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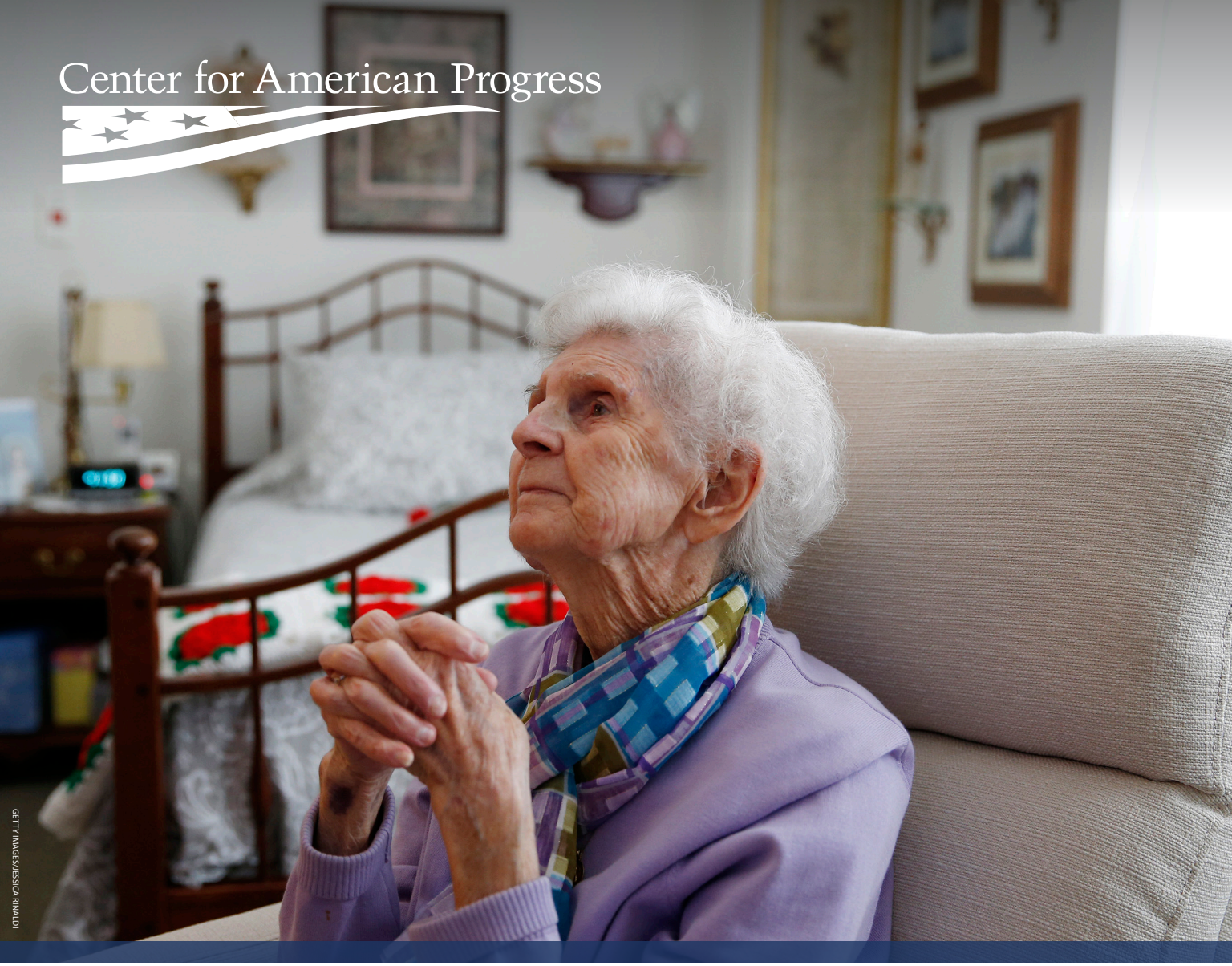

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State Options for Making Wise Investments in the Direct Care Workforce

By Madeline Twomey April 2019

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Introduction and summary

About 13 million Americans rely on some form of long-term care assistance,[1] ranging from meal preparation and transportation services to round-the-clock care. The existing long-term supports and services (LTSS) system in the United States is wholly inadequate, with recipients—older adults and individuals with disabilities—often relying on both formal and informal care in a variety of settings. Moreover, even though the majority of LTSS recipients would prefer to receive care at home, the existing system often puts this option out of reach.

Individuals turning 65 today will have about a 70 percent chance of needing long-term care services at some point in their lifetimes.[2] As a result, the demand for LTSS is only expected to increase: The population of adults ages 65 and older will almost double by 2050, increasing from 47.8 million in 2015 to 88 million. And the population of adults older than 85 will more than triple over the same period, from 6.3 million to 19 million.[3]

There is also a need for far more direct care workers. Low wages, limited professional development opportunities, and demanding workloads have all hindered the appeal of joining the direct care workforce. They have also affected providers' ability to retain workers. Moreover, insufficient training requirements leave direct care workers unprepared to care for clients with complex needs.

Workforce shortages have been associated with poor quality of care as well as higher costs for patients and providers. As direct care workers take on even greater workloads to make up for staff shortages, mistakes become more common, resulting in patients experiencing preventable infections and accidents. Turnover among direct care workers can also cost the system thousands of dollars per worker.[4] Initial investments in the direct care workforce present the opportunity for policymakers to improve quality of care delivered to patients in addition to reducing unnecessary costs—such as those incurred by turnover—over time. Strengthening the workforce can also help states expand access to home- and community-based services (HCBS), furthering efforts to improve patient satisfaction and increase the value for each dollar spent on LTSS.

This report outlines a number of actions that lawmakers can take to support the existing direct care workforce while increasing the number of available workers. Several states have already taken innovative approaches to addressing workforce shortages, including implementing payment reform to incentivize workforce initiatives. Additionally, states have increased wages and invested in workforce development and training in order to attract and retain direct care workers. In order to meet the growing demand for LTSS, state lawmakers should prioritize policy changes addressing workforce challenges, and the federal government should make investments to support states implementing meaningful reform.

Background

Cost of LTSS

The average cost of long-term care over an individual's lifetime has reached $172,000, and systemwide costs of LTSS are expected to double by 2047.[5] Not surprisingly, most consumers are unprepared to bear these high costs and incorrectly believe that Medicare, private health insurance, or retirement plans will cover these services. Although private long-term care insurance is available for purchase, very few individuals are actually covered by these plans. In reality, most Americans are forced to pay out of pocket or rely on Medicaid.[6]

These high costs only serve to harm patients and strain both state and federal resources. Since states and the federal government are responsible for financing Medicaid, both budgets are affected. In 2016, total LTSS costs amounted to $286.1 billion—approximately 10 percent of total U.S. personal health expenditures.[7] Medicaid covered $154.4 billion of this total, accounting for 30.6 percent of all federal and state Medicaid spending.[8] According to a 2019 Commonwealth Fund report, "Without an affordable, sustainable financing solution, Medicare beneficiaries with LTSS needs will continue to be at greater risk of delaying necessary care, being placed in a nursing home prematurely, and having to 'spend down' into the Medicaid program."[9]

Shift to HCBS

States have increasingly invested in HCBS to provide higher-value care. HCBS help older adults and individuals with disabilities remain in their homes and typically include habilitative services, home health aide services, adult day health care programs, personal care services, assistive technology, and case management services.[10] These can be provided at recipients' homes or in various community settings, such as adult day care facilities. HCBS generally rate higher on quality measures than institutional care—and, importantly, patients overwhelmingly report the desire

to remain in their own homes. According to a nationwide AARP survey, nearly 90 percent of seniors ages 65 and older would prefer to "age in place," or to receive care at home and in their communities as they age.[11]

Not only does expanding access to home- and community-based care allow states to address the wishes of those who need LTSS, but it can also be a more efficient use of state and federal resources. The average annual cost of a private room in a nursing home was about $92,000 in 2016, while the annual cost of a home health aide working about 30 hours per week was $31,000 that same year.[12] Of course, nursing home care is 24 hours a day, seven days a week, which explains some of the difference in costs; however, in cases where patients do not need round-the-clock support, HCBS can be the most cost-effective option.

Despite significant progress in expanding access to HCBS, more than 650,000 people remain on a waitlist to receive these services—most of whom are individuals with disabilities.[13] As technological innovations have allowed more nonelderly people with disabilities to live independently, HCBS have been essential in listening to the preferences of many of these individuals and moving them out of costly institutions. However, states continue to limit their HCBS programs, and many individuals with disabilities covered by Medicaid remain on waitlists for this type of care. Moreover, despite the fact that the overwhelming majority of older adults would also prefer to remain in their homes,[14] many seniors still opt to receive care in nursing homes because of financial burden and limited providers.

Another key issue affecting access to HCBS is the declining number of family caregivers. Family caregivers—also referred to as informal caregivers—are partners, friends, or relatives who provide any amount of long-term care assistance to their loved ones.[15] More than 17 million people in the United States serve as family caregivers to someone 65 years or older who has significant care needs.[16] According to the Congressional Budget Office, the value of unpaid care that caregivers provide to older adults was $234 billion in 2011.[17] Estimates are even greater when accounting for caregiving for individuals with disabilities.[18]

While family caregivers currently serve a key role in providing LTSS to individuals in their homes, changing family demographics are expected to influence the number of needed caregivers. Not only are the number of older adults increasing, but the size of American families is shrinking. As a result, there are an increasing number of aging adults who will not be able to rely on their children to provide the care necessary for them to remain in their homes.

Medicaid payment for HCBS

Until the 1990s, most LTSS paid for by Medicaid were furnished in institutional settings because of the program's historical bias toward nursing home care. The Medicaid statute generally only requires states to cover LTSS delivered in nursing homes.[19] However, states now have a number of different ways to expand access to HCBS under their Medicaid programs, including new options under the Affordable Care Act (ACA).[20] Although these options give states the flexibility to design their own Medicaid programs, this patchwork of coverage also means that there are no national standards for personal care and other HCBS; thus, quality and access to HCBS can vary significantly by state.[21]

Medicaid pays for HCBS in a number of different ways, and states can choose from various approaches or waiver combinations. First, states can include these services as part of their Medicaid state plans. For example, states can receive enhanced federal matching funds to provide HCBS to individuals who would otherwise require institutional care through the ACA's Community First Choice state plan option.[22]

Second, state officials can request federal approval for different types of waivers, which allows them to adopt policies and cover services, including HCBS, that differ from the requirements set forth in the federal Medicaid statute. This is a far more common approach, because the Medicaid default requires a state to offer comparable services to all beneficiaries in the same eligibility groups, while under a waiver, a state can limit services to particular groups.[23] For example, states can apply for Section 1915(c) waivers—named after the relevant section of the federal Social Security Act—which allow them to provide LTSS in home- and community-based settings in place of institutional care.[24] In addition to meeting certain quality guidelines, these waivers must demonstrate that home and community care will not exceed the cost of providing the same care in institutions.[25] A number of states also use Section 1115 waivers to administer LTSS through managed care arrangements.[26] These waivers allow states to waive a wider range of Medicaid requirements to test new approaches to delivering care, including expanded benefits or different payment structures.[27]

Recognizing that HCBS give patients the care they want, states have utilized a number of these methods to implement these services. In order to ensure all patients have the option to receive care at home, however, both state and federal policymakers should support efforts to increase the availability of direct care workers. Particularly as the demand for HCBS increases, it is critical that states work quickly to expand their workforce capacities.

The direct care workforce

With approximately 4.5 million people, the direct care workforce includes home health aides, nursing assistants, and personal care workers.[28] These individuals are employed in a variety of settings, including nursing homes, assisted living facilities, adult day centers, private homes, and home health agencies. According to the Bureau of Labor Statistics, the direct care workforce—home health and personal care aides in particular—is one of the fastest-growing sectors in the United States and is expected to grow by 41 percent from 2016 to 2026.[29]

Direct care wages are low, and workers often report having trouble making ends meet. In 2017, the median pay for home health and personal care aides was only $11.12 per hour, or $23,130 per year.[30] These positions rarely include benefits; more than 57 percent of home care workers rely on public assistance,[31] and an estimated 46 percent of home care workers rely on Medicaid for health insurance.[32] These low wages affect populations who already suffer from income inequality: 86 percent of the direct care workforce are women, and more than a quarter are black women.[33] Latina women and immigrants also make up a significant portion of the direct care workforce.[34]

Direct care workers experience low job satisfaction, leading to burnout and high turnover rates. With staff shortages, workers report heavy workloads and stressful working conditions.[35] Work-related injuries are common;[36] nursing assistants in particular experience extremely high injury rates and were among the Bureau of Labor Statistics' list of occupations that experienced the highest number of days away from work due to injury in 2015.[37] While federal standards exist for workers employed in nursing facilities, there are no federal guidelines for certification for home care assistants, and at least 10 states fail to implement any training requirements at all.[38]

Workforce challenges also affect the quality of care for patients.[39] Patients in areas with limited home health providers have gone without essential care, resulting in them being unable to use the restroom, skipping meals, and sometimes becoming injured.[40] Moreover, workforce shortages in nursing homes have resulted in patients being denied care altogether.[41] Turnover of direct care workers has also been associated with patients experiencing injuries and avoidable hospitalizations.[42]

Reforms to LTSS payments to support the workforce

Lawmakers can utilize payment and delivery reforms to support the direct care workforce. Like most of the health care system, LTSS providers traditionally operate using fee-for-service (FFS) payments. Under FFS, payers reimburse providers for each item or service delivered to a patient.[43] When LTSS providers operate under FFS, individuals receiving care can be charged separately for each medical procedure in addition to different types of personal care services. In some cases, patients require several LTSS professionals who are each billed separately—for example, one worker to administer medicines, another to provide meals, and so on. Research has shown that FFS incentivizes quantity over quality, encouraging providers to perform as many services as possible for maximum reimbursement, which can negatively affect quality and cost of care.[44]

In order to address some of these inefficiencies, states have implemented value-based payment models and managed long-term supports and services (MLTSS) through their Medicaid programs. These payment and delivery reforms can be used to achieve a number of goals, ranging from reducing avoidable hospitalizations to increasing access to HCBS. Both types of reforms serve to increase patient satisfaction and reduce unnecessary costs.

Value-based payments for LTSS

Implementing value-based payments can work to incentivize care coordination and to financially reward high-performing providers. Pay-for-performance in particular has been used to strengthen the direct care workforce by providing incentive payments to providers who meet benchmarks for workforce development and staff satisfaction.[45] For example, pay-for-performance requirements can include guidelines to properly train and compensate staff.

Pay-for-performance is a payment model that offers financial incentives for providers who meet certain quality domains.

Significant progress has been made to encourage the use of alternative payment models in the health care system, which has reduced unnecessary health care costs

and improved quality of care.[46] While these payment models are relatively new in LTSS, some states have experienced positive outcomes by utilizing them to support workforce education and development initiatives.

State example: Kansas' PEAK 2.0 program

Kansas introduced a Medicaid pay-for-performance program in 2012 as part of an overhaul of its original Promoting Excellent Alternatives in Kansas (PEAK) program.[47] Under PEAK 2.0, the state offers financial incentives through Medicaid reimbursement for nursing homes that meet certain quality measures. Specifically, the incentives are based on five domains of patient-centered care: the foundation, or implementation of the program; resident choice; staff empowerment; home environment; and meaningful life.[48] Some examples of staff empowerment initiatives include encouraging team development, ensuring consistent staffing, and empowering certified nursing assistants to set their own schedules.[49] The goal is to create systemwide culture change with permanent and consistent staff who form meaningful relationships with patients.[50]

Kansas' program demonstrates how strengthening the workforce can coincide with increasing quality of care for LTSS recipients. According to state officials, surveys have indicated that workers participating in the person-centered care model are primarily motivated to improve quality of life for patients, demonstrating workers' desire for meaningful work in addition to adequate pay.[51] The program has already seen improved quality measures for patients, including increased overall resident satisfaction and reduced number of residents experiencing major depressive symptoms, pressure ulcers, and urinary tract infections.[52]

Managed care delivery of LTSS

MLTSS are responsible for delivering a wide range of medical and personal care services. An increasingly popular trend in LTSS, states contract with managed care organizations (MCOs) through their Medicaid programs, which then contract with individual LTSS providers.[53] Like managed care for acute medical services, Medicaid pays MLTSS organizations a fixed payment per beneficiary rather than reimbursing for each service furnished to a patient.[54] As of 2017, 24 states have implemented 41 MLTSS programs, enrolling 1.8 million Medicaid beneficiaries.[55]

Evaluations of managed care and LTSS

States often turn to MLTSS to make Medicaid spending more predictable, but when designed properly and with ongoing oversight, these arrangements can also improve care coordination and encourage the use of HCBS. Under these agreements, states can provide payments for services not traditionally covered under Medicaid, such as appointing care coordinators—typically social workers or nurses—to develop care plans for patients.[56] Among other things, care coordinators assess the needs of patients and connect them with local providers.[57] In some cases, MLTSS organizations provide both physical and behavioral health services, giving patients a single point of contact for all of their care needs.[58] Care coordination services can improve quality and lower costs by helping patients find services in their communities. For example, a 2018 Government Accountability Office report found that Florida's MLTSS program resulted in $716 million in avoided institutional costs from 2014 through 2016, and the projected savings for the program is $200 million per year after 2016.[59]

The Centers for Medicare and Medicaid Services has also been testing managed care plans for dual-eligible beneficiaries—individuals who qualify for both Medicare and Medicaid—dating back to the 1990s.[60] Dual-eligible beneficiaries often have greater health and LTSS needs and subsequently incur higher costs. A 2018 Medicare Payment Advisory Commission report details several site visits of ongoing managed care demonstrations for dual-eligible beneficiaries that provide both acute care and LTSS.[61] The authors highlight the need for more evaluation of these programs; however, they found that, based on the data available, the results have been relatively positive: "Enrollment is stable, quality of care appears to be improving, payment rates appear adequate, plans have grown more confident about their ability to manage service use, and stakeholders remain supportive of the demonstration."[62]

The report also highlights previous demonstrations that have yielded success: For example, Minnesota's managed care program for dual-eligible beneficiaries ages 65 and older reduced enrollees' likelihood of inpatient hospitalizations by 8 percent and emergency room visits by 6 percent, in addition to increasing the likelihood of enrollees utilizing HCBS by 13 percent.[63] The authors concluded that managed care for these beneficiaries has successfully improved the transition from institutional to community care in addition to reducing hospital use and emergency department visits.

States have also used MLTSS to directly enhance the direct care workforce. In 2018, Pennsylvania began implementing its mandatory MLTSS program, Community HealthChoices (CHC), in order to improve care coordination and expand access to HCBS for patients.[64] Under CHC, the state Medicaid program contracts with three MCOs throughout the state to deliver both medical care and LTSS to two eligibility groups: individuals who are dually eligible for Medicare and Medicaid and individuals with physical disabilities.[65] According to state officials, participating MCOs are required to implement a home care workforce innovation component to their programs—including but not limited to training and credentialing programs—and will ultimately be required to report their progress on a quarterly basis.[66] Citing the success of mandatory MLTSS programs in other states,[67] Pennsylvania officials say they believe that CHC will increase transparency and give the state more predictability in LTSS spending.[68] Although the state is still in the process of rolling out the program, 450,000 Pennsylvania residents will ultimately qualify for coverage under this program.[69]

Still, states must remain extraordinarily vigilant when structuring these arrangements and conducting ongoing oversight to ensure that implementing managed care does not translate into cutting essential services for LTSS recipients. For example, patient advocates flagged serious problems with New York's Medicaid transition to mandatory MLTSS in 2011.[70] They found that the MLTSS organizations were selecting enrollees based on health status—recognizing that they would retain larger profits by selecting healthier patients while denying patients with greater needs.[71] Moreover, there were reports that, even in cases where patients with significant care needs were enrolled, they were not being granted the appropriate level of care in order to reduce costs for providers.[72]

New York's experience exemplifies the need for constant state oversight and close coordination with the patient community. Like any other robust payment reform, quality and accountability measures must be in place in order to ensure that patients are receiving high-quality care. When transitioning to MLTSS, policymakers should establish clear, attainable goals and standards and keep open channels of communication with all of the relevant stakeholders: patients, providers, family caregivers, and payers.

State example: Tennessee's integration of MLTSS and the pay-for-performance model

Several states have embedded value-based payments into their MLTSS programs. As part of the state contracts, MLTSS programs can utilize value-based payments to incentivize certain quality measures, including workforce standards. For example, Tennessee has implemented a pay-for-performance model under its MLTSS program, resulting in robust training and credentialing requirements for direct care workers.

In 2014, the state launched its Quality Improvement in Long-Term Services and Supports (QuILTSS) program, serving older adults and adults with physical disabilities through the state's CHOICES MLTSS program.[73]

Under QuILTSS, the state's Medicaid program, TennCare, sets reimbursement rates for nursing facilities based in part on a comprehensive score measuring the nursing home's performance. The score is based on a number of quality measures, such as resident satisfaction, quality of life, and clinical performance. A key component of the score—accounting for 25 percent of the overall rating—is "Staffing/Staff Competency." This includes quality measures such as staff retention, staff hours per day, staff training, and consistent staff assignment.[74] These objectives are intended to measure staff satisfaction as well as the provider's ability to retain direct care workers. Under the new reimbursement structure, TennCare MCO payments to nursing facilities include a quality incentive component valued at the greater of either $40 million or 4 percent of total nursing facility payments each year. Other components of the rate are also quality-informed, meaning performance can have a significant impact on a facility's annual Medicaid revenue.[75] Importantly, during the nearly five years since payments began, initial quality measures have showed significant signs of improvement.

Although the QuILTSS program was initially launched with nursing facilities, it has now expanded to HCBS. Tennessee state officials have noted that implementing a pay-for-performance model in HCBS has been more difficult than in nursing facilities, because many of these workers are employed in private homes. Still, officials in Tennessee are working with stakeholders to address these challenges and to achieve the original goal of improving quality of care through a stronger workforce.[76] Noting that direct care workers can face low wages and harsh working conditions, stakeholders in Tennessee continue to put forth measures that improve workers' quality of life. In 2016, Tennessee launched its newest MLTSS program, Employment and Community First CHOICES, serving individuals with intellectual and developmental disabilities.[77] In 2017, TennCare began rolling out a workforce development

initiative that aims to make direct care work a more viable career through competency-based education, training, and credentialing that can apply toward postsecondary education credits and other career pathways.[78]

The growing need for LTSS—and patients' desire to stay in their homes—requires investments today to build up the direct care workforce. In addition to implementing payment reforms, states can strengthen the direct care workforce by raising Medicaid reimbursement rates and increasing professional development opportunities. These initial investments not only work to improve quality of care, but they also increase worker satisfaction and can reduce unnecessary costs over time. Directly raising wages presents an opportunity to reduce turnover in addition to attracting more workers. Similarly, investing in professional development works to further professionalize the direct care field—making it more attractive to workers—and to improve the overall quality of care delivered to patients.

Reforms to investments in the direct care workforce

Given the low wages, demanding day-to-day responsibilities, and limited career growth opportunities, it is unsurprising that attracting and retaining workers is a significant issue plaguing the LTSS system. Turnover of home care workers alone costs an estimated $6 billion annually,[79] and the cost of hiring and training new direct care workers has been estimated at $4,872 per position.[80] Furthermore, the annual turnover rate has been estimated at 70 percent in nursing facilities and 50 percent in home care.[81] This undoubtedly affects quality of care: California's In-Home Supportive Services program found that patients whose home care provider changed in a given year were more likely to experience a new injury or hospital admission.[82]

Examples of raising payment rates to expand access to HCBS

Given the robust evidence that low wages are a barrier to recruiting and retaining workers, raising Medicaid rates is a wise investment for states seeking to increase access to HCBS.

A 2018 Government Accountability Office review of HCBS in five states—Arizona, Florida, Mississippi, Montana, and Oregon—revealed significant shortages in the home care workforce, particularly in rural areas.[83] All five states reported issues related to recruitment and retainment of direct care workers. Officials in Montana and Oregon reported low wages directly contributing to the limited availability of direct care workers.[84] Unsurprisingly, residents in these states face significant barriers to receiving HCBS.

In order to address shortages in rural areas and to increase the overall availability of direct care workers, officials from Mississippi and Montana reported increasing payment rates beginning in 2017. Mississippi raised payment rates for providers and agencies employing direct care workers in 2017, and the Montana Legislature approved funding to raise the hourly rate for workers in certain Medicaid HCBS programs that will take effect in 2019.[85] With similar goals in mind, Arizona and Montana officials reported efforts to allow Medicaid beneficiaries to use Medicaid funding to pay family members for care.[86] Not only do these initiatives attract and retain more workers, but they also serve as a sensible investment to help prevent rehospitalizations and other avoidable medical costs.

However, raising payment rates alone is not enough to ensure that home care workers receive higher wages; states must ensure that additional payments result in higher wages specifically, instead of simply going toward administrative overhead or provider profit. To this end, some states have implemented wage pass-through requirements that direct these funds to direct care workers.

States have utilized a variety of methods to meet the growing demand on the direct care workforce, including increasing funding for workforce development and training. According to a survey conducted by the Kaiser Family Foundation, 15 states raised wages for direct care workers in 2018, and 24 states reported plans to implement wage increases in 2019.[87] A total of 22 states reported efforts to implement workforce development initiatives over the same two-year period.[88] In addition to raising wages, states can also help reduce turnover by encouraging professional development opportunities in order to increase employee satisfaction and to professionalize the field. Strong training and credentialing requirements also work to improve the quality of care delivered to patients.

The ACA set forth several opportunities to invest in workforce development. The Personal and Home Care Aide State Training program offered to six states grants that supported efforts to implement training and credentialing for personal and home care aides. Results from this program showed that training resulted in enhanced job satisfaction and career stability.[89] Several states have also utilized the Money Follows the Person Grant (MFP)—a federal Medicaid grant that helps transition nursing home residents back to their communities—to invest in the direct care workforce.[90] For example, Ohio used MFP funding to establish the Direct Service Workforce Initiative in 2012, which worked to identify core competencies for direct care workers to facilitate upward mobility.[91]

In 2012, California received a grant from the Centers for Medicare and Medicaid Innovation to test a program titled "care team integration of the home-based workforce," training an estimated 6,000 home-based providers.[92] The demonstration was projected to save nearly $25 million by reducing emergency room (ER) visits and hospital admissions from the ER.[93] The program also aimed to reduce the average length of stay in nursing homes by 10 percent.[94] Results so far have been mixed, with some evidence of reducing emergency department visits but also some evidence of slight increases in hospitalizations and overall money spent.[95] Building on the progress of this demonstration, states should review the available data and continue experimenting with methods that utilize workforce development to improve quality and control costs of LTSS.

Washington state's home care training program

As part of a 2011 ballot initiative,[96] Washington state established robust training and credentialing requirements for the home care workforce.[97] The requirements include 75 hours of paid precertification training and 12 hours of annual continuing education for all home care workers, including individuals working in home as well as those employed by licensed home care agencies and assisted living facilities.[98] Efforts to standardize Washington's training requirements for the home care workforce date back to the 1990s as part of a statewide initiative to shift away from institutional care, in favor of HCBS.[99] Depending on the circumstances of their employment, home care workers can receive the training through a network of contracted community providers or through the Training Partnership school.[100]

Workers who are employed by Medicaid consumers[101] and those who are covered by the Service Employees International Union's (SEIU) collective bargaining agreement can complete training requirements by attending the Training Partnership school.[102] Established by SEIU 775, the Training Partnership offers classes both in person and online in 13 core languages, with interpreters available for additional languages.[103] The content of the training ranges from skills such as physical emergency preparedness to conflict management and dementia care. At the end of the training, workers are given an assessment to determine credentialing.[104] On any given day, the partnership trains more than 45,000 workers and it is the largest provider of certified home care workers in Washington state.[105] The program also offers additional training and apprenticeship for individuals seeking advanced certification.

When asked about the implementation of the program, state officials said that ongoing issues include meeting the needs of non-English speakers and working on disparities for workers completing the certification requirements.[106] While results of the program—including turnover rates—are difficult to measure, officials noted that employers have reported that workers are better prepared for the job.

Conclusion

As America's population continues to age, an even greater strain will be placed on the long-term care system. As it currently stands, states are not prepared to meet this demand. Direct care workers are instrumental in meeting the daily needs of older adults and individuals with disabilities who require LTSS. It is critical to build up the long-term care workforce, which can improve the value of each dollar spent on LTSS, allow individuals to receive services in their own homes, and improve overall quality of care for patients.

States should continue to strengthen the direct care workforce by implementing value-based payments, increasing wages, and investing in professional development opportunities. To build on these advancements, Congress should support states looking to develop workforce development initiatives through grants, waiver programs, and other dedicated funding. These wise investments are critical to improving quality of care while getting the best value for every dollar spent on LTSS.

About the author

Madeline Twomey is the research assistant for Health Policy at the Center for American Progress.

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