interrupt the continuity of care for consumers. Additionally, making too little to pay for the basics such as food, housing, and health care can lead to increased dependence on public assistance programs.
- Medicaid, administered by the state and jointly financed by the state and federal government, is the primary funding source for long-term services and supports (LTSS) for people with disabilities and seniors. Reimbursement by Medicaid programs, in large part, creates the framework in which employers set wages for direct care workers.
- North Carolina’s reimbursement rates have been frozen or reduced since 2009 and the most recent reduction places North Carolina rates more than \$4 per hour lower than the national average rate paid to provider agencies.
- To address these challenges North Carolina must raise the wage floor for paid caregivers in the context of the state’s Medicaid program and look to best practices in states like Montana and Maine that tie wage-improvement strategies to reimbursement rates.
- These include: An automatic update mechanism, such as a link to an annual inflation-adjustment; A way to ensure enforcement through mandatory reporting and data collection; A built-in mechanism for evaluating reimbursement rates, or the wage floor, over time to ensure that the rate remains competitive
- Additionally, the state should pursue common sense policies that make work pay by improving workplace standards for the lowest-paid workers, including: raising the minimum wage; supporting collective bargaining rights; ensuring paid sick days; expanding Medicaid; and providing career paths for home care workers.

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## INTRODUCTION: Wages Matter

**D**irect care workers provide critical support to older adults and people with disabilities, allowing loved ones who need care to live with dignity and independence. As our state rapidly ages, the need for this vital work force is increasing. The number of direct care jobs is rising, yet the persistence of low wages in caregiving occupations keeps many care workers from achieving economic security for their own families and weakens the quality and consistency of care.

Over the past decade, North Carolina has experienced a decline in middle-wage jobs and an explosion in jobs that pay too little to lift families out of poverty.<sup>1</sup> The median wages of direct care occupations are some of the lowest in the state, with a full-time year-round worker bringing home almost exactly the amount of pay corresponding to the federal poverty level for a family of three.

The effects of low pay ripple beyond direct care workers' inability to make ends meet. Low pay can affect the stability and quality of care for those who need it. If a care worker is late because of the inability to afford reliable transportation, for example, a client may be left waiting. Moreover, low wages and few health benefits—along with the physical difficulty of the work—can lead to high turnover. National data show that more than half of the direct care workforce turns over every year.<sup>2</sup> This lack of consistency can be disruptive and stressful for both the client and the client's family. Consistent follow-through and communication, an increased likelihood of noticing subtle changes in health, and the establishment of a trusting relationship can all be tied to consistency of care.

Addressing insufficient wages of direct care workers also helps decrease reliance on public benefits. In North Carolina, almost half of home care workers receive some type of public assistance (for example, cash assistance, food stamps, or Medicaid).<sup>3</sup> When low-wage workers, such as home care workers, receive a wage hike, they spend most of that increase on the basics such as food, transportation, and basic repairs. The money is spent locally, contributing to the local economy and strengthening economic growth.<sup>4</sup>

States, including North Carolina, are shifting spending for Medicaid long term services and supports toward home care, in part because of individuals' preference for this type of care and the lower cost compared to institutional care. The challenge for lawmakers is to find and implement innovative ways to ensure high quality, person-centered care through judicious policy and spending decisions.

Ensuring that workers can earn wages that support their families is one important aspect of stabilizing the home care system, and state lawmakers have concrete tools at their disposal to address wage inadequacy. Raising the wage for all low-income workers as well as looking specifically at the role of public funding reimbursement rates are critical for ensuring stability and quality of care, offering the best possible care to our loved ones, and creating thriving communities.

## North Carolina is Aging and the Need for Direct Care is Growing

North Carolina, similar to the rest of the country, is rapidly aging. In 2012, approximately 1.3 million North Carolina residents (13 percent of the population) were 65 and older. By 2050, that number is expected to grow to 2.8 million, and the proportion of those over 65 will be close to 20 percent. The population over 85 will be the fastest growing group of those above 65, projected to increase by 269 percent by 2050 (see figure 1).<sup>5</sup>

The significant growth in the older adult population will correspond with an increase in community members with functional and cognitive limitations. National data show that

**FIGURE 1: North Carolina’s older population groups are projected to grow over time**

Population and Projections	Year	State Pop (1,000’s)	% of Total Population	% Change from 2012
All ages	2012	9,848		
	2032	12,265		25%
	2050	14,537		48%
Age 65 and older	2012	1,321	13.4%	
	2032	2,331	19.0%	76%
	2050	2,811	19.3%	113%
Age 85 and older	2012	176	1.8%	
	2032	347	2.8%	97%
	2050	651	4.5%	269%

SOURCE: Houser, Ari, Wendy Fox-Grage, Kathleen Ujvari, September 2012. “Across the States 2012: Profiles of Long-Term Services and Supports,” AARP.

more than one in three (37 percent) of those ages 65 or older live with a sensory, physical, mobility, self-care, or cognitive disability that affects the ability to accomplish tasks of everyday living.<sup>6</sup> Approximately one in ten have difficulties with self-care and the same percentage report cognitive difficulties, both of which are most likely to result in the need for long-term services and supports.<sup>7</sup> Among the population aged 85 and older, approximately two-thirds report functional limitations or physical problems that

limit daily activities such as dressing, eating, and bathing.<sup>8</sup>

As community members age, they not only have higher rates of disability, they are more likely to be widowed and lacking a spouse to provide assistance with daily activities. One-third (34 percent) of people age 75 and older report living alone.<sup>9</sup>

Many depend on other family members, such as children, to provide care, but the availability of all family caregivers is decreasing. Family caregivers still provide the majority of care for those needing help with daily activities. North Carolina is currently home to approximately 1.18 million family caregivers.<sup>10</sup> The number of potential unpaid family caregivers (aged 45-64) available to care for those aged 80 and older, however, is shrinking. Due in part to transformations in family size and compositions, the “family caregiver support ratio”—the ratio of the number of people of common caregiving age divided by the number of those most at risk of needing long-term care—is expected to decrease over time (see figure 2).<sup>11</sup>

Even for available family caregivers, providing consistent care is not only emotionally difficult—caregivers report higher levels of stress than the general population—it can lead to financial hardship. A recent study reported that family caregivers over the age of 50 who quit a job to care for a parent lose an average of \$300,000 in lifetime wages and benefits.<sup>12</sup>

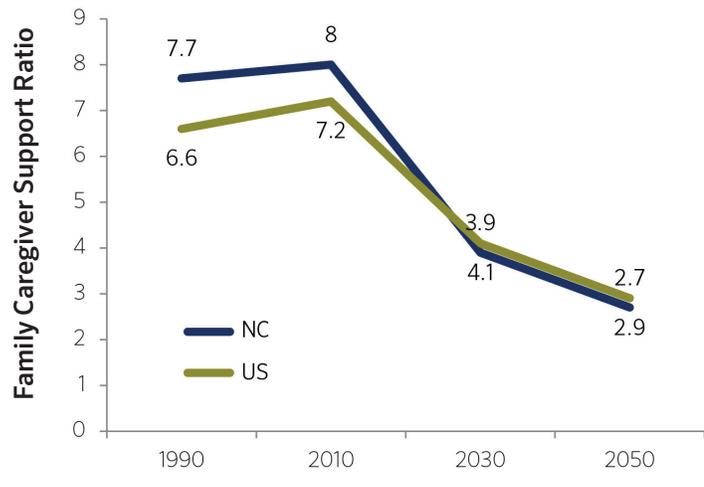
While we continue to depend on family caregivers to provide the bulk of care, few policies exist to provide support for these caregivers. According to the AARP Public Policy Institute, one of the best protections for working caregivers is having access to paid leave.<sup>13</sup> Yet the data show that the majority of low-wage workers simply don't have access to short or long-term paid leave. In North Carolina, only four of ten full-time workers earning less than \$20,000 per year have access to earned paid sick days.<sup>14</sup>

The rapid aging of our state, the decrease in family caregivers, and the financial hardships of family caregiving all point toward a greater need for affordable, quality, publicly-funded long-term services and support. Providing this care falls on the shoulders of North Carolina's direct care workforce, the key to providing older adults and those with disabilities with quality care and the opportunity to live with dignity.

## The Number of Direct Care Jobs Is on the Rise, but Workers Remain Mired in Low Wages and Few Benefits

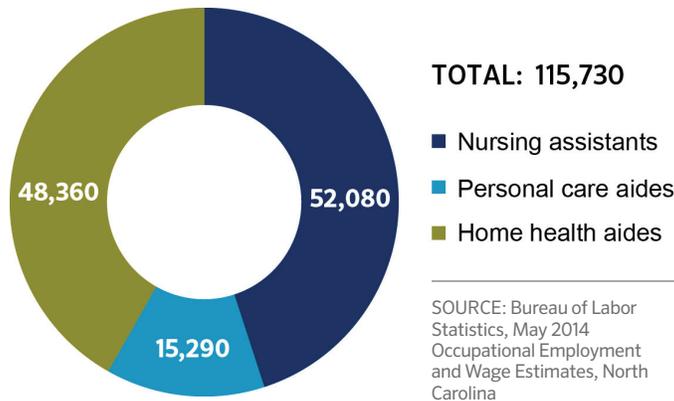
Home care workers fall into two main occupational categories tracked by the Bureau of Labor Statistics: Personal Care Aides and Home Health Aides. Together with Nursing Assistants, who generally work in nursing homes, assisted living facilities, or community-based facility settings, these occupations make up the direct care work force. Home Health Aides provide similar services as Nursing Assistants—assisting clients with activities of daily living (ADL's) such as eating and dressing as well as some clinical tasks—but provide these services for people in their homes or in community settings. Personal Care Aides work in both private or group homes, providing assistance with ADL's as well as such tasks as housekeeping, meal preparation and medication management.<sup>15</sup>

**FIGURE 2: The ratio of available family caregivers to those likely needing care is projected to drop over time.**



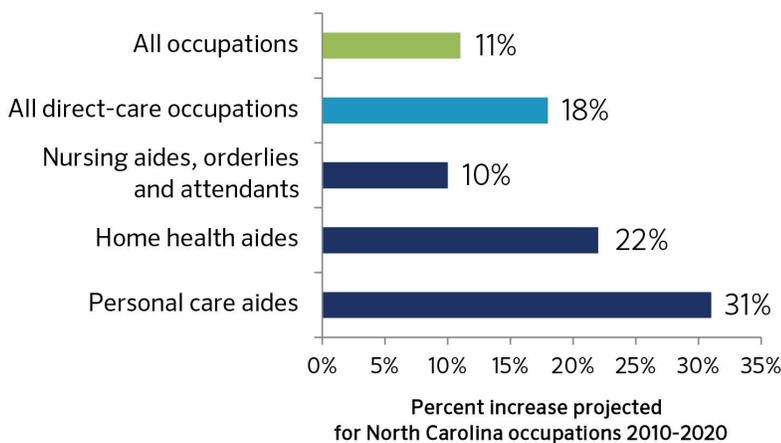
SOURCE: Redfoot, Donald, Lynn Feinberg, and Ari Houser, 2013. "The Aging of the Baby Boom and the Growing Care Gap: A Look at the Future Declines in the Availability of Family Caregivers," AARP Public Policy Institute.

**FIGURE 3: Over 115,000 North Carolinians currently work in the direct care industry**



The official counts of all direct care workers in these three categories number close to 116,000 in North Carolina (see figure 3). The state has one of the highest Home Health occupational employment levels in the country with 48,360 Home Health Aides—or 11.996 Home Health Aides per 1,000 jobs.<sup>16</sup> Beyond these numbers, thousands of uncounted direct care workers care for individuals and their families through private arrangements.

**FIGURE 4: Employment in direct care occupations is expected to grow over time.**



SOURCE: PHI analysis of 2010-20 occupational employment projections by the NC Department of Commerce

Direct care occupations also constitute some of the fastest growing occupational groups in the state and across the country. Direct care occupations in North Carolina are expected to grow by 18 percent by 2020, or nearly twice the rate of overall job growth projected in the state (see figure 4).<sup>17</sup> A total of 36,100 openings are projected to be created within direct care work in the state within the decade, including over 19,000 in Home Health, over 11,000 in the Nursing Aide occupation, and almost 6,000 openings in the Personal Care Aide occupation.<sup>18</sup>

Despite the increase in job numbers, direct care occupations offer some of the lowest median wages in the state. Of the direct care occupations, Home Health and Personal Care jobs pay the least—median wages are under \$10 per hour in North Carolina, translating to less than \$20,000 per year for a full-time, year-round worker. The median wages of Nursing Assistants are slightly higher, in part reflecting the fact that direct care jobs in institutional settings (nursing care and hospitals) are often part of institutional rate setting plans that provide greater upward wage pressure.<sup>19</sup>

Not only are current wage levels low, over the last decade, real wages (wages adjusted for inflation) in all three occupational categories have declined in North Carolina (see figure 6).

In 2014 dollars, the median wages of Personal Care Aides dropped from \$10.29 per hour in 2004 to \$9.18 per hour and the median wages of Home Health Aides dropped from \$10.42 per hour to \$9.03 per hour.

The annual median wages of direct care occupations are close in value to the federal poverty guidelines for a family of three (one adult and two children).<sup>20</sup> North Carolina's Living Income Standard, which provides a more realistic estimate of what it actually takes for a family to afford the basics of housing, food, child care, health care, transportation and other necessities in North Carolina, outpaces median wages in direct care occupations by more than two to one (see figure 7).<sup>21</sup>

Moreover, this comparison of annual wages assumes full-time, year-round work. Home care occupations, however, are known for part-time and often inconsistent hours. In the South Atlantic region, which includes North Carolina, just over one in three (34 percent) of home care workers works full-time, year round. The remaining workforce works either part-time, or works full-time but only part of the year (see figure 8). The nature of the work can reinforce the lack of consistent schedules. Some clients need care for only a few hours per day or week, and schedules are impacted when clients are hospitalized, pass away or when care is reduced.<sup>22</sup>

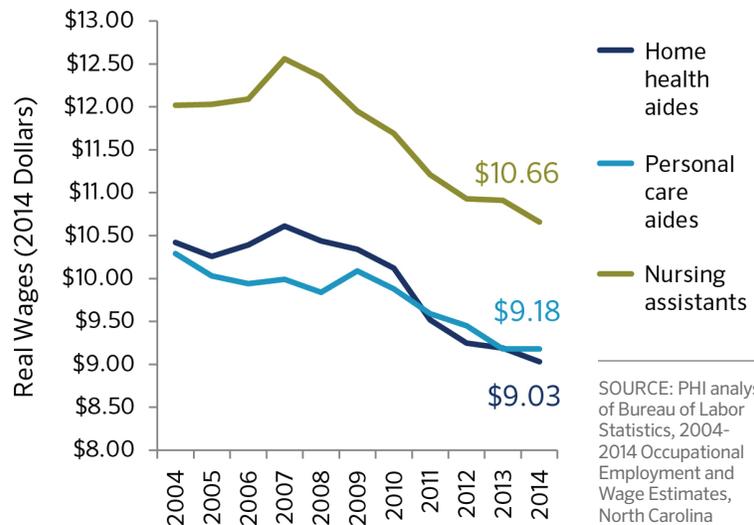
Direct care workers have one of the most physically demanding jobs in the health sector and the rates of job-related injuries are high. Injury rates among Personal Care Aides and Home Health Aides are 48 percent and 28 percent higher, respectively, than the total injury rate for all occupations.<sup>23</sup> Despite the realities of physical injuries, estimates for North Carolina show that almost half (46 percent) of home care workers remain uninsured (see figure 9).

**FIGURE 5: The median wages of North Carolina's direct care occupations are some of the lowest wages in the state**

Occupation	Median Hourly Wage	Median Annual Wage	Mean Hourly	Mean Annual
Personal care aides	\$9.18	\$19,094	\$9.52	\$19,790
Home health aides	\$9.03	\$18,782	\$9.34	\$19,430
Nursing Assistants	\$10.66	\$22,173	\$10.89	\$22,650
All NC occupations	\$15.63	\$32,510	\$20.81	\$43,280

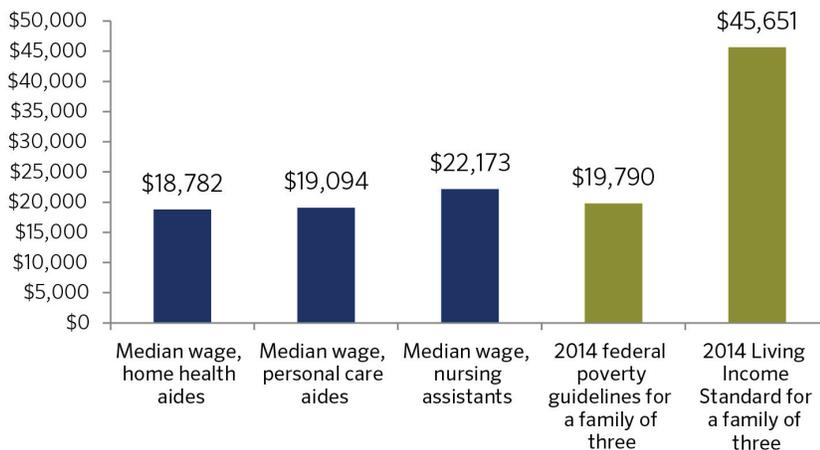
SOURCE: Bureau of Labor Statistics, May 2014 Occupational Employment and Wage Estimates, North Carolina (annual wage assumes a 40-hour work week, 52 weeks per year)

**FIGURE 6: Median wages, adjusted for inflation, have decreased over the last decade**



SOURCE: PHI analysis of Bureau of Labor Statistics, 2004-2014 Occupational Employment and Wage Estimates, North Carolina

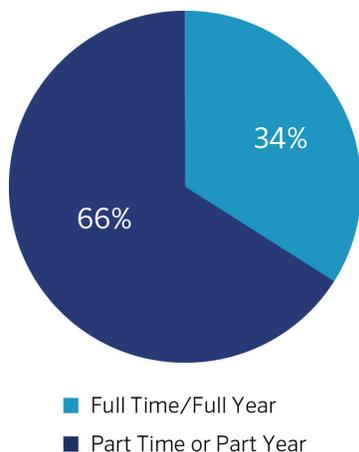
**FIGURE 7: The median wage of direct care occupations is less than half of North Carolina's Living Income Standard (LIS)**



SOURCE: Bureau of Labor Statistics May 2014 Occupational Employment and Wage Estimates, North Carolina (annual wage assumes a 40-hour work week, 52 weeks per year); Department of Health and Human Services, 2014 Poverty Guidelines, and Sirota, Alexandra Forter, Tazra Mitchell, Cedric Johnson, June 2014. "Living Income Standard 2014: Boom in Low-Wage Work Means Many North Carolinians Don't Make Adequate Income, NC Budget and Tax Center.

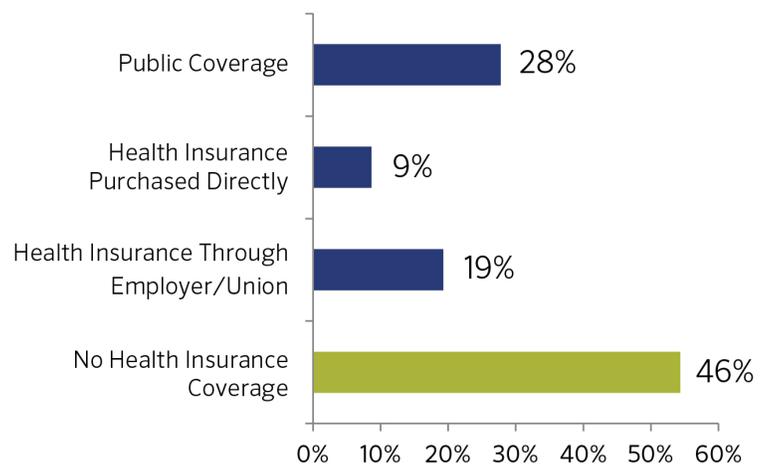
In addition, the majority of home care workers have no earned paid sick days to take time to recover from injuries or illness. In North Carolina, almost seven out of ten (69 percent) full-time workers in the Personal Care and Service occupational category have no access to even a single paid sick day.<sup>24</sup> This means that thousands of care workers in North Carolina will eventually face an impossible choice: call in sick and lose wages or possibly even a job, or work sick and risk their health as well as that of the person they assist.

**FIGURE 8: The Majority of Home Health Care Workers in the South Atlantic Work Part Time or Part Year**



SOURCE: PHI Analysis of U.S. Census Bureau, American Community Survey 2014 1-year Estimate: Public Use Microdata Sample. North Carolina is located in the South Atlantic U.S. Census Division (DE, MD, DC, VA, WV, NC, SC, GA, FL).

**FIGURE 9: Almost half of home care workers in North Carolina remain uninsured**



SOURCE: PHI Analysis of U.S. Census Bureau, American Community Survey 2014 1-year Estimate: Public Use Microdata Sample

## EMPLOYEE PROFILE:

## TIFFANI, 26, Raleigh, NC

Tiffani has been working as a home healthcare provider for two years and currently makes \$9.50 an hour. She is also the primary care provider for her mother. Tiffani is concerned with her lack of flexibility to take off in case of sickness or injury and has even had to take up a second job just to make ends meet.

“It’s hard to love your job and love taking care of people but be in such

a precarious position. I work hard, I work 30-50 hours a week and I still had to take on another part time job to supplement my income. I typically work 7 days a week. I don’t have access to any paid leave or paid vacation time. Home health care is becoming more and more of an urgent need as our loved ones age, and we need to invest more in our home health providers.”

## Worker empowerment—and higher wages—through unionization and worker-owned models

In recent years, a growing unionization movement has emerged in the direct care industry. Attacks on collective bargaining for those workers in contract with state governments have been visible recently, but a larger movement to incorporate the voices of home care workers within the fight for \$15 has helped bring the need for unionization into the national spotlight.<sup>25</sup>

Nationally, about a quarter of home care workers have unionized. Data on the rates of unionization in the home care industry are not available for North Carolina, which remains the least unionized state in the nation. The need for unionization and the benefits of union membership in this particular industry, however, is clear. Union membership provides workers with a much needed

voice to negotiate workplace standards, and collective bargaining results in higher wages and benefits. The median wage of all unionized workers in North Carolina is approximately \$19.46 as opposed to \$14.70 for those who are not unionized.<sup>26</sup>

Cooperative and worker-owned models have also emerged in the field of home care. Bronx-based Cooperative Home Care Associates (CHCA), for example, employs more than 2,000 aides. Worker-owned cooperatives – based on the model of one member, one vote – increase wages over time and CHCA has also restructured work schedules to guarantee full-time hours for many of its workers. The company attributes its low turnover rate – less than 15 percent – to its investment in quality jobs.<sup>27</sup>

## Insufficient Wages Lead to High Industry Turnover and Increased Dependence on Public Assistance

Insufficient wages translate into less consistent care and higher costs for providers, for the simple reason that low wages have long been understood to increase employee turnover<sup>28</sup>—many workers just can't afford to stay. A recent study in the *Journal of Applied Gerontology* focused specifically on the home care workforce and the factors that influence job fulfillment. Researchers found that the issues most often tied to low job satisfaction and intent to leave include low pay, fewer hours, high injury rates, and racial/ethnic discrimination.<sup>29</sup>

Turnover rates in the home care industry are high. According to the 2015 Private Duty Benchmarking Study, a study summarizing the survey results from over 700 home care companies nationwide, 61.6 percent of caregivers working for home care companies left their jobs over the last year. The median turnover rate in the Southern region was slightly lower at 54.5 percent, yet notably, the rate is the highest recorded since the survey began in 2010.<sup>30</sup>

The costs of turnover are also high. Direct provider costs include advertising and recruitment as well as staff time for interviewing, training and on-the-job learning. Indirect costs may include a loss of productivity and lowered quality of services. One national estimate puts the dollar amount related to turnover at \$6 billion per year.<sup>31</sup>

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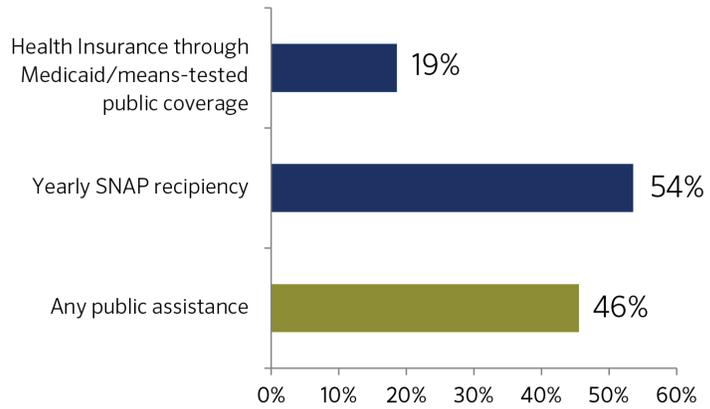
Consumers of care also pay for turnover in decreased stability and quality of care. Care is intimate and any change in caregiver means losing familiarity and trust. Moreover, consistency allows for better communication and follow-through, increases the likelihood that subtle changes in health will be noticed,

and allows for predictability. Studies have demonstrated that the reduction of turnover in the direct care industry is associated with increased quality of care.<sup>32</sup> Consumers and providers cite the importance of uninterrupted service delivery and a trusting relationship between client and caregiver.<sup>33</sup>

Case studies in home care around the country have demonstrated that improved job conditions, including an increase in wages, can translate to a dramatic reduction in turnover. In San Francisco County, for example, researchers looked at the impact of a wage increase from \$4.25 per hour in 1995 (the state minimum wage at the time) to \$10 per hour in 2002—a raise that was accomplished through unionization, a campaign for a living wage ordinance, and the establishment of a consumer-labor coalition. Analyses showed that the wage increase and the eventual addition of health insurance and dental insurance contributed to a dramatically increased annual retention rate, rising from 39 percent to 74 percent over 52 months. Based on this increase, researchers estimated that a \$1 per hour increase in wages could increase retention nationally by 17 percent.<sup>34</sup> Similarly, in North Dakota, after wages for direct care workers were raised through funding from the American Recovery and Reinvestment Act—a raise of \$1 per hour reduced turnover rates from 43 percent to 33 percent.<sup>35</sup>

For workers, making too little to pay for the basics—food, housing, and health care—can also lead to increased dependence on public assistance programs. In North Carolina, almost half of home care workers live in households that receive some type of public assistance. More than half of households depend on Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps) to put food on the table and almost one in five are covered by Medicaid (see figure 10).

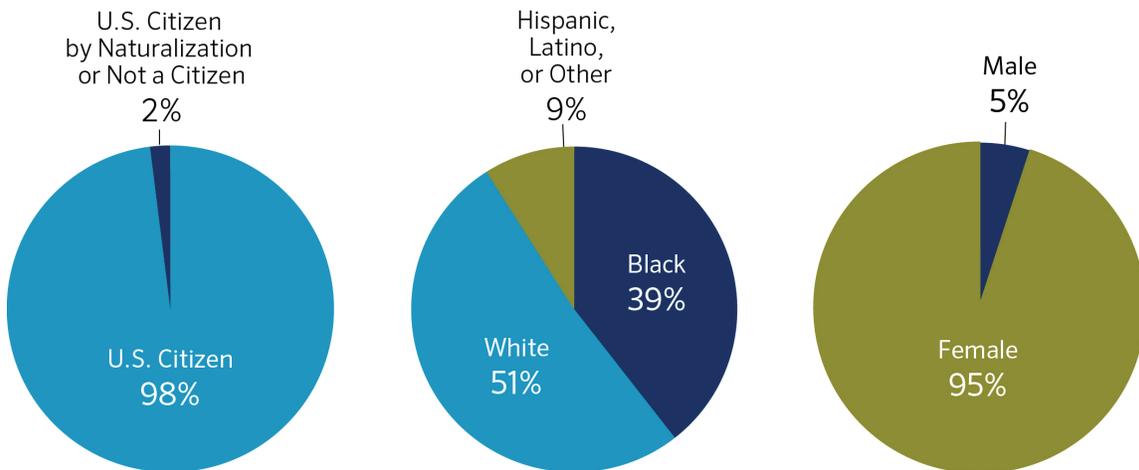
**FIGURE 10: Almost half of home care workers in North Carolina rely on some type of public assistance to make ends meet**



SOURCE: PHI Analysis of U.S. Census Bureau, American Community Survey 2014 1-year Estimate: Public Use Microdata Sample.

► **WHO ARE NORTH CAROLINA'S HOME CARE WORKERS?**

**FIGURE 11: The majority of NC's home care workers are women; more than half are people of color; and most are U.S. citizens.**



Source: PHI Analysis of U.S. Census Bureau, American Community Survey 2014 1-year Estimate Public Use Microdata Sample.

## ► WHAT IS THE HOME CARE INDUSTRY?

Direct care occupations are more clearly defined than the “direct care” or “home care” industry. In fact, what is usually thought of as the “home care industry” is not an official industry category as defined by the Census Bureau. The home care industry includes part—but not all—of two Census defined industry sub-sectors: Home Health Services (NAICS 6216) and Services for the Elderly and Persons with Disabilities (NAICS 62412). In North Carolina, together, these industry sectors employ almost 57,000 workers.<sup>36</sup>

Complicating the definition of the industry further are independent providers who may not be captured in standard industry accounting. Independent providers fall into two major categories: those reimbursed through public program such as Medicaid or Medicare and those contracted by clients paying out-of-pocket. The latter are mostly unreported and constitute a “grey market” with little, if any oversight.

In North Carolina, the NC Division of Health Service Regulation (DHSR) differentiates between “home health care” and “home care” agencies and oversees both. Home

care at these agencies. Home care agencies typically provide home care services not considered to be skilled care such as assistance with daily activities, personal care, and homemaking services. Home care agencies in North Carolina undergo licensure and oversight by DHSR.<sup>37</sup>

## Who is the employer?

As stated above, employers of home care workers are typically agencies, however some home care aides are independent providers. In the agency model, a private for-profit or non-profit entity employs and assigns workers and is responsible for allocating resources and monitoring services. The roles and responsibilities of the agency employer are relatively clear. In the independent provider model, however, some or all of the employer’s responsibilities are taken on by the consumer.

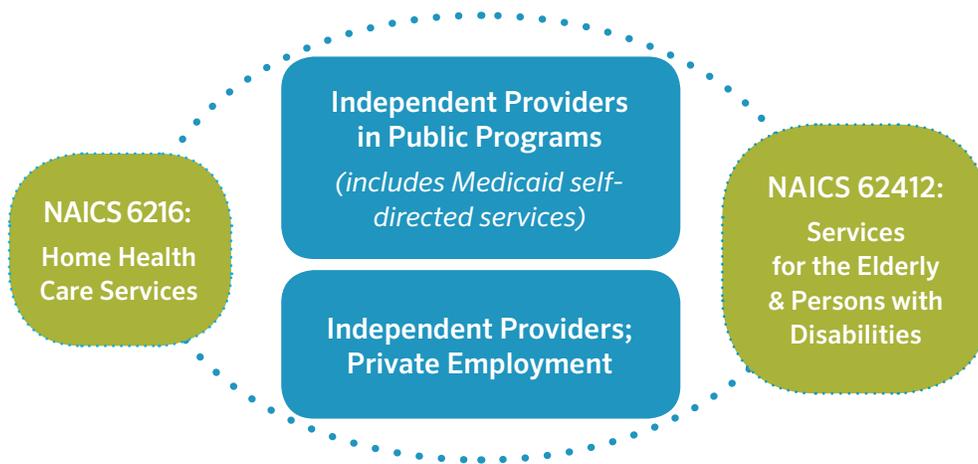
Self-directed Medicaid services, for instance, provide three types of consumer decision making authority: employer authority, budget authority, or a combination of both. In essence, a consumer with employer authority can hire, fire and supervise personal support workers and budget authority allows the consumer to manage financial resources. Under employer authority alone, participants usually do not set hourly wages, but under budget authority, consumers may negotiate wages and benefits.

In North Carolina, both models exist. Financial Management Services (FMS) exist to help consumers through the administrative process of being an employer and to ensure that workers are being paid in compliance with state and federal rules and regulations. Within FMS models, however, there is variability about

health agencies are typically Medicare certified, meeting federal guidelines in providing skilled care such as skilled nursing, physical or occupation therapy, or social work. A small number of home health aides may also supplement

which party or parties constitute the “employer(s)” and for what purposes. Being able to define both the employers and the employers’ responsibility is key in ensuring both fair wages and the payment of those wages.

**FIGURE 12: The in-home services and supports industry sector**



Source: Seavey, Dorie and Abby Marquand, December 2011. “Caring in America, A Comprehensive Analysis of the Nation’s Fastest-Growing Jobs: Home Health and Personal Care Aides,” PHI.

The costs of these programs can be significant. National estimates of enrollment and costs of public support programs for home care workers show that the average cost per enrolled family of all public programs is \$7,740 per enrolled family. This cost translates to \$6.3 million across five public support programs analyzed: EITC, Medicaid/CHIP, Food Stamps, and TANF.<sup>38</sup>

## A Shift Toward Home Care and the Role of Medicaid

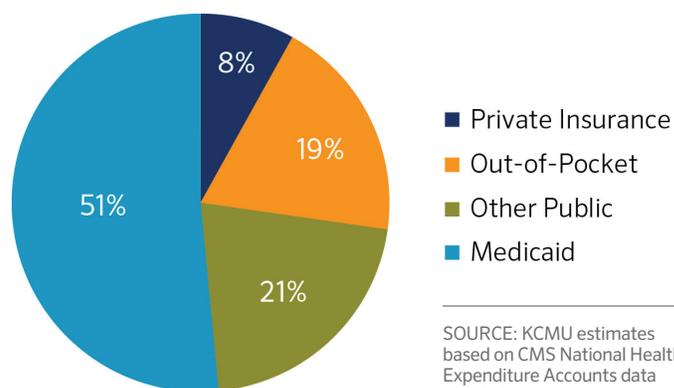
### Paying for Long-Term Care

The aging of our state will increase the demand for long-term services and supports. Although much of the personal care for those needing help with daily activities is still provided by unpaid family caregivers, the need for formal, paid care is increasing. Paying for that care can be difficult.

A market survey of long-term care costs found that, on average, the cost of a private room in a nursing home in North Carolina is \$228 per day or over \$83,000 per year. Home care is less expensive, but can still represent a significant financial burden for families. The market rate for home care costs in the state averages to approximately \$19 per hour. Assuming a care schedule of 44 hours per week of care, this equates to \$43,472 per year.<sup>39</sup>

Most seniors have limited resources and a fixed income, and few individuals can afford to pay for all needed long-term services out-of-pocket. In addition, the private long-term care insurance market is relatively small due in part to high premium prices. As such, Medicaid, administered by the state and jointly financed by the state and federal government, is the primary funding source for long-term services and supports (LTSS) for people with disabilities and seniors (see figure 12).<sup>40</sup> Medicaid's mandatory eligibility categories include very low-income families, pregnant women, people with disabilities, as well as older adults who qualify for Supplemental Security Income. While many low-income older adults and persons with disabilities qualify for Medicaid before needing care, hundreds of thousands of higher-income people needing care are estimated to end up relying on Medicaid after depleting their resources by paying for needed care.

**FIGURE 12: Nationwide, Medicaid is the Primary Funding Source for LTSS**

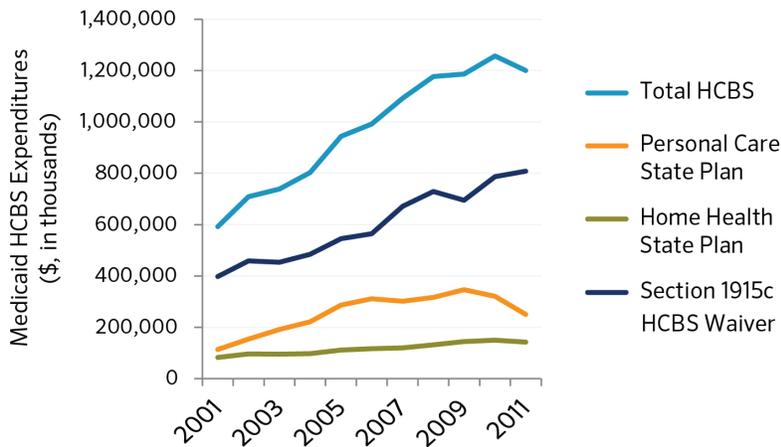


### A Shift toward Home Care

There is a bias in Medicaid funding for long-term care toward paying for institutional services over home and community based services. Nursing facility care is a mandatory entitlement under Medicaid, while many home and community-based services (HCBS) are optional. However, all states cover HCBS through federal waiver and state plan services, including personal care services, and the percentage of public spending on

HCBS is growing across the nation, and in North Carolina.<sup>41</sup>

**FIGURE 13: North Carolina’s Medicaid HCBS Expenditures have increased over the last decade (\$, in thousands)**



SOURCE: KFF, KCMU and compilation of UCSF analyses of Medicaid Home Health and Personal Care Services Policy Surveys and CMS Form 372. Note: Total Medicaid HCBS includes Medicaid home health state plan services, personal care state plan services, and Medicaid 1915(c) HCBS waivers.

There are three primary categories through which states provide Medicaid HCBS: mandatory home health state plan benefits; optional personal care services state plan benefits; and optional Section 1915(c) waivers. Mandatory state plan services are more likely to fall on the medically-related services spectrum (for example, outpatient hospital services, nursing services, or prescription drugs). Optional state plan services, including personal care services, fall more on the community-based

service end (for example, therapies, rehabilitative services, and case management services). State spending, as a proportion of LTSS spending, has increased across all three categories over the last decade and approximately 43 percent of Medicaid LTSS spending is currently directed toward HCBS in North Carolina.<sup>42</sup>

This shift toward home and community care is due in part to states’ obligations under the Supreme Court’s *Olmstead* decision, which affirms the right of individuals to receive services in the most integrated setting, but also because of the increased preference for home care and the lower cost of providing care in home or community-based settings.<sup>43</sup> A recent study by AARP found that Medicaid dollars can support almost three older adults or adults with physical disabilities in their homes compared to one person in institutional care (see figure 13).<sup>44</sup>

### The Importance of Medicaid’s Reimbursement Rate

Because Medicaid is the primary funder of home care, reimbursement by Medicaid programs create the framework in which employers set wages for direct care workers.<sup>45</sup> Medicaid provider reimbursement rates are most often set by states as

part of the budget process and declining state budgets have resulted in payment reductions to providers nationwide. North Carolina has been no exception.

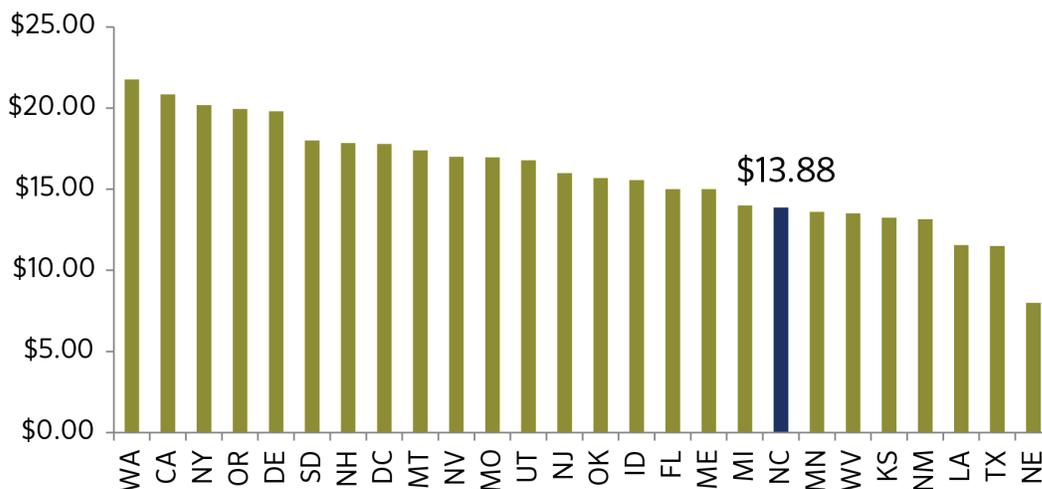
Within North Carolina’s State Plan Personal Care Services (PCS) program, wages are set by the employers, but are influenced by reimbursement rates. PCS rates in North Carolina are somewhat difficult to track over time as PCS was consolidated into one rate for all provider settings effective January 1, 2013.<sup>46</sup> However, overall, the rates in North Carolina have been either frozen or reduced since 2009. The rate underwent a drastic rate cut over the last year.<sup>47</sup> PCS reimbursement rates were reduced from \$15.52 per hour to \$13.88 as of January 1, 2014 (see figure 14).<sup>48</sup>

**FIGURE 14: North Carolina’s PCS reimbursement rate was cut in 2013**

Date of Services	Rate (Per 15 minutes)	Rate (Per Hour)
Prior to 10/1/2013	\$3.88	\$15.52
10/1/2013 - 12/31/13	\$3.58	\$14.32
1/1/2014 Forward	\$3.47	\$13.88

SOURCE: North Carolina DHHS, North Carolina Medicaid Special Bulletin, “Personal Care Services Revised Payment Adjustment Plan,” August 2014.

**FIGURE 15: Medicaid Personal Care State Plan Services Agency Reimbursement Rates, 2013 (\$)**



SOURCE: KCMU and UCSF analyses of Medicaid Home Health and Personal Care Services Policy Surveys. Note that data is not available for all states.

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## Reimbursement by Medicaid programs create the framework in which employers set wages for direct care workers.

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The reduction in reimbursement places North Carolina rates more than \$4 per hour lower than the national average rate—\$18.20—paid to provider agencies (see figure 15).<sup>49</sup> Industry operating profits, in turn, have been under pressure, resulting in lower pay to care workers.<sup>50</sup>

States around the country are moving forward with wage-improvement strategies for home care workers tied to Medicaid reimbursement rates. Best practices include starting with the cost of workers' wages and benefits and then layering administrative costs on top.<sup>51</sup>

### States move forward with bi-partisan reimbursement rate proposals

Innovative proposals have emerged. These proposals recognize how important it is to increase the pay of direct care workers to attract and keep dedicated employees. They would save state government money on the funding of long-term care by shifting care from facilities to less expensive home care. While some states have opted for pass-through initiatives, some newer proposals aim to ensure a basic level of compensation for direct care workers by focusing on the wage floor.

A bi-partisan coalition of lawmakers in Maine is calling for an increase of the Medicaid reimbursement rate from \$15/hour to \$25 per hour, requiring 85 percent of the increase to be used for wages and employee benefits. The raise in the reimbursement rate could translate to a pay raise for workers from about \$9 per hour to about \$15, with a possibility of health benefits and mileage reimbursement.

“We need to pay people more than Walmart to attract and keep the employees who do this important, valuable work,” said House Speaker Mark Eves said. “Not

only do seniors want to live independently in their homes as long as possible, it's also the least expensive long-term care option.”<sup>52</sup>

Implemented state wage initiatives included Montana's HB 2, passed in the 2011 session, which included an amendment for a two-year wage appropriation in the form of a pay increase or lump sum bonus for direct-care workers employed by Medicaid-funded nursing homes and community-based services. Eligible Medicaid-funded long-term care providers could apply to receive higher reimbursement rates to raise their direct-care employees' wages.

“This funding is critical to the ability of providers to recruit and retain staff and for our workers who need this money to make ends meet,” said Rose Hughes, Executive Director of the Montana Health Care Association, a long-term care facilities professional association. “We feel strongly that we must continue to value these dedicated workers who are so committed to providing excellent care to those who need their help, and this funding is part of doing that.”<sup>53</sup>

## Conclusion and Policy Recommendations

As our state's demographics shift and more and more of North Carolina's Baby Boomers reach older age, the demand for direct care will continue to increase. The challenge for our state is to find responsible ways to address the direct care workforce gap and, at the same time, deliver high quality care to those who need it.

Increasing wages and benefits for direct care workers is a critical step in meeting this challenge. The inclusion of home care workers under the protection of federal minimum wage laws is an important step. However, for the thousands of workers currently working full-time and still only bringing home poverty-level wages, current minimum wage protections are insufficient. These protections, while necessary, fail to reflect the actual needs and budget challenges of low-income families. Increasing wages for low-income workers also provides a much-needed boost to our economy as additional dollars are spent locally on such basics as food, housing, and repairs. Studies have estimated that every \$1/hour increase in wages for low-income workers leads to \$1.20 in increased economic activity.<sup>54</sup>

Finally, increasing wages can help decrease turnover in the industry, impacting the quality and consistency of care for consumers and costs for providers.<sup>55</sup> Case studies around the country have demonstrated that improved job conditions, including an increase in wages, translate to a reduction in turnover.<sup>56</sup> Turnover is costly, both in replacement and training costs, and due to the indirect cost of interrupted care. The money lost would be better spent investing in a stable workforce.

Specific policy recommendations include:

- **Raise Medicaid reimbursement rates.** Public reimbursement will continue to play a large role in the funding of care as long as North Carolina maintains a fee-for-service structure. Increasing Medicaid's provider reimbursement rate would allow providers to give their workers a raise while remaining competitive in the market. Ideally, reimbursement rates should be built from the ground up—starting with the costs of workers' wages and benefits and building administrative costs on top. At the very least, rates should be determined based on projected needs.

Best practices for a wage-improvement strategy include:

- An automatic update mechanism, such as a link to an annual inflation-adjustment.
- A way to ensure enforcement through mandatory reporting and data collection.
- A built-in mechanism for evaluating reimbursement rates, or the wage floor, over time to ensure that the rate remains competitive.<sup>57</sup>
- **Expand Medicaid.** On-the-job injury rates are high in the direct care professions, while insurance rates remain low. Approximately half of the home care workforce would be eligible for expanded Medicaid. In total, expanding Medicaid in North Carolina would provide coverage to about 500,000 low-

income people. More than 300,000 of these state residents have no other insurance options available to them.

- **Provide career paths for paid caregivers.** The opportunity for less-skilled workers to move up into higher skilled, higher-paid positions is a win-win for workers and employers. In the early 2000s, the North Carolina legislature stopped funding career pathway programs that had been established as part of welfare reform, but local workforce boards, nonprofit workforce intermediaries, and community-based organizations have picked up the mantle and have been experimenting with models targeted toward specific populations and industries. North Carolina has been recognized nationally for innovative programs targeting the direct care workforce.<sup>58</sup> Career pathways—connecting education and training programs with student support services—are effective tools for addressing the fundamental disconnect between industry demands and the labor market’s ability to provide it. Career pathways help workers attain mobility and provide employers with a skilled, dedicated workforce.
- **Raise the minimum wage.** Raising the current minimum wage from \$7.25 to, for example, \$12 per hour (as the federal Raise the Wage Act proposes) would represent an approximate 25 percent increase above median wages for direct care workers. This raise would be a much-needed boost for struggling workers as well as an opportunity to impact local economies as additional dollars are spent locally. While raising the minimum wage for workers would impact provider costs and potentially raise market rates for care, a raise through policy would provide an even playing field for care providers.
- **Support collective bargaining rights.** Collective bargaining gives workers a voice in negotiating their own workplace standards and increases workers’ investment in the workplace. A growing unionization movement in the home care industry has led to higher wages and improved benefits as well as more job satisfaction and less turnover. Removing current barriers to unionization in addition to supporting employees in their organizing efforts is essential to providing a strong, stable work force.
- **Ensure paid leave.** Direct care workers have one of the most physically demanding jobs and are in close contact with vulnerable populations, yet have one of the lowest rates of paid sick days (and insurance coverage) in the state. Nearly seventy percent of North Carolina’s direct care workforce lacks even a single paid sick day. For many of these workers, losing a day’s pay is as easy as catching a cold. Without paid sick days, direct care workers are faced with the impossible choice of going to work sick (and risking the health of those they care for) or losing critical pay.

North Carolina is at a pivotal point in time as the need for care, and quality care, is increasing. In addition to increased investment in services and supports for older adults and disabled residents and their caregivers (including access to Medicaid), a “good jobs” agenda is crucial to addressing our state’s care gap in a responsible and sustainable way. ■

1. Freyer, Allan and Alexandra Forter Sirota, 2014. "North Carolina's Low-Wage Recovery is Hurting Workers and the Economy," NC Budget and Tax Center.
2. Home Care Pulse, "2015 Private Duty Benchmarking Study," 2015.
3. Based on PHI Analysis of U.S. Census Bureau, American Community Survey 2014 1-year Estimate: Public Use Microdata Sample.
4. See NELP, February 2015. Data Brief: "Giving Caregivers a Raise: The Impact of a \$15 Wage Floor in the Home Care Industry."
5. Houser, Ari, Wendy Fox-Grage, Kathleen Ujvari, September 2012. "Across the States 2012: Profiles of Long-Term Services and Supports," AARP.
6. Ibid.
7. Ibid.
8. See Congressional Budget Office, "Rising Demand for Long-Term Services and Supports for Elderly People," 2013.
9. Houser, Ari, Wendy Fox-Grage, Kathleen Ujvari, September 2012. "Across the States 2012: Profiles of Long-Term Services and Supports," AARP.
10. Feinberg, Lynn, Susan C. Reinhard, Ari Houser, and Rita Choula, July 2011. "Valuing the Invaluable: 2011 Update," AARP Public Policy Institute.
11. Redfoot, Donald, Lynn Feinberg, and Ari Houser, 2013. "The Aging of the Baby Boom and the Growing Care Gap: A Look at the Future Declines in the Availability of Family Caregivers," AARP Public Policy Institute.
12. MetLife Mature Market Institute, "The MetLife Study of Caregiving Costs to Working Caregivers," June 2011.
13. Feinberg, Lynn, 2013. "Keeping Up with the Times: Supporting Family Caregivers with Workplace Leave Policies," AARP Public Policy Institute.
14. Institute for Women's Policy Research, "Briefing Paper: Access to Paid Sick Days in North Carolina," June 2014; IWPR analysis of 2011-2012 National Health Interview Survey and 2012 IPUMS American Community Survey (61 percent of full-time, year-round workers earning \$1 - \$19,999 - or 199,305 workers - had no access to paid sick days).
15. PHI, "Who are Direct-Care Workers?" February 2011 update.
16. Bureau of Labor Statistics, Occupational Employment Statistics: May 2014 Occupational Employment and Wage Estimates.
17. Nationally, the home health occupation is projected to grow expected to grow by 48.5 percent from 2012 to 2022. US DOL, Bureau of Labor Statistics, Fastest Growing Occupations.
18. PHI analysis of 2010-2020 occupational employment projections by the NC Department of Commerce.
19. Seavey, Dorie and Abby Marquand, December 2011. "Caring in America, A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides," PHI.
20. Department of Health and Human Services, 2014 Poverty Guidelines
21. Unlike the federal poverty guidelines, the LIS takes into account regional cost of living variances and the cost of major expenses like child care.
22. Seavey, Dorie and Abby Marquand, December 2011. "Caring in America, A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides," PHI.
23. PHI analysis of Injuries, Illnesses, and Fatalities (IIF) data, Bureau of Labor Statistics.
24. Institute for Women's Policy Research, "Briefing Paper: Access to Paid Sick Days in North Carolina," June 2014.
25. On May 12, 2015, a joint committee of the Missouri legislature rejected an agreed-upon wage raise for home care workers under Missouri's consumer-directed services program. On May 22, 2015, Ohio Governor John Kasich signed an executive order rescinding an executive order for independent home care and child care providers under contract with the state of their right to collectively bargain. <http://www.newtribune.com/news/2015/may/13/joint-committee-rejects-proposed-home-care-pay-rul/http://www.washingtontimes.com/news/2015/may/26/dems-look-to-ohio-budget-to-restore-certain-union/>.
26. Schoenbach, Sabine, February 2013. "RTW is the Wrong Approach to Economic Recovery and a Strong Middle Class," NC Justice Center.
27. PHI, "Paying the Price: How Poverty Wages Undermine Home Care in America," 2015.
28. See, for example, Chapman, Jeff and Jeff Thompson, February 2006. "The Economic Impact of Local Living Wage Laws," Economic Policy Institute. One study focusing on San Francisco airport screeners found that annual turnover decreased from 95% to 19% when wages were raised from \$6.45 to \$10.00 per hour.
29. Jang, Yuri, May 2015. "Determinants of job satisfaction and turnover intent in home health workers: The role of job demands and resources," Journal of Applied Gerontology.
30. Home Care Pulse, "2015 Private Duty Benchmarking Study," 2015.
31. PHI, "Paying the Price: How Poverty Wages Undermine Home Care in America," 2015 citing Seavey, D., 2004. "The Cost of Frontline Turnover in Long-Term Care," Better Jobs Better Care.
32. See, for example, Castle, Nicholas G., John Engberg, and Aiju Men, 2007. "Nursing Home Staff Turnover: Impact on Nursing Home Compare Quality Measures," The Gerontologist.
33. See for example, Woodward, CA, Abelson, J, Tedford, S, Hutchison, B, 2004. "What is important to continuity in home care? Perspectives of key Stakeholders," Soc Sci Med.
34. PHI, "Paying the Price: How Poverty Wages Undermine Home Care in America," 2015 citing Howes, Candace, 2004. "Living Wages and Retention of Homecare Workers in San Francisco."
35. Ibid citing "Recruitment and Retention of Direct Support Professionals in North Dakota: Analysis of 2010 NDACP Data."
36. BLS, QCEW, 2014 Annual Average for NAICS 6216 and NAICS 62412
37. NC DHHS Division of Health Service Regulation, "Consumer's Guide to Home Care."

38. UC Berkeley Labor Center calculations from 2008-2012 March CPS, 2007-2011 ACS, 2011 OES, program administrative data.
39. MetLife, 2012. "Market Survey of Long-Term Care Costs." See also Nursing Facility Rates for non-private rooms at NCDHHS: <http://www.ncdhhs.gov/dma/fee/index.htm>.
40. Reaves, Erica L. and MaryBeth Musumeci, May 2015. "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation.
41. Ibid.
42. Houser, Ari, Wendy Fox-Grage, Kathleen Ujvari, September 2012. "Across the States 2012: Profiles of Long-Term Services and Supports," AARP.
43. Olmstead v. L.C., 527 U.S. 581 (1999); Reaves, Erica L. and MaryBeth Musumeci, May 2015. "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation.
44. Houser, Ari, Wendy Fox-Grage, Kathleen Ujvari, September 2012. "Across the States 2012: Profiles of Long-Term Services and Supports," AARP.
45. Seavey, Dorie and Abby Marquand, December 2011. "Caring in America, A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides," PHI.
46. Communication with NC Department of Health and Human Services, Division of Medical Assistance, 5/12/15
47. NC DHHS Division of Medical Assistance, "Personal Care Services" accessed at <http://www.ncdhhs.gov/dma/pas/pas.html>
48. Rates for Personal Care Services under the Innovations waiver may vary by MCO. For example, Alliance Behavioral Healthcare's rate for personal care under the Innovations waiver is 3.54/15 minute unit while the rate for personal assistance for state funded services is 4.46/15 min unit. Different categories of PCS rates were consolidated for all provider settings in 2013 making it difficult to compare the rate over time.
49. KFF, KCMU and compilation of UCSF analyses of Medicaid Home Health and Personal Care Services Policy Surveys and CMS Form 372. Note: Total Medicaid HCBS includes Medicaid home health state plan services, personal care state plan services, and Medicaid 1915(c) HCBS waivers
50. Seavey, Dorie and Abby Marquand, December 2011. "Caring in America, A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides," PHI.
51. PHI Brief on Wage Initiatives, Best Practices, May 13, 2015. Research on states that have established wage pass-throughs has not shown this strategy to ensure a sufficient base wage rate.
52. Portland Press Herald, "Legislation says Maine's home care workers deserve better pay," May 18, 2015.
53. PHI, "Montana Budget Bill Includes Wage Increase or Bonus for Direct-Care Workers," April 2011.
54. Cooper, D. & Hall, D. (2013). Raising the federal minimum wage to \$10.10 would give working families, and the overall economy, a much-needed boost. Economic Policy Institute.
55. One study estimates that the high rates of turnover cost \$6 billion annually. PHI, "Paying the Price: How Poverty Wages Undermine Home Care in America," 2015 citing Seavey D, 2004. "The Cost of Frontline Turnover in Long-Term Care. Better Jobs Better Care."
56. PHI, "Paying the Price: How Poverty Wages Undermine Home Care in America," 2015.
57. PHI Wage Initiatives, May 2015.
58. For example, WIN A STEP UP was an initiative aiming to enhance care in nursing homes by addressing nurse aide turnover. The program aimed to improve skills and increase career commitment. NC NOVA has also been recognized as a model as a special licensure program aimed at improving direct care jobs, reducing turnover, and improving quality care. See Harmuth, Susan and Thomas R. Konrad, 2010. "Strengthening the Direct Care Workforce in North Carolina," NC Medical Journal.





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