# Helping Hands: An Assessment of the Personal Care Aide Workforce in Nevada

Guinn CENTER

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# Executive Summary

Nevada has approximately 13,000 personal care aides (PCAs) who provide non-medical supports and assistance with daily tasks to older adults and individuals with disabilities in their homes. PCAs assist with bathing, dressing, grooming, toileting, transferring/positioning, mobility/ambulation, and eating, along with light housekeeping, laundry, essential shopping, and meal preparation. Demand for their services is growing rapidly as Nevadans age. It is estimated that, by 2026, Nevada will need to add 5,300 personal care aides to its workforce as a result of growing demand. As of 2028, personal care services (PCS) will be the fourth most in-demand job sector nationwide. But those statistics belie a potential structural distortion: a "care gap" is emerging, whereby demand for services is expected to outstrip supply over the long term.

This policy report summarizes the personal care aide landscape in Nevada and identifies challenges faced by personal care aides in the workplace. The Guinn Center analyzed data from a broad range of governmental, academic, and non-profit entities, while using official government documents to inform our research further, as well as secondary sources to provide context.

Our team evaluated four primary dimensions of the workforce to provide a comprehensive assessment: demographic, social, and economic characteristics; training requirements; employment, occupational projections, and wages; and public financing of personal care services. The Guinn Center's findings are as follows:

## Demographic, Social, and Economic Characteristics of the Personal Care Aide Workforce in Nevada

- Almost half of all personal care aides are **older middle-aged adults** (48.7 percent), or those aged 45 to 64.
- Nevada's personal care aide workforce is **predominantly female**. More than 8 in 10 personal care aides (83.7 percent) in Nevada are women.
- A breakdown by racial categories evinces disproportionate representation.
  - More than one-half of all personal care aides are white, but they are underrepresented in the PCA workforce; at 66.1 percent of Nevada's total population in 2018, they account for 55.8 percent of personal care aides.
  - African Americans and Asians are overrepresented in the PCA workforce. The African American share of Nevada's population is 8.9 percent, and the Asian share is 8.0 percent. Amongst Nevada's PCAs, 14.3 percent are African American, and 13.5 percent are Asian.
  - People of color make up 33.9 percent of Nevada's population but 44.2 percent of the personal care aide workforce.

## Demographic, Social, and Economic Characteristics of the Personal Care Aide Workforce in Nevada (cont'd)

- **Women of color make up 17.3 percent of the total population but 35.2 percent of the PCA workforce**.

❖ One-quarter of Nevada's PCAs (25.0 percent) are Latino, but with Latinos accounting for 28.4 percent of Nevada's population, there is a slight underrepresentation in the PCA workforce.

❖ While a high school diploma is not required to become a personal care aide in Nevada, **over one-third of PCAs (33.5 percent) have at least a high school diploma**, and a slightly smaller percentage (30.1 percent) additionally have completed some college or received an Associate's Degree.

❖ Health insurance coverage is a challenge for some of Nevada's personal care aides.

- Nearly **one in five PCAs (19.9 percent) is uninsured**, which is eight percentage points higher than Nevada's overall uninsurance rate of 11.9 percent in 2018.
- Just under **one-third of personal care aides (32.0 percent) in Nevada receive health care coverage through Medicaid**; the greatest share of PCAs receive coverage through this program. At the same time, Medicaid is the largest public payer of personal care services. This means that personal care aides in Nevada, much like the population they serve, depend on federal health benefits.

## Personal Care Aide Workforce Training

❖ In Nevada, personal care aides complete **a minimum of eight hours of initial training** prior to providing care as agency employees; the training covers 16 initial topics upon hire. A minimum of **eight hours of annual continuing education** is required, as well.

❖ The University of California, San Francisco (UCSF) Health Workforce Research Center on Long-Term Care has identified "leader states" in PCA training standards, and Nevada lags behind these states.

❖ Research shows that training is important for a number of reasons, including the development and maintenance of appropriate skill sets to ensure client well-being, higher job quality and satisfaction, and better wages.

## Historical Employment, Occupational Projections, and Wages of Personal Care Aides in Nevada

- Between 2010 and 2018, Nevada saw a **near-tripling of the PCA workforce**, with 198.4 percent growth.
- The **primary demand driver is demographic change, with a projected 163.0 percent increase in the population aged 65 years and older between 2010 and 2040**. (Nevada is ranked first in the percent change of this age cohort over time.)
- State-level demand projections are not available, but one estimate predicts a **national shortfall** of direct care workers of 355,000 by 2040.
    - Approximately 50 percent of people currently turning 65 are expected to need long-term services and support at some point. If all require personal care services, and that data point holds into the future, by 2040, when Nevada's population aged 65 years and older reaches 852,984, then 426,492 personal care aides would be necessary to meet demand.
    - With 13,130 Nevadans working as PCAs in 2018, that would translate into a significant unmet need, barring extraordinary growth in the field. Perhaps a more accurate metric is the percentage of Nevadans reporting a self-care difficulty in 2018, or 2.8 percent. Roughly 23,884 seniors would require personal assistance in 2040 if that percentage holds. Assuming a one-to-one ratio of personal care aides to those aged 65 and older, Nevada would need to add 10,754 personal care aides to its workforce–an increase of about 81.9 percent.
- On the supply side, Nevada's **personal care aide workforce is projected to remain flat** through 2026 (when adjusted for population).
- A **care gap would occur if demand for personal care services were to outstrip supply of personal care aides**. There are structural reasons underlying a potential care gap, most notably the demographics of labor force participation. And these effects may be fairly pronounced in Nevada.
    - Nearly half of all personal care aides in Nevada are between the ages of 45 and 64.
    - Over time, these individuals will age from participants in the caregiver economy to potential recipients of care. In other words, the **most concentrated age cohort of personal care aides will exit the labor force**.
- But occupational attributes may be even more salient to the potential care gap: **Personal care assistance in the home is one of the most low-paid occupations in the country**, with a high prevalence of income insecurity, which is a major contributor to higher turnover rates.

## Historical Employment, Occupational Projections, and Wages of Personal Care Aides in Nevada (cont'd)

- Median wages for personal care aides in Nevada have remained flat over time. In 2018, **Nevada was ranked 31st in the nation with an annual median PCA wage of $23,020, which is below the national annual median PCA wage of $24,020**.
- To put the annual median wage of $23,020 for a personal care aide in Nevada in perspective, our team assessed this wage against cost-of-living expenses using the Economic Policy Institute's Family Budget Calculator.
  - For a personal care aide residing in the Las Vegas/Henderson/Paradise metro area who is single and has no children, **his or her annual costs would amount to $32,410, or $9,390 more than the annual median wage**.
  - In order to make up the difference, the PCA would need to work **more than 56 hours per week or earn $15.58 per hour**.

## Public Financing of Personal Care Services

- **Nevada's expenditures for personal care services have been increasing over time**, both in current and constant (inflation-adjusted) dollars. In State Fiscal Year (FY) 2018, Medicaid **reimbursements were more than 1.5 times higher** than they were in FY 2013 in current dollars. However, this may be driven by increased utilization rather than investment in the workforce.
- Medicaid is the primary public payer for long-term care services nationwide, and each state sets its own provider reimbursement rates under Medicaid. Reimbursement rates thus establish the ceiling for what personal care aides can be paid under Medicaid, which explains some of the variation in median wages across states.
- In October 2003, the personal care aide **reimbursement rate in Nevada was set at $17.00 per hour**. Although the rate increased twice in subsequent years, it was returned to the 2003 rate as of July 2009 and **remained in effect through December 2019**. In 2019, the Nevada **Legislature passed a 3.3 percent increase** for personal care service providers (effective January 1, 2020) to **$17.56 per hour**. However, budget cuts necessitated by the COVID-19 pandemic resulted in a Medicaid PCS reimbursement rate decrease to **$16.52 per hour** as of August 2020, which is the **lowest reimbursement rate for Medicaid-reimbursable PCS in Nevada since 2003. Had the reimbursement rate set in October 2003 kept pace with inflation, it would have increased to $23.81 per hour in July 2020.**

# Introduction

Nevada has approximately 13,000 personal care aides (PCAs) who provide non-medical supports and assistance with daily tasks to older adults and individuals with disabilities. Although personal care services (PCS) may be offered in institutionalized settings, such as nursing homes, PCAs often help people who wish to remain in their homes and communities and live independently.

Personal care aides form part of the direct care workforce, which also includes home health aides and certified nursing assistants. PCAs assist with bathing, dressing, grooming, toileting, transferring/positioning, mobility/ambulation, and eating (Activities of Daily Living; ADLs); and light housekeeping, laundry, essential shopping, and meal preparation (Instrumental Activities of Daily Living; IADLs).[1] Home health aides and certified nursing assistants often assist with ADLs and IADLs, as well, but may have clinical responsibilities that they perform under the supervision of medical professionals (typically, licensed nurses); personal care aides' work is limited to non-medical assistance only.

Personal care aides provide more hands-on home care than any other occupational group, and demand for their services is growing rapidly as the population ages. Nevada, which is one of the fastest-growing states in the nation, is also witnessing growth in the retirement-age population. From 2010 to 2018, the U.S. Census Bureau reports that the senior population in Nevada grew by 149,000 people such that one out of every six Nevadans is now 65 or older.[2]

It is estimated that, by 2026, Nevada will need to add 5,300 personal care aides to its workforce as a result of growing demand.[3] As of 2028, PCS will be the fourth most in-demand job sector nationwide.[4] But those statistics belie a potential structural distortion: a "care gap" is emerging, whereby demand for services is expected to outstrip supply over the long term.[5]

Inasmuch as demographic changes have been driving demand for home care services–a process that is expected to accelerate with time–the labor force may evolve in ways that exacerbate shortages, such as stagnant growth in participation. But intrinsic occupational attributes may be a hindrance to the resilience of the PCA workforce.

Despite the importance of the work of personal care aides to the safety and well-being of clients and their families, home care continues to offer poor-quality jobs that lead to high turnover and widespread vacancies. One in two workers leaves the job within a year of taking it.[6] These trends in turn undermine the quality of care available to those who need it most. Noted challenges in this industry include low wages and irregular hours. In Nevada, the median hourly wage of a personal care aide is $11.07.[7]

## Objective

This policy report will summarize the personal care aide landscape in Nevada and identify challenges faced by personal care aides in the workplace, many of whom are in low-wage positions, and are dependent on federal benefits, such as Medicaid, much like the population they serve. Its primary focus is on home-based personal care assistance.

## Methodology

A comprehensive assessment of the personal care aide landscape in Nevada requires a mixed-method approach that is both quantitative and qualitative in nature. The Guinn Center analyzed data from a broad range of governmental, academic, and non-profit entities, while using official government documents to inform our research further, as well as secondary sources to provide context. The data includes:

- *Attributes of the PCA Workforce*: Age, sex, race, ethnicity, educational attainment, and health insurance status. American Community Survey (ACS) Public Use Microdata Sample (PUMS) – 2014-2018 ACS 5-year PUMS estimates;
- *Personal Care Aide Training Requirements*: Description, proof of competency, and required duration (selected states): PHI, an organization with expertise on the direct care workforce | Identification of "leader states": University of California, San Francisco (UCSF) Health Workforce Research Center on Long-Term Care (conducted through a Cooperative Agreement with the U.S. Bureau of Health Professions, National Center for Health Workforce Analysis);
- *Personal Care Aide Employment in Nevada*: U.S. Bureau of Labor Statistics, Occupational Employment Statistics (OES Data, by State, 2010 – 2018);
- *Population Projections*: Population aged 65 years and over, 2010-2040: Weldon Cooper Center for Public Service, Demographics Research Group (University of Virginia) | Total population in 2026: Centers for Disease Control and Prevention (CDC) WONDER Online Database;
- *Occupational Projections*: Projected personal care aide employment, 2016 – 2026: Projections Managing Partnership (PMP), which is funded by the U.S. Department of Labor, Employment & Training Administration, with technical support from the U.S. Bureau of Labor Statistics;
- *Occupational Employment and Wage Estimates*: Employment and median wage for all states, 2018: U.S. Bureau of Labor Statistics, May 2018 State Occupational Employment and Wage Estimates;
- *Home and Community-Based Services Expenditures*: All states, per capita, for federal Fiscal Year (FFY) 2016: *Medicaid Expenditures for Long-Term Services and Supports in FY 2016*, IAP Medicaid Innovation Accelerator Program and IBM Watson Health;

- *State Expenditures for Personal Care Services in Nevada*: For State Fiscal Year (FY) 2013–FY 2018: *Medicaid Provider Services Spend, by Provider Type* (October 10, 2019), provided to the Guinn Center by the Nevada Department of Health and Human Services; and
- *Personal Care Services Provider Reimbursement Rates (Medicaid)*: Kaiser Family Foundation (KFF): FFY 2017: *Key State Policy Choices About Medicaid Home and Community-Based Services* (April 2019) | FFY 2018: *Key State Policy Choices About Medicaid Home and Community-Based Services* (February 2020).

In addition, our team conducted interviews with a diverse set of stakeholders along the personal care aide spectrum:

- Officials from the Nevada Department of Health and Human Services;
- Program specialists and administrators from other (selected) states' public health agencies;
- Representatives from Nevada-based home care agencies, which provide in-home services to consumers (some caregivers are direct employees of these agencies);
- Agency-employed personal care aides based in Las Vegas, Nevada (conducted as a focus group to learn about their lived experience); and
- Personal care aide workforce policy experts.

## Organization of Report

The second section provides an overview of the institutional arrangements governing the system in which personal care aides operate, as the explanation and definition of terms may be useful in understanding the information contained in the pages that follow. The third section constructs a profile of the personal care aide workforce. The fourth section examines training requirements for personal care aides in Nevada, situating them in comparative context. The fifth section analyzes employment data, including occupational history, occupational projections in light of demand, and wages. The sixth section assesses public financing of personal care services. The seventh section concludes.

## Summary of Findings

### Demographic, Social, and Economic Characteristics of the Personal Care Aide Workforce in Nevada

- Almost half of all personal care aides are **older middle-aged adults** (48.7 percent), or those aged 45 to 64.
- Nevada's personal care aide workforce is **predominantly female**. More than 8 in 10 personal care aides (83.7 percent) in Nevada are women.
- A breakdown by racial categories evinces disproportionate representation.
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# Institutional Arrangements: The Personal Assistance Industry

There are two primary service delivery models for personal care aides: traditional full-service agencies and self-direction (sometimes referred to as consumer-direction or participant-direction).

Under the agency model, personal care/home care agencies provide full-service in-home supports. They employ personal care aides, match caregivers with clients, monitor service delivery, and, in so doing, assume all responsibility for hiring and training employees.[8] The agencies serve as the employer of record. Consumers may be private payers or eligible for assistance though a public program – such as Medicaid – with payment or reimbursement, respectively, remitted to the agency.[9]

Self-directed care is a publicly financed model in which the consumer has a great deal of latitude over the employment of PCAs by directing his or her own services and supports.[a] As of federal Fiscal Year (FFY) 2018, every state offered Medicaid-reimbursable self-direction.[10] Depending on how the self-directed care program is structured, the consumer may be the employer of record or a co-employer with another entity, such as the state, as discussed below under the Independent Provider type program.

In Nevada, "Self-Directed Care is available statewide…and is designed for Consumers who desire more independence and control over their personal care services and caregivers. Under this option, the Consumer or their PCR [Personal Care Representative] have the primary responsibility and authority to hire, train, schedule, supervise, and dismiss their caregivers if necessary. The Consumer maintains control over how and when care is provided according to the approved tasks and hours on the care plan. With guidance and support from an Intermediary Service Organization (ISO), which provides fiscal and supportive services, the Consumer or their PCR develops a care delivery and back-up plan, then arranges and directs their own care and services."[11]

There are two main self-direction features: employer authority and budget authority.[12] Under employer authority, consumers are authorized "to hire, schedule, supervise, and dismiss their own personal assistance workers."[13] Budget authority incorporates employer authority but expands on it by providing consumers with "a monthly budget with which to purchase a range of goods and services to meet their assessed needs (as specified in their service plan), including but usually not limited to personal assistance."[14] The authorization of employer authority (alone) versus budget authority, along with the employer of record, gives

[a] Consumers may hire and pay professional caregivers privately. Direct employment by households gives consumers discretion over employment matters, as well, but does not constitute self-direction which specifically refers to public programs that provide PCS.

rise to three main types of self-direction programs, of which some states may have more than one.

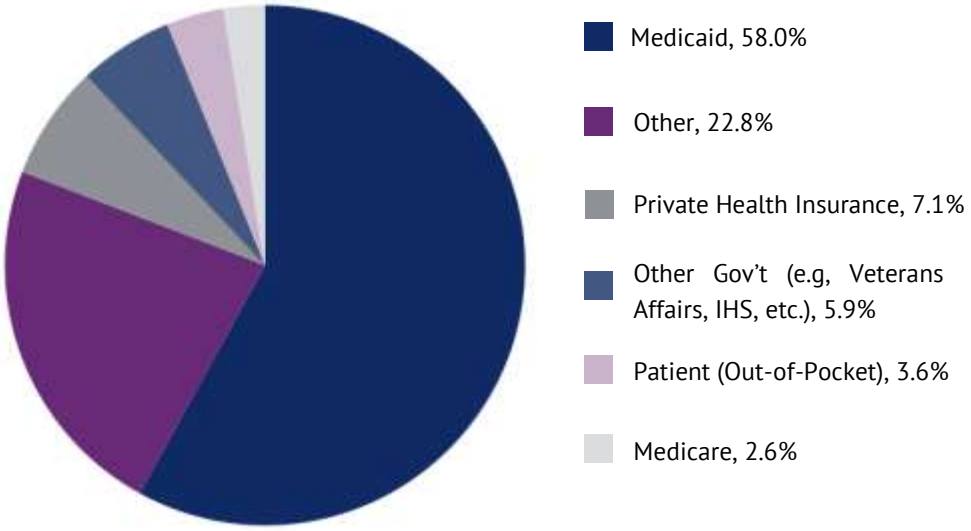
- Agency with Choice (AWC). This is defined as: "a co-employment arrangement between the consumer and a traditional home care agency [whereby] the consumer is the managing employer–recruiting, interviewing, selecting, training, managing, and dismissing workers–while the agency is the legal employer for IRS purposes, officially hiring the worker and managing payroll."[15] Nevada's only Medicaid-reimbursable option for self-direction is AWC. The Intermediary Service Organization (ISO) described previously is a home care agency that serves as the legal employer.
- Fiscal Management Services (FMS). The consumer is both the managing employer and the legal employer. Consumers have budget authority, and by definition, employment authority. A fiscal intermediary manages certain employment-related tasks, which, depending on the state, can include billing, documentation, payroll, and related taxes.[16]
- Independent Provider (IP). This variant is similar to AWC in that consumers have employer authority only in a co-employment arrangement. However, unlike AWC, the state, rather than the agency, is the legal employer and can set wages and hours. Some states, such as California, use quasi-governmental entities–public authorities or workforce councils–as the employers of record.[17] The distinction here is that public authorities can engage in collective bargaining, which means that many IPs are part of a unionized workforce.[18]

What is perhaps most important to note about self-direction is that it permits individuals close to consumers, such as family members or friends, to serve as their PCAs. For some consumers, the preference to self-direct care lies with the belief that a known caregiver ensures greater autonomy, privacy, and dignity.[19] Insofar as self-direction is Medicaid-reimbursable, this can help offset any forgone wages that a family member or friend might incur as an opportunity cost for caring for his or her loved one. While most states, including Nevada, do not permit reimbursement to consumers' legally responsible individuals (i.e., spouses or parents of children under the age of 18), one estimate shows that about 70 percent of providers in self-directed programs are family members or friends.[20]

It should be noted, too, that while some consumers prefer self-direction, others favor the more traditional full-service agency model.[21] While self-direction allows individuals to customize their care, it also requires additional vetting and management.[22] Research has shown that the majority of seniors exhibit a strong preference for the latter.[23] Based on the most recent data, in 2016, just 572 Nevadans elected to self-direct care.[24] With an adjustment for population, Nevada ranked 43rd in self-directed participant enrollment, by state.

Discussion of public funding for personal care aides typically centers on Medicaid, as it is the primary payer for long-term care services nationwide.[25] As shown in Figure 1, Guinn Center analysis of National Health Expenditure Accounts data indicates that, in 2018, Medicaid was the largest payer (58.0 percent) for personal care services (or approximately so, given that other health and residential expenditures are included in the service group).[26] Medicare contributed the smallest share (2.6 percent), which is consistent with the fact that it only covers PCS in the short term for post-acute services.[27] Generally, "[p]ersonal care services…are not reimbursable by Medicare because they are not defined as medical services."[28] It is difficult to estimate the size of the private non-agency pay market, which is sometimes referred to as the "gray market," as there is no formal mechanism to collect this data; it likely is not reflected in full in Figure 1.[29]

Figure 1. Other Health, Residential, and Personal Care Expenditures, by Source, 2018




One study notes that "Medicaid largely defines the LTSS [long-term services and supports] sector."[30] Put simply, states' PCS programs primarily are designed and administered through (state) Medicaid. A brief summary of the structures and authorities may be helpful in understanding public funding of personal care assistance.

Although Medicaid is a joint federal-state partnership, states are afforded considerable flexibility in implementing their programs for certain services, provided that they conform with federal laws and rules, which have superseding authority.[31] Personal care services fit this criteria: payment mechanisms, training requirements, reimbursement rates, and regulations, amongst many others–even definitions–vary widely across states.[32] There are two primary Medicaid payment sources in Nevada: State Plan optional services, and 1915(c) waivers, both of which are discussed below.

Federal law requires states to offer a set of mandatory benefits, which include, amongst others, inpatient and outpatient hospital services, nursing facility services, home health services, and physician services.[33] States may cover up to 28 optional benefits, one of which is personal care services.[34] Including PCS, Nevada offers 17 optional Medicaid benefits (e.g., pharmacy, optometry, psychologist, etc.).[35] Going forward, we will refer to PCS provided as an optional benefit through Nevada Medicaid as "the State Plan option," "State Plan optional services," or "optional Medicaid State Plan benefit." In federal Fiscal Year (FFY) 2018, thirty-four states provided PCS as an optional Medicaid State Plan benefit.[36] Nevada submits its State Plan (and when necessary, amendments) to the Centers for Medicare & Medicaid Services (CMS) for review and approval.[37] As part of its State Plan option, Nevada provides PCS both through traditional full-service agencies and self-direction via its agency with choice/Intermediary Service Organization service delivery model.

Under Section 1915 of the Social Security Act, states may also develop home and community-based services (HCBS) waivers to provide a combination of medical and non-medical services; these are commonly referred to as 1915(c) waivers, which is a reference to subsection (c) of Section 1915.[38] They are payment sources that permit states to waive certain Medicaid program requirements to allow provision of services to those where need is the greatest or where only certain provider types are available; to certain groups who are otherwise at risk of institutionalization; and to those who could only otherwise be Medicaid-eligible in an institutional setting because of income and resource rules.[39]

These waivers encompass a broad range of services, including, but not limited to: "case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care."[40] This means that 1915(c) waivers are not dedicated solely to personal care services, though many states offer PCS through their waivers. Currently, Nevada has three 1915(c) waivers: NV Frail Elderly, NV HCBW for Persons with Physical Disabilities, and NV HCBS Waiver for Individuals with Intellectual and Developmental Disabilities.[41]

Amongst other HCBS, Nevada's waivers provide "PCS-like services," which, depending on the waiver, may include attendant care, homemaker, chore, respite, and adult companion.[42] Because states must use financial criteria for eligibility and tailor benefits to certain populations under the waivers, they can cap 1915(c) enrollment, which may result in waiting lists.[43] As of October 2019, the Home and Community-Based Services (HCBS) Waiver for the Frail Elderly wait list total was 855; the HCBW for Persons with Physical Disabilities wait list total was 273.[44] Note that neither Nevada's State Plan option nor its 1915(c) waivers requires a specific service delivery model; consumers may choose a traditional agency or self-direction regardless of the authority under which they are receiving services.[45]

Nevada has considered the addition of what is called a 1915(j), or Self-Directed Personal Assistance Services.[b, 46] This is a benefit under Medicaid that can be offered through a State Plan option or 1915(c) waiver.[47] It effectively extends budget authority to those who self-direct care.[48] Testimony by officials from the Nevada Department of Health and Human Services before the Senate Committee on Health and Human Services (Nevada Legislature), indicated that, while the State was still learning about the 1915(j) benefit, should it be proposed, it would be offered through a 1915(c) waiver; it would not replace the AWC model already in place; and it would allow the State to pay a capitated rate per member per month for administrative functions outside of the reimbursement rate, with the actual reimbursement allocated as benefits to the consumer who could then determine his or her caregiver's wages.[49]

Along with Medicaid-reimbursable PCS, Nevada administers three additional publicly funded personal care services programs through the Nevada Department of Health and Human Services' Aging and Disability Services Division: the Personal Assistance Services (PAS) Program, the Community Service Options Program for the Elderly (COPE), and the Homemaker Program. They are primarily, though not entirely, funded with State money. All PCAs serving clients of the three programs must be contracted with Medicaid.[50]

- The Personal Assistance Services Program, or PAS, "provides community-based, in home services to enable adult persons with severe physical disabilities to remain in their own homes and avoid placement in a long-term care facility."[51] Assistance with ADLs and IADLs is provided through PAS based on recipient needs, income guidelines, and available funding for non-Medicaid-eligible individuals.[52] The State General Fund is its only funding source.[53] Self-direction is authorized explicitly in PAS but depends on the services that are authorized.[54]
- The Community Service Options Program, or COPE, "provides non-medical services to older persons to help them maintain independence in their own homes as an alternative to nursing home placement."[55] Assistance with ADLs and IADLs is provided through COPE to non-Medicaid-eligible individuals who are 65 years of age or older who are at risk of institutionalization in a long-term care setting.[56] There are income guidelines, however, and provision of services is capped at available program funding levels.[57] Its funding sources are the State General Fund and the Fund for a Healthy Nevada, which is a special fund created in the State Treasury in which certain proceeds from

[b] The 1915(j) benefit was added to the Social Security Act under Section 6087 of the Deficit Reduction Act of 2005. *Source*: Kenya Cantwell. 2017. "Self-Directed Services Under Medicaid §1915(j) and (k) State Plan Authorities." Centers for Medicare & Medicaid Services. Available: http://www.appliedselfdirection.com/sites/default/files/Self Direction under 1915j and k Slides_0.pdf.

manufacturers of tobacco products are deposited.[58] Self-direction is not authorized explicitly under COPE, though its person-centered approach to building a service plan means that recipient choice may be permitted on a case-by-case basis.[59]

- The Homemaker Program provides "in-home supportive services for individuals requiring assistance with activities such as housekeeping, essential shopping, meal preparation and laundry to prevent or delay placement in a long-term care facility."[60] These are IADLs only. It is the only program across the spectrum of Nevada's publicly funded PCS offerings that does not require clients to meet the ADL criterion to receive IADL services.[61] The Homemaker Program is designed for low-income individuals, some of whom may be Medicaid-eligible but otherwise would be excluded from receiving PCS on the basis of not requiring ADL services.[62] There are financial eligibility guidelines, and, as with PAS and COPE, services are provided until programmatic funding is exhausted.[63] Its funding sources are the State General Fund, the Fund for a Healthy Nevada (described above in the discussion of COPE), and Title XX of the Social Security Act, as amended.[64] (Title XX is federal money–specifically, the Social Services Block Grant–that is distributed to states for certain service categories, including, amongst others, services for persons with disabilities and protective services for adults.)[65] Self-direction is not authorized explicitly for the Homemaker Program, but, like COPE, its emphasis on person-centered planning means that it may be permitted under certain circumstances.[66]

Note that PAS, COPE, and the Homemaker Program, collectively, are considerably smaller than Medicaid, which is a function of their lower funding levels.[67] In State Fiscal Year (FY) 2018, the closing caseloads for the three programs totaled just 502 clients: 129 served by PAS, 50 served by COPE, and 323 served by the Homemaker Program.[68] Although there may be some duplication in the numbers, the Nevada Medicaid caseload count for PCS provided through its State Plan option (both agency and self-directed) and 1915(c) waivers (both agency and self-directed) amounted to 10,269 in FY 2018.[69]

The foundation provided in this section is designed to serve as context for the analysis to follow. In the next section, we construct a profile of the personal care aide workforce in Nevada.

## Demographic, Social, and Economic Characteristics of the Personal Care Aide Workforce in Nevada

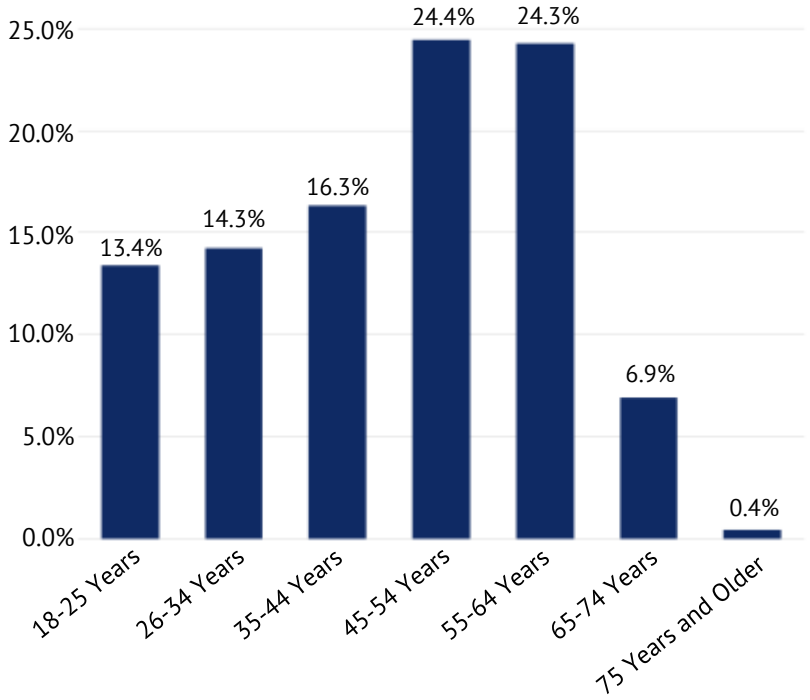
A substantial body of research exists on the demographics of the personal care aide workforce at the national and state levels, and the findings are fairly uniform: the PCA workforce comprises mostly women, especially women of color, who face high poverty rates, despite increasing education.[70] Nationally, about 87 percent of home care workers–which also includes those who perform clinical tasks–are female, with a median age of 46.[71] Nearly two-thirds (62 percent) of home care workers are people of color, and half have no formal education beyond high school.[72] One in six lives below the federal poverty line, and more than half require public assistance.[73]

As detailed below, the demographics of Nevada's PCA workforce resemble national estimates. The Guinn Center obtained American Community Survey (ACS) Public Use Microdata Sample (PUMS) data to examine the characteristics of personal care aides in Nevada in 2018. Following the methodology employed by researchers who compile the Area Health Resources Files for the U.S. Health Resources and Services Administration (HRSA), our team retained non-working individuals in the workforce but excluded those no longer in the workforce who identified their occupation as "Personal Care Aide."[74] Metrics include age cohort, sex, race, ethnicity, educational attainment, and health insurance coverage. (A geographic breakdown in Nevada is displayed in Appendix A.)

Figure 2 presents the distribution of the personal care aide workforce in Nevada by age cohort.[75] Amongst Nevada's PCA workforce, those in middle age (45 to 54 years of age and 55 to 64 years of age) comprise the largest shares, at 24.4 percent and 24.3 percent, respectively. Almost half of all personal care aides are older middle-aged adults (48.7 percent), or those aged 45 to 64. There are several possible reasons for the concentration in middle age: economic circumstances, such as loss of spouse, that may necessitate a return to work; family experience with caregiving that makes the career attractive; less age discrimination than in some other fields; amenability to part-time work; and a welcoming environment attributable to expectations around reliability and life experience.[76]

The share of the PCA workforce by age cohort drops sharply after middle age, with those aged 65 and older comprising only 7.3 percent of the PCA workforce; as part of the retirement-age population, they may require caregiving themselves. Those aged 18 to 25 years (13.4 percent), 26 to 34 years (14.3 percent), and 35 to 44 years (16.3 percent) collectively make up 44.0 percent of the PCA workforce in Nevada. This is consistent with research that shows that younger direct care workers are more likely to be employed by nursing care facilities and hospitals rather than home-based settings.[77]

Figure 2. Personal Care Aides in Nevada, by Age Cohort, 2018




Nevada's personal care aide workforce is predominantly female, as shown in Figure 3.[78] More than 8 in 10 personal care aides (83.7 percent) in Nevada are women, which is slightly below the national rate of 87 percent. However, in 2018, Nevada's population was split nearly evenly by sex, with just under 50 percent identifying as female. This suggests that women are overrepresented in Nevada's PCA workforce. One study attributes the concentration of female workers in the caregiving sector as rooted in an historical legacy of "work that traditionally was done by women at home, and often continues to be done almost exclusively by women when it is paid."[79]

Figure 3. Personal Care Aides in Nevada, by Sex, 2018

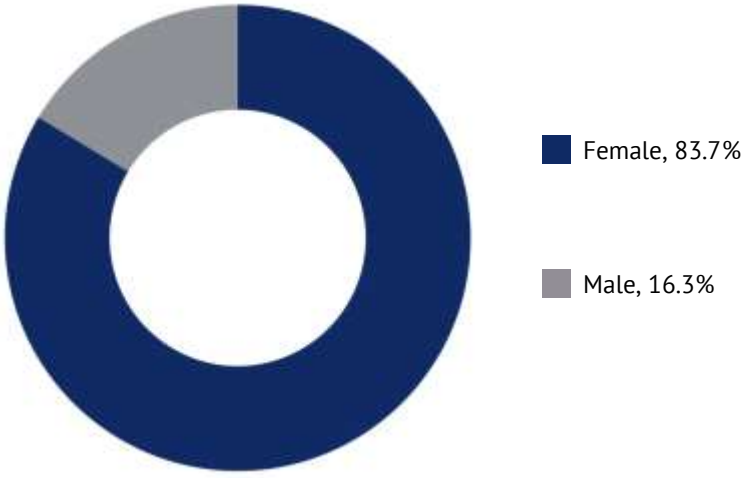
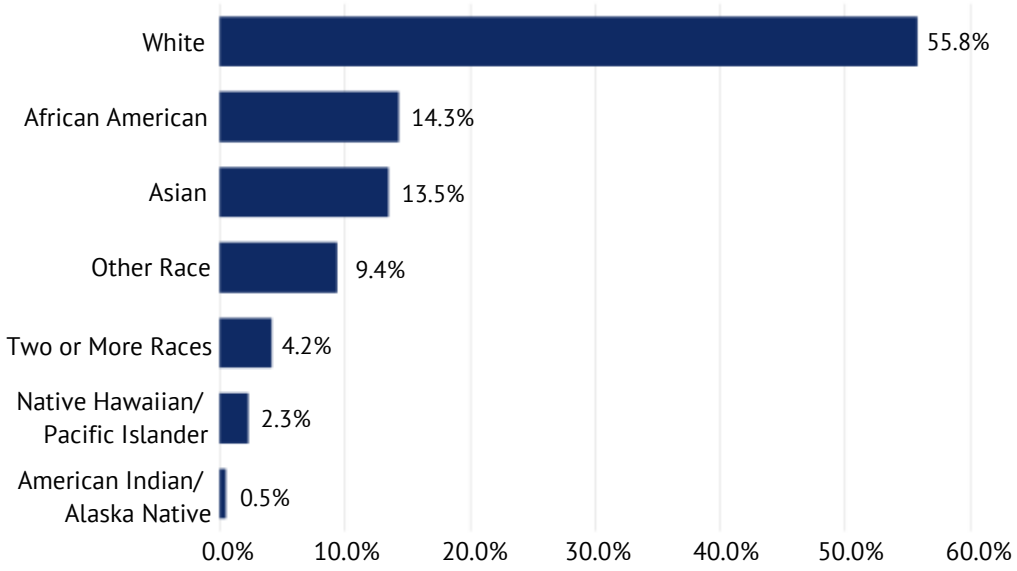


Figure 4 shows the racial breakdown of the PCA workforce in Nevada.[c80] Although the estimates would seem to suggest that the distribution of personal care aides along racial lines is representative of the population, it obscures disproportionate representation within demographic categories. More than one-half of all personal care aides are white, but they are underrepresented in the PCA workforce. At 66.1 percent of Nevada's total population in 2018, they account for 55.8 percent of personal care aides.

On the other hand, African Americans and Asians are overrepresented in the PCA workforce. The African American share of Nevada's population is 8.9 percent, and the Asian share is 8.0 percent. Amongst Nevada's PCAs, 14.3 percent are African American, and 13.5 percent are Asian. People of color make up 33.9 percent of Nevada's population but 44.2 percent of the personal care aide workforce.

Figure 4. Personal Care Aides in Nevada, by Race, 2018



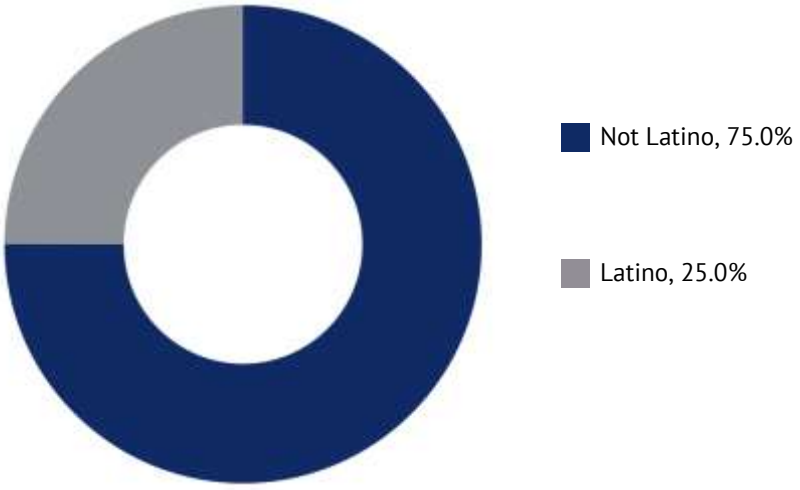

At the intersection of sex and race in Nevada, we find that women of color make up 17.3 percent of the total population but 35.2 percent of the PCA workforce. The percentage-point gaps in racial representation within the PCA workforce, which ranged from -10.3 for white individuals to 5.4 for African Americans, translates into a more pronounced interaction effect for sex and race, whereby women of color are represented at more than double their share in the population as a whole.

[c] Note that 24.6 percent of white PCAs are Latino; 1.7 percent of African American PCAs are Latino; 100.0 percent of PCAs identifying as "Other Race" are Latino; 31.3 percent of PCAs identifying as "Two or More Races" are Latino; and 55.6 percent of American Indian/Alaska Native PCAs are Latino. No Asian or Native Hawaiian/Other Pacific Islander PCAs are Latino.

The Guinn Center's focus group of agency-employed personal care aides based in Las Vegas, Nevada, was comprised entirely of women of color. All reported having experienced occasional racial discrimination and sex discrimination in their clients' homes. While they agreed that agencies generally were supportive–none was required to return to those workplaces, and clients were flagged for their behavior–the general understanding was that another PCA subsequently would be assigned to the position rather than denying care.

The distribution of personal care aides by ethnicity is displayed in Figure 5.[81] One-quarter of Nevada's PCAs (25.0 percent) are Latino, while the remainder (75.0 percent) are not Latino. As total Latino population in Nevada is 28.4 percent, this means that there is a slight underrepresentation in the PCA workforce. By 2038, Nevada's Latino population is expected to grow to over 1.3 million (1,302,240).[82] ACS data shows that the 2018 population totaled 831,548, which means an increase of 24.1 percent over that time frame. Spanish-speaking Latinos may exhibit a preference for PCAs that share their language, and if so, a more representative workforce could be essential for meeting consumers' needs.

Figure 5. Personal Care Aides in Nevada, by Ethnicity, 2018

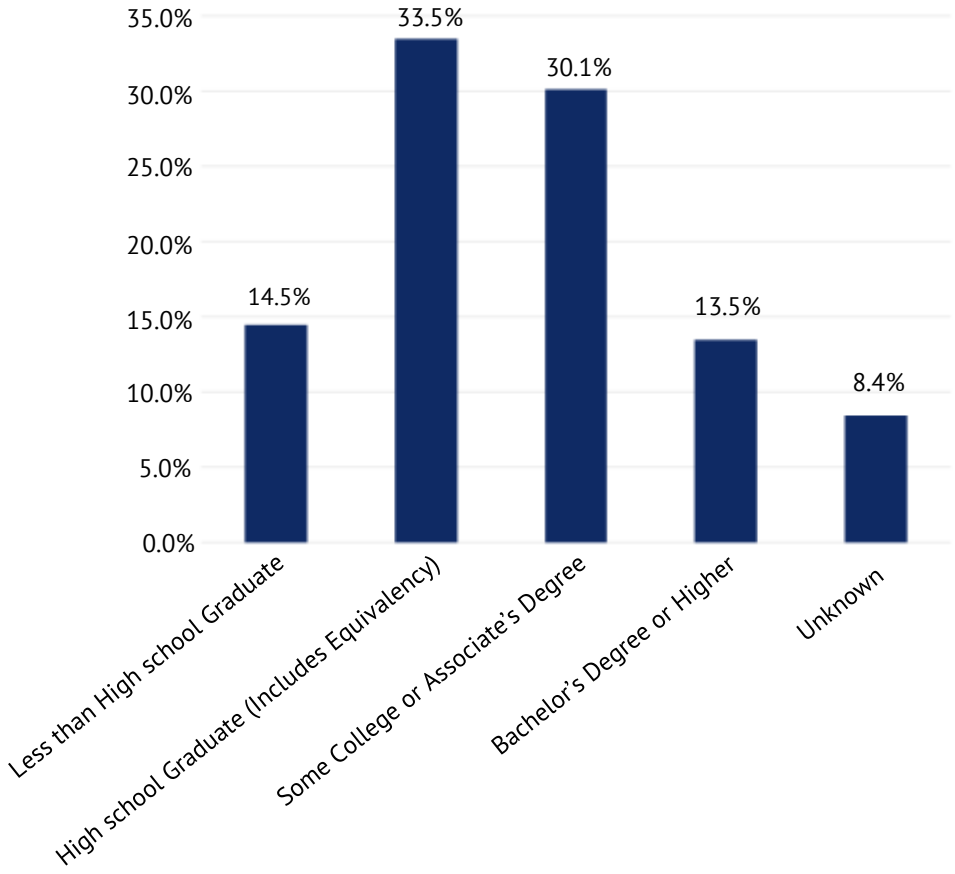



Nevada does not require personal care aides to have attained their high school diplomas.[83] However, assuming that "Unknown" educational attainment does not skew the data, only 14.5 percent of Nevada's personal care aides have not finished high school, as Figure 6 shows.[84] Over one-third of PCAs (33.5 percent) have at least a high school diploma, and a slightly smaller percentage (30.1 percent) additionally have completed some college or received an Associate's Degree. In Nevada, just 13.5 percent of PCAs have completed a Bachelor's degree or higher.

As one study observes, "Given the very low wages of these jobs, one might expect the education level of the workforce to be well below national averages. It is not. In-home workers in both child and health care are only slightly less likely to hold

high school degrees: between 81 and 88 percent of these workers graduated from high school, compared to 91 percent in the national workforce."[85]

Figure 6. Personal Care Aides in Nevada, by Educational Attainment, 2018

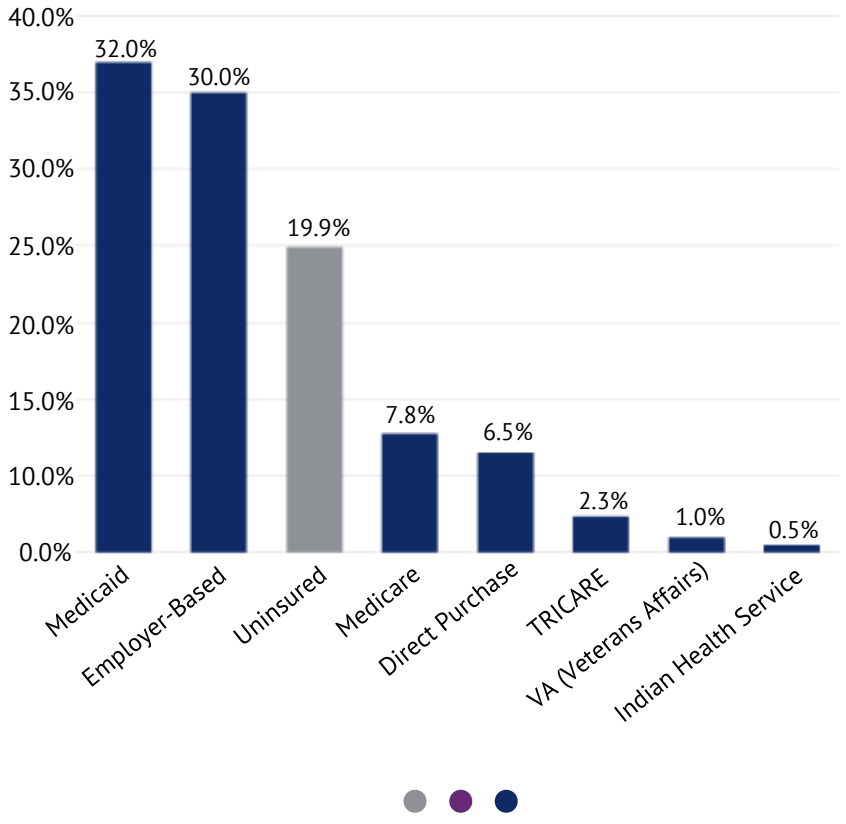



As illustrated in Figure 7, health insurance coverage is a challenge for some of Nevada's personal care aides.[86] Nearly one in five PCAs (19.9 percent) is uninsured, which is eight percentage points higher than Nevada's overall uninsurance rate of 11.9 percent in 2018.[87] Businesses with 50 or more full-time employees or full-time equivalent employees must provide affordable minimum essential coverage.[88] It is possible that some personal care aides are uninsured as a result of working for smaller agencies that do not provide health care coverage, while others may be independent contractors in the private pay market who do not elect to purchase coverage. Approximately 30.0 percent of PCAs receive employer-based health insurance. Just under one-third of personal care aides (32.0 percent) in Nevada receive health care coverage through Medicaid, which reveals that the largest public payer of personal care services in the State is the same program through which the greatest share of PCAs receive health care coverage.

Structural factors underlying PCA demographics thus merit careful consideration as decision makers evaluate policy options to strengthen the personal care aide

workforce system. There is evidence to suggest the existence of a gender wage gap, not only within occupations, but between occupations; that is, "[m]ale-dominated occupations tend to pay more than female-dominated occupations at similar skill levels."[89] Workers with lower levels of education tend to be disadvantaged in the labor force, as are older workers, and persons of color are overrepresented in the low-wage workforce.[90] While we make no inferences about causality, Nevada's concentration of women, persons of color, older middle-aged adults, and the less educated amongst personal care aides mirrors the low-wage workforce more broadly.

Figure 7. Personal Care Aides in Nevada, by Health Insurance Coverage, 2018




## Personal Care Aide Workforce Training

Experts in the long-term care field recently have begun to repudiate the descriptor "low-skilled job" for home care work.[91] In fact, they observe, while personal care aide positions tend to be low-wage, a diverse skill set is required, including: clinical knowledge; symptom prevention and management; support with activities of daily living (ADLs); the ensuring of safety and security; physical and emotional strength; and communication and problem-solving.[92] While personal assistance in the home may not be low-skilled, some PCAs receive more skills training than others.

The adequacy of training largely is determined by the state in which the PCA works. Skills requirements for personal care aides vary widely by state, primarily as a function of Medicaid rules, which allow states to design their own programs.[93] Because other direct care workers, such as certified nursing assistants (CNAs) and home health aides (HHA), are Medicare-reimbursable, they are subject to federal training standards.[94] The distinction is that Medicare is a fully federal program, while Medicaid, as a federal-state partnership, can devolve authority to the states.

In Nevada, personal care aides complete a minimum of eight hours of initial training prior to providing care as agency employees.[95] The training covers 16 initial topics upon hire: duties and responsibilities; documentation of PCS; time cards/time card verification; communication skills; clients' rights and confidentiality; special needs of the elderly; infection control; recognizing/responding to emergencies; techniques for provision of personal care; maintenance of clean/safe environment; skin care and contractures intervention and prevention; nutrition, hydration, and special diets; bowel and bladder care; dealing with adverse behaviors; fall prevention, body mechanics, and transfer techniques; and elder abuse.[96] In order to provide care, employees must demonstrate competency through a skills test.[97] A minimum of eight hours of annual continuing education is required, as well.[98] In addition, Nevada requires agency workers to undergo federal and State background checks, obtain certification in CPR and First Aid, and take an annual tuberculosis (TB) test.[99]

PCAs who provide care through a self-direction program in the State receive somewhat higher levels of training, and the Nevada Department of Health and Human Services (DHHS) confirmed that federal and State background checks and annual TB tests are required.[100] Chapter 2600 of the Nevada *Medicaid Services Manual* states that, "The IC [self-directed personal care aide] may be required to obtain training in the following areas, if directed to do so by the recipient….[b]asic training….[which] shall be a minimum of 16 hours in length."[101] The basic training areas are similar in nature to those in the initial training required by agency-employed PCAs.[102] In testimony before the Senate Committee on Health and Human Services (Nevada Legislature), DHHS stated that the Intermediary Service Organization (ISO) is responsible for ensuring that training requirements are met under Medicaid-reimbursable self-direction in Nevada.[103]

As noted in the second section, all personal care aides serving clients through the Personal Assistance Services (PAS) Program, the Community Service Options Program for the Elderly (COPE), and the Homemaker Program must be contracted with Medicaid. This means that training requirements for those working as PCAs for clients served by the three non-Medicaid programs are identical to those with clients receiving Medicaid-reimbursable services.[104]

Participants in the Guinn Center focus group of agency-employed personal care aides based in Las Vegas, Nevada, described the eight hours of annual training as

"useless" (all had been in the field for some time so could not speak to the initial training). One PCA characterized it thusly: "We watch a video. It has been the same video for nine years. Then, I need to show that I can take off my PPE [personal protection equipment], which I don't carry with me to a training session. And after so many years [as a PCA], they want to make sure I know how to use a mask and gloves? That's it?" Another concurred, reiterating that she, too, had watched the same "eight-hour video" for "years on end." While some agencies do pay for the training, within the focus group, all had paid $45 for the annual class. Moreover, participants in this group observed that the eight hours of time spent in training translated into lost wages, as their clients need care at certain times, and if they are not available in that time frame, they simply do not work.

The consensus amongst these personal care aides is that the training largely is unnecessary, but as none were new to the field, perhaps the question raised is whether or not it is sufficient. To evaluate this, our team compiled a set of requirements for identified "leader states" in PCA training standards using the most recent information available from the University of California, San Francisco (UCSF) Health Workforce Research Center on Long-Term Care. The "leader states" are: Alaska, Arizona, Arkansas, Idaho, Minnesota, Virginia, and Washington. Descriptive information, along with proof of competency and required duration, is presented in Table 1.[105] (Note that data is provided only for agency-employed PCAs, as that is factored into the determination of "leader states.")

As Table 1 indicates, Nevada lags behind the "leader states" in training requirements for its PCAs. Neighboring state Arizona offers a model curriculum, "Principles of Caregiving," while the other contiguous state amongst the leaders, Idaho, requires training in 11 detailed competencies in accordance with the Idaho Skills Matrix. Washington provides the most comprehensive curriculum; it is not only competency-based but population-specific, with curricula that is standardized across 222 detailed topics (contra Nevada's 16).

Four states–Alaska, Arkansas, Idaho, and Virginia–mandate that the training be provided by a registered nurse. Standardized competency exams are required in Alaska, Arizona, Minnesota, Virginia, and Washington, unlike Nevada. The Silver State does require a skills test, and skills demonstration is required in most of the "leader states," with the exception of Alaska and Minnesota. While not all "leader states" specify a certain number of training hours, those that do have required durations that exceed Nevada's eight hours of initial training. Alaska requires 40 hours of training, as does Arkansas, which additionally mandates 16 hours of hands-on practical training and 12 hours of annual continuing education. Virginia's requirements are similar to that of Arkansas, albeit without the hands-on practical training. Washington far exceeds other states in required duration, with 75 hours of initial training and 12 hours of continuing education.

## Table 1. Training Standards in "Leader States"

| State | Description | Proof of Competency | Required Duration |
|---|---|---|---|
| Alaska | Agency-employed personal care assistants who provide Medicaid-funded services must complete training that follows a state-sponsored curriculum within their first four months of employment. Trainers may use their own curricula if they receive approval from the state. Training must be provided by a registered nurse. | Personal care assistants must pass a standardized competency exam administered by a home care agency or other training agency. After passing the test, they receive a portable certificate. | 40 hours |
| Arizona | Under the state's Medicaid managed long-term care system, direct care workers who are employed by home care agencies must complete a state-approved training program within 90 days of starting employment. The state provides a model curriculum, Principles of Caregiving. Although training entities may create their own curricula, they must cover the same topics as the Principles of Caregiving. At a minimum, trainers must pass the direct care worker competency test, and they are required to have one year of experience in caregiving and one year of experience teaching adults. Trainers may allow prospective direct care workers to take a challenge test. | Once direct care workers pass a standardized competency exam and skills demonstration, they are listed in a central registry. Employers may allow experienced direct care workers to skip training and take a challenge test instead. | Regulations do not prescribe training hours for pre-service training, but workers must complete 6 hours of continuing education annually. |
| Arkansas | Personal care aides who are employed by any Medicaid-reimbursed home care agency must complete training in 13 detailed state-designated topics, but agencies have flexibility in crafting their curricula. Training must be provided by a registered nurse. | Home care agencies (or other training entities) must assess worker competency through a written or oral exam and a skills demonstration. Agencies have broad discretion over assessment tools. After passing the test, workers receive a portable certificate. | 40 hours, including 16 hours of hands-on practical training, plus 12 hours of continuing education annually. |
| Idaho | All aides providing personal care services under Medicaid waiver programs must be successfully trained in 11 detailed competencies, which are delineated in the Idaho Skills Matrix. Home care agencies have flexibility in determining training methods, but training content must be approved by a registered nurse. | Personal care aides must demonstrate competency through a written test, oral exam, skills demonstration, or trainer attestation. The Idaho Skills Matrix delineates which method must be used for each skill. Some assessment tools require verification by a registered nurse. Employers must develop their own assessment tools and maintain training and testing records. Workers must retrain when they start with new employers. | No training duration specified. |

(Table 1 continues next page)

| Training Standards in "Leader States" (cont'd) | | | |
|---|---|---|---|
| **State** | **Description** | **Proof of Competency** | **Required Duration** |
| Minnesota | Under state Medicaid programs, personal care aides must complete a state-sponsored online training, which covers nine broad topics. This training must be completed prior to providing services. | Personal care aides must pass an online, standardized test. Testing records are maintained by the state. | No training duration specified. |
| Virginia | All home care agencies must be licensed by the state. All licensed agencies must train home attendants using the state-sponsored Personal Care Aide Training Curriculum. Training must be provided by a registered nurse with two years of experience. | Aides must pass a standardized written test and skills demonstration before providing services to consumers. Agencies must maintain training records, and training is transferable among employers. | 40 hours. Home attendants employed by Medicaid-reimbursed agencies must also complete 12 hours of continuing education annually. |
| Washington | All home care agencies must be licensed by the state. Home care aides employed by licensed agencies and most aides who provide Medicaid consumer-directed services must complete an orientation, safety training, and basic training, which must be comprised of a core module and population-specific module. Trainers may use the state-sponsored Revised Fundamentals of Caregiving or develop their own curricula that cover the same 222 detailed topics. All curricula must be approved by the state and all training must be competency-based and adult learner-centered. State regulations prescribe detailed instructor qualifications related to experience, education, and competency in adult learner-centered teaching methods. | Home care aides must pass a standardized competency exam and skills demonstration within 200 days of hire, or within 260 days for trainees with limited English proficiency. Exam records are maintained centrally by the state. | 75 hours, plus 12 hours of continuing education annually. |

While Nevada may fall short of other states in that it lacks a state-sponsored curriculum and a standardized competency exam, while requiring comparatively few initial training hours, it outperforms some states which do not have any training requirements for personal care aides. There are seven such states: Connecticut, Indiana, Kansas, Nebraska, Tennessee, Texas, and Vermont.[106]

Training is important for a number of reasons, including the development and maintenance of appropriate skill sets to ensure client well-being, higher job quality and satisfaction, and ideally, as personal care aides shared with our team, better wages.[107] In fact, "[a] wide range of research indicates that higher basic

skills and postsecondary credentials are linked to higher wages and that they can improve the likelihood of finding a better job and experiencing wage growth over time."[108]

Moreover, as one study notes:

> Training and career advancement opportunities are important elements of a quality job. Research and experience show that direct care workers succeed when they can access high-quality entry-level training, ongoing training to enhance their skills, and specialized training that improves care and provides opportunities for advancement. Strong training requirements and an effective training system are essential to realizing these benefits.[109]

Findings from a demonstration program financed by the federal government suggest that investment in training can yield considerable benefits for the personal care aide workforce. The Personal and Home Care Aide State Training (PHCAST) Demonstration Program was authorized under the Social Security Act.[110] Between federal Fiscal Year (FFY) 2010 and FFY 2012, $5 million in annual appropriations under the Patient Protection and Affordable Care Act (ACA) of 2010 supported six grantees–California, Iowa, Maine, Massachusetts, Michigan, and North Carolina–for the development and implementation of competency-based curricula, recruitment and training of qualified applicants, provision of trainee support services, and certification upon successful completion of the program.[111] (Note that many, if not most, states do not require certification for PCAs.)

The enabling legislation required grantees' curriculum to cover 10 core competencies, including, amongst others, personal care skills, nutritional support, safety and emergency training, and consumer needs.[112] Results from the demonstration program show improvement in knowledge and skills, increased job satisfaction levels three-month post-training that was attributed directly to PHCAST (in Michigan, where that was evaluated), and a decrease in the unemployment rate amongst trainees (also in Michigan).[113]

Research on the relationship between training and wages suggests that the key to workforce development is the establishment of a career pathway. That is, connecting competencies to wages, in part, means that entry-level training would constitute the "first rung" on a ladder to more highly skilled positions, which tend to have higher wages in kind.[114] This would require integration of skill sets within a cluster such that initial training is creditable toward advanced positions. Within the direct care workforce, this might entail instituting training requirements for personal care aides that would serve as the foundation on which to build additional skills to become a certified nursing assistant or home health aide. Under PHCAST:

The Maine, Massachusetts, and North Carolina grantees helped to create career ladders for the direct care workers, expanding career opportunities for workers who pursue ongoing education and workforce training. Specifically:

- The Maine grantee developed a common core curriculum and three job-specific specialty curricula that allowed trainees to be certified to provide services to other LTSS populations.
- The Massachusetts grantee aligned its PHCA curriculum with its state Department of Public Health nurse aide standards and plans to develop a PHCA to Nurse Aide Bridge curriculum. PHCAST trainings will serve as the foundation.
- The North Carolina grantee's comprehensive, multi-phased training program was developed to provide multiple pathways to direct care work for PHCA trainees.[115]

Based on Nevada's personal care aide training requirements, it does not appear that the position establishes a pathway to higher skilled jobs within the direct care workforce. While home health aides and certified nursing assistants may be distinct careers in other states, it appears that they are synonymous in Nevada, with only the workplace setting as a clear line of demarcation.[116] Pursuant to Nevada Revised Statutes (NRS) 632.2856, certification of a nursing assistant requires 75 hours of instruction in conformity with federal regulation.[117] Training must be provided by a registered nurse, and prospective nursing assistants must pass a test on theory with an overall score of 80 percent and a pass/fail skills test.[118] Certification requires an examination administered by the State Board of Nursing.[119]

Thus, the requirements for PCAs do not align with those for home health aides/certified nursing assistants, which suggests that the career is not a "first rung" on the ladder in the Nevada. Currently, seven states–the District of Columbia, Florida, Oklahoma, Ohio, New Jersey, Rhode Island, and Wyoming–require PCAs to undergo home health aide or certified nurse aide training, which may mean that those states are helping to build career pathways for non-medical home caregivers.[120]

Adoption of a more stringent set of training requirements for personal care aides in Nevada, either to ensure more comprehensive care for consumers, especially those with complex needs, or to establish a career track for PCAs, might pose a challenge for decision makers, however. As representatives from Nevada-based home care agencies shared with the Guinn Center, to the extent that agencies incur training costs, it can become very expensive. These costs may be direct, such as payment for classes, and indirect, including the logistics of meeting clients' needs while new employees undergo initial training and current employees complete their continuing education requirements. Furthermore, agency representatives stated that, while they invest in workforce training prior to onboarding PCAs, they often defray such costs by shifting the burden to private

pay clients, which, in turn, disproportionately affects seniors and people with disabilities. They assert that any additional training requirements could become cost-prohibitive and likely would require either additional public funding or cost increases to private pay clients to offset the expense.

Public funding may not be simply a question of allocation of more resources, though. In State Fiscal Year (FY) 2018, approximately $2.7 billion of Medicaid's total budget of about $3.6 billion, or roughly 75.5 percent, was federal money (State revenue sources accounted for the remainder).[121] Recall that, at the outset of this section, we observed that training requirements are the prerogative of the states, and, as such, it should be noted that, "[t]he lack of national requirements creates another barrier as well–no federal Medicaid funds are available to support state-based training for this workforce."[122] Nevada's Medicaid funding from State sources amounted to $889,304,389, which is dispersed across multiple programs and services authorized under Nevada Medicaid. Budgetary constraints may inhibit the State from investing additional resources to support enhanced training for personal care aides.

Mindful, too, of the well-documented health care workforce shortage in Nevada, which extends to non-medical but adjacent fields, such as personal care aides, benefits of the imposition of more rigorous training requirements must be balanced against the need for workforce retention and expansion. As the U.S. Government Accountability Office (GAO) notes, "In deciding what, if any, training to require of attendants, states may balance making sure attendants are qualified to provide care with the need for an adequate supply of attendants to support the demand for in-home PCS. While more training can be beneficial for beneficiaries, training requirements can pose a barrier to participation for some attendants and diminish the supply of attendants."[123]

The next section takes a closer look at workforce supply and demand, as well as wages of personal care aide workers.

## Historical Employment, Occupational Projections, and Wages of Personal Care Aides in Nevada

A confluence of factors has contributed to increased demand for home and community-based services (HCBS), and concomitantly, in-home, non-medical personal assistance.

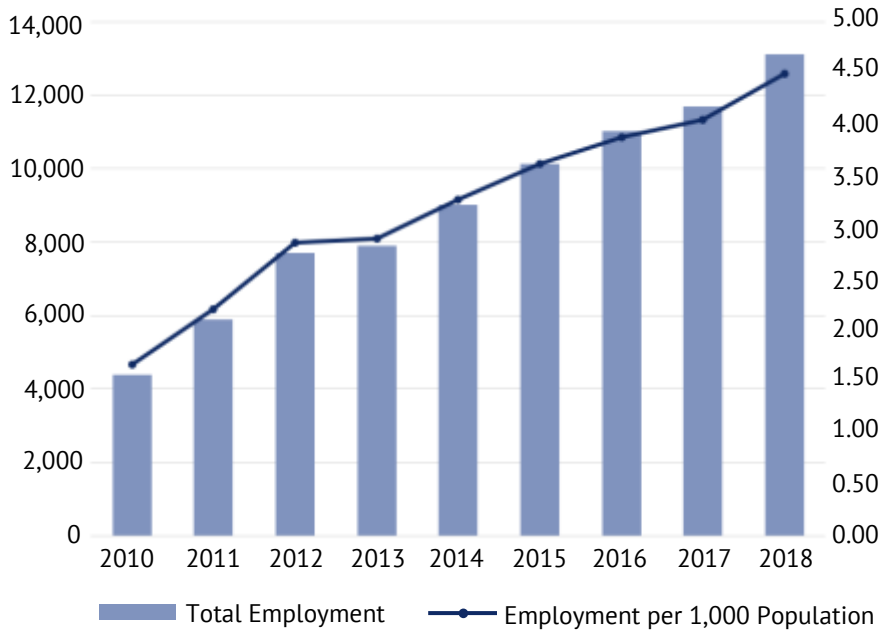
- Many seniors exhibit a strong preference for "aging in place." According to the AARP, "[n]early 90 percent of people over age 65 indicate they want to stay in

their home as long as possible, and four of five in that age bracket believe their current home is where they will always live."[124]

- States can realize cost savings by "substituting less costly HCBS for more expensive care in nursing homes and other long-term care institutions."[125] One study shows that "[t]he 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."[126] The calculation for cost savings is the institutional cost(s), or "avoided nursing home costs," less the HCBS cost. The Nevada Department of Health and Human Services (DHHS) provided cost savings data for its 1915(c) waivers to the Guinn Center, which covers disparate but somewhat overlapping time periods. Net savings are the average costs per recipient for each waiver. The data shows that the HCBS cost is less than institutional costs:
    - *Frail Elderly, State Fiscal Year (FY) 2017*. Institutional Costs: ($79,803)–HCBS Cost ($9,511) = Net Savings of $70,292
    - *Physical Disability, calendar year (CY) 2017*. Institutional Costs: ($867,566)–HCBS Cost ($34,907) = Net Savings of $832,659
    - *Intellectual Disability, federal Fiscal Year (FFY) 2017*. Institutional Costs: ($176,524)–HCBS Cost ($59,759) = Net Savings of $116,495
- Compliance with the Supreme Court's 1999 ruling in *Olmstead v. L.C.*, which "required government-run programs to provide health care in the least restrictive environment available. The justices ruled that it was a violation of the Americans With Disabilities Act for the government to send people with disabilities to facilities that limit their freedom if they can continue living at home with some help."[127]
- The addition of Section 1915(k) to the Social Security Act under Section 2401 of the Patient Protection and Affordable Care Act (ACA) of 2010 (i.e., the Community First Choice option, or CFC), which "allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan….[it] provides a 6 percentage point increase in Federal matching payments to States for service expenditures related to this option."[128] This is a state plan optional service, not a waiver; to this date, Nevada does not include it amongst its optional Medicaid benefits.

The interplay of sociocultural forces, budgetary constraints, and institutional factors has coalesced into heightened demand for personal care services. It has exerted upward pressure on the supply side, as well. As Figure 8 shows, total employment of personal care aides in Nevada and employment per 1,000 (Nevada) population increased substantially between 2010 and 2018.[129]

Figure 8. Personal Care Aide Employment in Nevada, 2010 – 2018



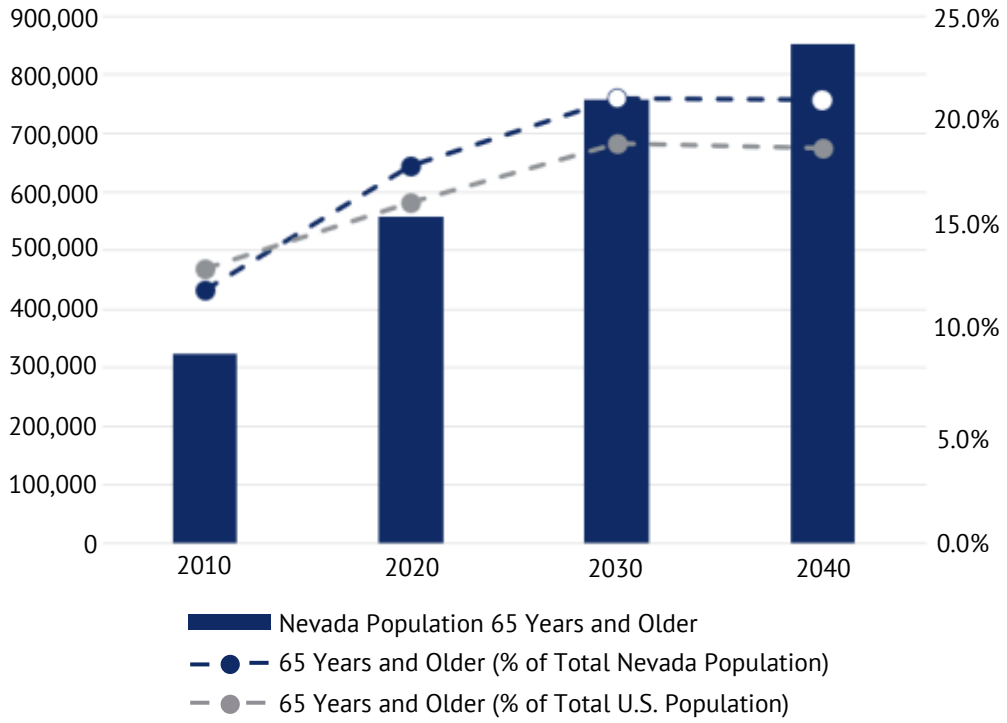

In 2010, approximately 4,400 Nevadans were employed as personal care aides, or fewer than two PCAs per 1,000 population (1.67). The highest year-over-year employment growth was between 2011 and 2012: the number of personal care aides increased from 5,900 to 7,700, for a total increase of 1,500 (30.5 percent). Total employment grew steadily over the time frame, with no year-over-year decreases. By 2018, Nevada's personal care aide workforce had grown to 13,130 for 4.49 PCAs per 1,000 population. That is a near-tripling of the workforce, with 198.4 percent growth between 2010 and 2018.

Demand for personal care services "is expected to increase precipitously in the years ahead."[130] The primary demand driver is demographic change, as the population of those aged 65 years and older is expected to nearly double nationwide by 2050.[131] Comorbidities may compound the effect as seniors can suffer from chronic conditions (e.g., hypertension) and such age-related ailments as Alzheimer's disease.[132] If "demography is destiny," then Nevada may be on the precipice of a crisis, as one official from the Nevada Department of Health and Human Services shared with the Guinn Center. Nevada's senior population, that is, those aged 65 years and older, is expected to grow by over half a million between 2010 and 2040, as Figure 9 illustrates.[133]

While Nevada will not have the largest senior population as a share of total population in 2040–more than one-quarter of Maine's population (26.5 percent) is expected to be aged 65 years and older by 2040, ranking it the highest amongst states–more than one in five Nevadans (21.0 percent) will be a senior citizen by 2040. However, with a projected 163.0 percent increase in the population aged

65 years and older between 2010 and 2040, Nevada is ranked first in the percent change of this age cohort over time. As of 2040, the share of Nevada's population that is 65 and older will exceed the U.S. share (18.7 percent) by 2.3 percentage points.

Figure 9. Population Projections for Nevada (65 Years and Older), 2010 – 2040

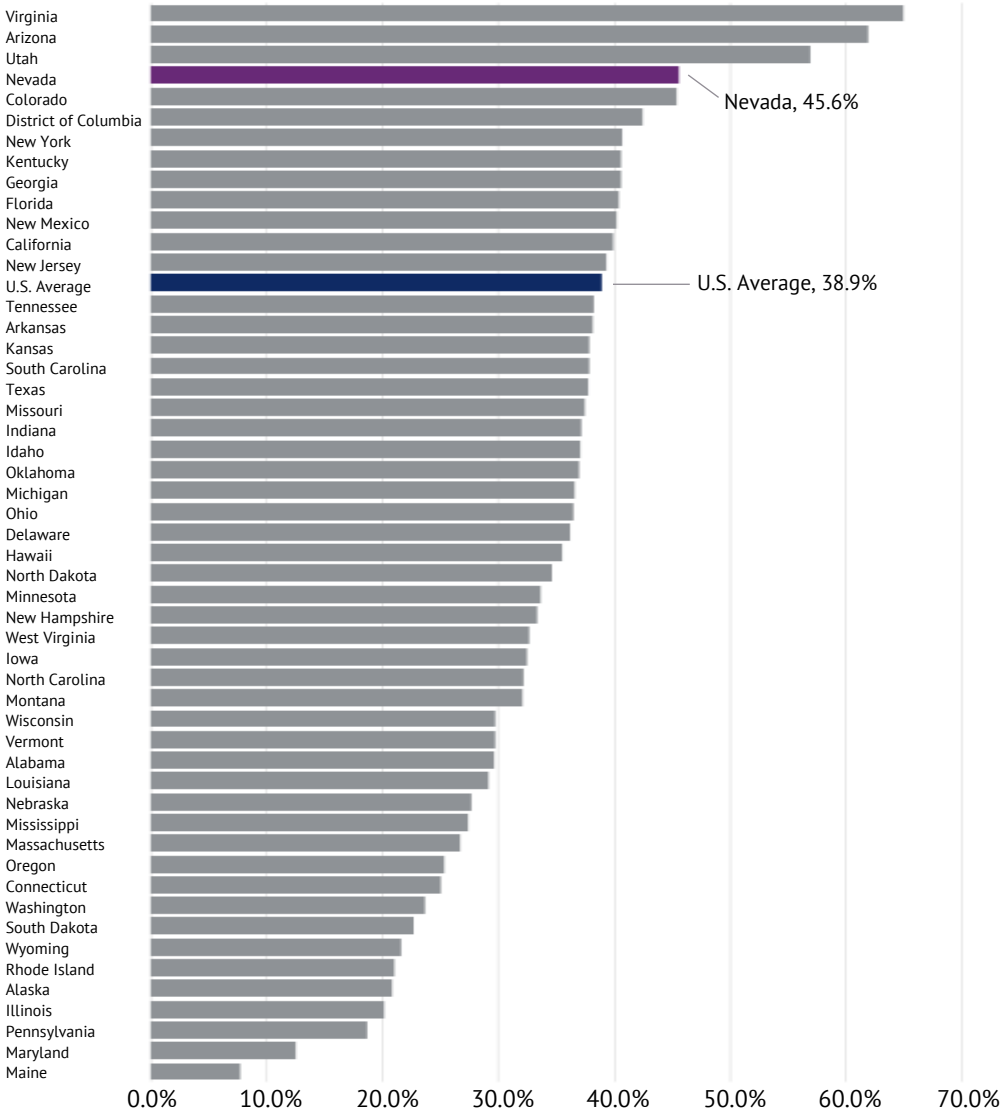



However, while state-level demand projections are not available, one estimate predicts a national shortfall of direct care workers of 355,000 by 2040.[134] Approximately 50 percent of people currently turning 65 are expected to need long-term services and support at some point.[135] If all require personal care services, and that data point holds into the future, by 2040, when Nevada's population aged 65 years and older reaches 852,984, then 426,492 personal care aides would be necessary to meet demand.[136] With 13,130 Nevadans working as PCAs in 2018, that would translate into a significant unmet need, barring extraordinary growth in the field. Perhaps a more accurate metric is the percentage of Nevadans reporting a self-care difficulty in 2018, or 2.8 percent.[137] Roughly 23,884 seniors would require personal assistance in 2040 if that percentage holds. Assuming a one-to-one ratio of personal care aides to those aged 65 and older, Nevada would need to add 10,754 personal care aides to its workforce–an increase of about 81.9 percent.

Supply-side occupational projections at the state level are available only through 2026. Nevada is expected to have the fourth-highest percent change in employment between 2016 and 2026, from 11,630 to 16,930, for a 45.6 percent increase, as shown in Figure 10.[138]

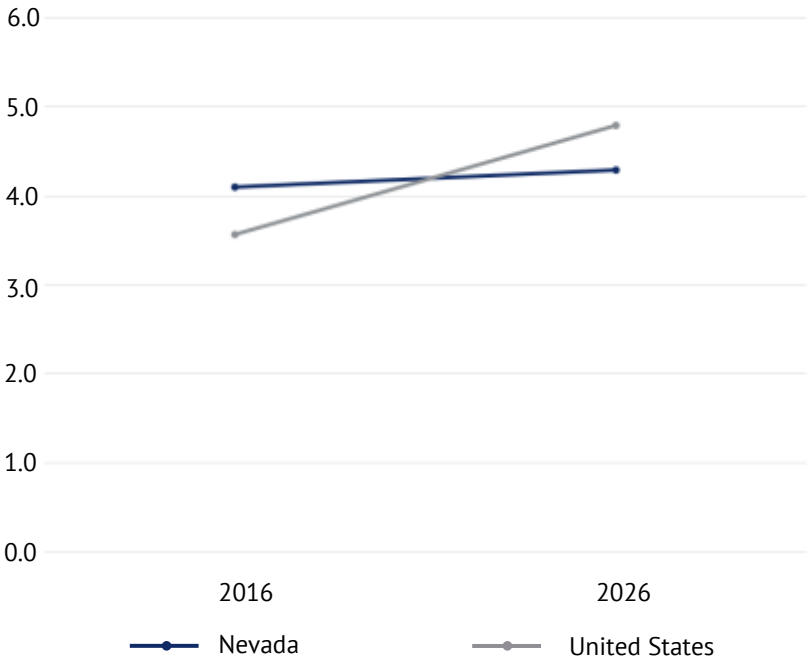
That is higher than the U.S. average of 38.9 percent, and while it is lower than Virginia's, for which the PCA workforce is expected to increase by 64.9 percent from 43,700 in 2016 to 72,070 in 2026, it outpaces the state with the lowest percent increase, Maine (14,490 PCAs in 2016 to 15,600 in 2026, a 7.7 percent increase). This is notable, because, as detailed above, by 2040, Maine is expected to have the highest population share of those aged 65 years and older. This would seem to suggest that Nevada's workforce supply is growing in tandem with population-associated demand.

Figure 10. Percent Change in Projected Personal Care Aide Employment, by State, 2016 – 2026



However, when adjusted by population, Nevada's personal care aide workforce is projected to remain flat through 2026, as Figure 11 indicates. [139] In 2016, the number of PCAs in Nevada per 1,000 population was 4.10, and by 2026, the number is projected to increase slightly to 4.29 per 1,000 population. For the United States, on average, the number of personal care aides in 2016 was 3.57 per 1,000 population and is expected to increase to 4.79 per 1,000 population. This means that, on a population basis, projected employment for personal care aides in Nevada is not growing as much as in other states. For example, in California, the number of PCAs per 1,000 population is expected to reach 19.45 by 2026. If the rate of personal care aide employment keeps apace of population, that is, remains flat, as Figure 10 seems to imply, that might be sufficient in the short term. But as noted above, Nevada's population of those aged 65 years and older is expected to increase substantially by 2040. Were the rate of personal care aide employment growth to outpace what Nevada experienced between 2010 and 2018, there might be less concern amongst various stakeholders about a forthcoming shortage, or care gap.

Figure 11. Personal Care Aides per 1,000 Population in 2016 and 2026




A care gap would occur if demand for personal care services were to outstrip supply of personal care aides. There are structural reasons underlying a potential care gap, most notably the demographics of labor force participation. And these effects may be fairly pronounced in Nevada. As Figure 2 (page 15) showed, nearly half of all PCAs in the State are between the ages of 45 and 64. Over time, these individuals will age from participants in the caregiver economy to potential recipients of care. In other words, the most concentrated age cohort of personal care aides will exit the labor force.

Additionally, more than eight in ten personal care aides in Nevada are female workers (see Figure 3, page 15). One study notes, "the number of women joining the labor force is declining in comparison to recent decades; whereas the female share of the labor force increased by nearly 7.7 million workers from 1996 to 2006, the increase was only 3.2 million in 2006 to 2016, and is projected to be 3.5 million in 2016 to 2026."[140] A shrinking female labor pool might attenuate the supply of personal care aides in Nevada.

But occupational attributes may be even more salient to what is perceived by some as an ever-decreasing appeal of a career in personal care services. This is reflected in high rates of churn (turnover), low levels of retention, and worker vacancies.[141] Participants in the Guinn Center focus group of agency-employed personal care aides based in Las Vegas, Nevada, spoke passionately about their love for their clients, and most stated that they could not imagine "doing anything else [for a living]." All agreed, however, that wages were too low for a financially sustainable career. That is, none could "make ends meet" by working as PCA alone. For some, that means taking on additional part-time jobs to support themselves; others were aided by partners' salaries.

A considerable body of research exists to support the claim that personal care assistance in the home is one of the most low-paid occupations in the country, with a high prevalence of income insecurity, which is a major contributor to higher turnover rates. One study links wages and retention thusly: "direct care workers that provide home and community-based long-term care are paid low wages, compounded by limited benefits and unstable work schedules...low job quality leads to high turnover in the caregiving fields[.]"[142] Another study finds that, even as demand for care work increases, wages have stagnated or decreased.[143]

In Nevada, the problem is exacerbated by competition from other sectors. The most recent data shows that more than half (53.5 percent) of private employment is concentrated in accommodation/food services and leisure/hospitality.[144] Higher paying jobs that are readily available in these "large industries," which require comparable skill sets, can entice PCAs away from the field.[145] And in northern Nevada, where distribution and fulfillment centers are enjoying rapid rates of growth, creation of higher paid positions has begun to siphon the supply of personal care aides.[146]

Figure 12 presents a map that displays Nevada's annual median wage for personal care aides in comparative perspective (see Appendix B for a table of underlying data).[147] The most deeply shaded states are those with the highest annual median wages, while the lightest shades are those with the lowest annual median wages; states with a medium hue form the "middle 17."

The map shows something of a regional patterning to the wage distribution, though there are exceptions.

Personal care aides working in the South received the lowest annual median wages, while those in the Northeast and Pacific Northwest, along with Alaska and Hawaii, enjoy the highest annual median wages, with some scattering throughout the Midwest. The middle group, which includes Nevada, is concentrated in the Southwest and upper Midwest, with outliers in Maine, Iowa, and South Dakota. The annual median wage for a personal care aide is highest in Alaska ($33,160) and lowest in Louisiana ($18,640). Nevada is ranked 31st in the nation with an annual median PCA wage of $23,020. It falls toward the bottom of the "middle 17" states and is below the national annual median PCA wage of $24,020.

Figure 12. Annual Median Wage for Personal Care Aides, by State, 2018

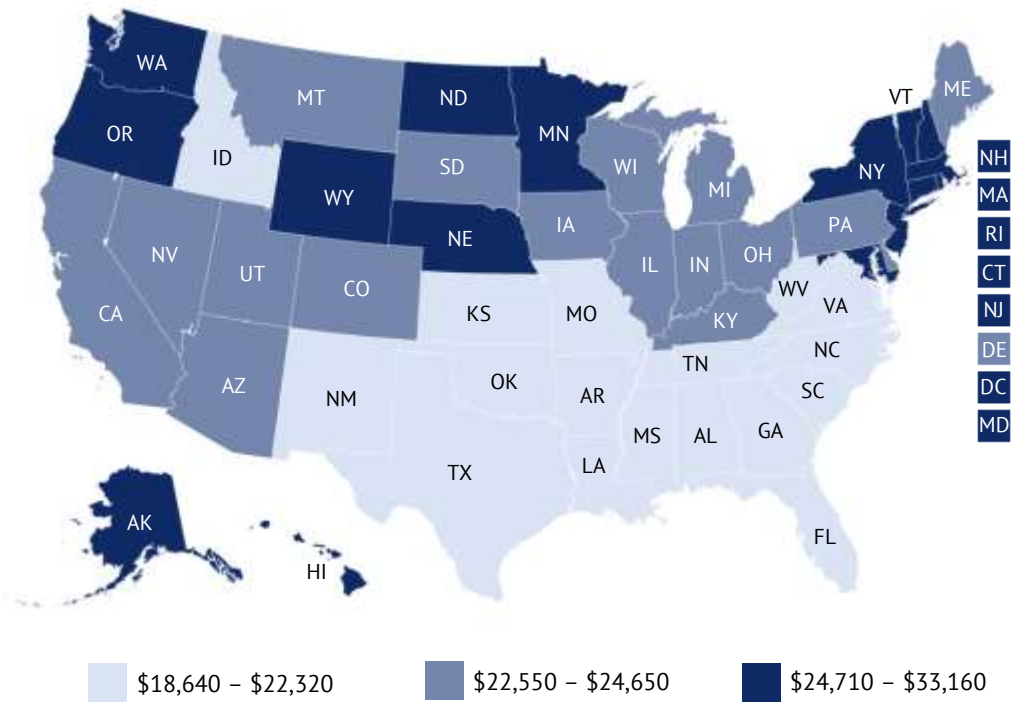



Figure 13 shows that median wages for personal care aides in Nevada have remained flat over time.[148] As noted in the first section and displayed below in Table 2, the hourly median wage of a personal care aide in 2018 is $11.07, which roughly computes to the aforementioned annual median wage of $23,020 (based on a 40-hour workweek at 52 weeks a year; we will discuss the limitations of this assumption later in this section, but note here that the U.S. Bureau of Labor Statistics [BLS] reported the hourly and annual medians, and while the arithmetic "works," it is not the Guinn Center's computation).

For the first time, in 2017, the annual median wage of a PCA dropped below the national annual median for the occupation, $22,900 versus $23,100, respectively. The gap widened further in 2018 with an annual median wage of $23,020 for a personal care aide in Nevada and the national annual median wage for a PCA of $24,020.

Figure 13. Median Wage in Nevada for Personal Care Aides vs. All Occupations, 2010 – 2018

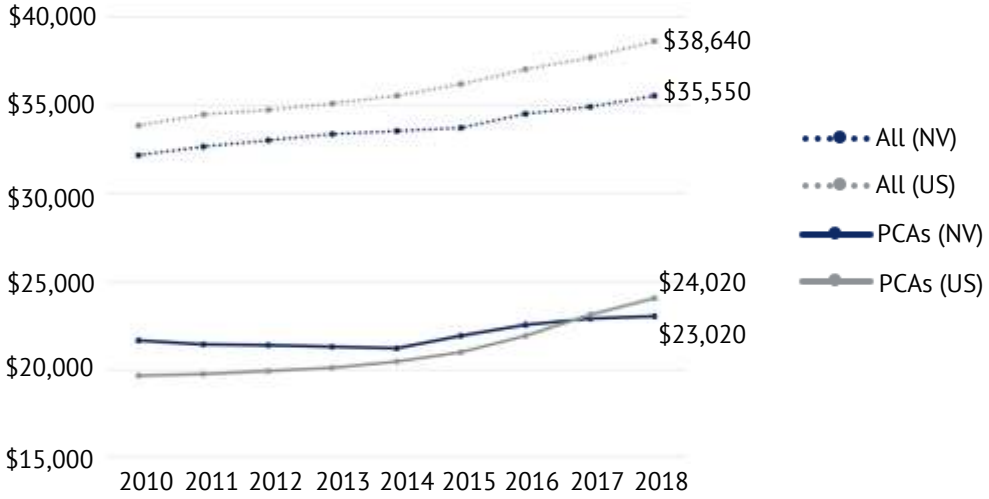



**Table 2. Hourly Wage for Personal Care Aides in Nevada: Percentiles and Reported Hourly Means**

| Hourly Wage for Personal Care Aides in Nevada: Percentiles and Reported Hourly Means | | |
|---|---|---|
| **Percentiles** | | |
| **Percentiles** | **Amount** | **Source** |
| 10th Percentile | $9.32 | U.S. Bureau of Labor Statistics (Occupational Employment Statistics, May 2018) |
| 25th Percentile | $10.06 | U.S. Bureau of Labor Statistics (Occupational Employment Statistics, May 2018) |
| 50th Percentile (Median) | $11.07 | U.S. Bureau of Labor Statistics (Occupational Employment Statistics, May 2018) |
| 75th Percentile | $12.21 | U.S. Bureau of Labor Statistics (Occupational Employment Statistics, May 2018) |
| 90th Percentile | $14.24 | U.S. Bureau of Labor Statistics (Occupational Employment Statistics, May 2018) |
| **Reported Hourly Means (Averages)** | | |
| **Hourly Means (Averages)** | **Amount** | **Source** |
| Reported Hourly Mean: Source 1 | $10.88 | Personal care aide workforce policy expert (survey of Nevada PCAs) |
| Reported Hourly Mean: Source 2 | $11.34 | U.S. Bureau of Labor Statistics (Occupational Employment Statistics, May 2018) |

In 2010, the annual median wage of a Nevada-based personal care aide was $21,660 but continued to dip incrementally in each subsequent year through 2014, when it reached its low (over this time frame) of $21,220. In each of the following years, the annual median wage increased slightly over the previous year. Between 2010 and 2018, the annual median wage for a personal care aide in Nevada increased by just 6.3 percent. Although a gap between the annual median wage for all occupations and personal care aides has persisted over time, the divergence between the two was $10,520 in 2010 but widened the most in 2018 to $12,530. The data suggests that even as demand for personal care services has grown, wages are comparatively lower for those working as PCAs in Nevada, relative to other parts of the country; they have, at best, stagnated over time; and they are failing to increase at the same rate as other occupations in the State.

To put the annual median wage of $23,020 for a personal care aide in Nevada in perspective, our team assessed this wage against cost-of-living expenses using the Economic Policy Institute's Family Budget Calculator.[149] For a personal care aide residing in the Las Vegas/Henderson/Paradise metro area who is single and has no children, his or her annual costs–that is, housing, food, transportation, health care, other necessities, and taxes–would amount to $32,410, or $9,390 more than the annual median wage. In order to make up the difference, the PCA would need to work more than 56 hours per week or earn $15.58 per hour.

However, many personal care aides in Nevada do not work as caregivers for 40 hours per week. Participants in the Guinn Center focus group of agency-employed personal care aides based in Las Vegas, Nevada, shared that they worked, on average, 10 to 20 hours per week. That is why BLS's assumption in its computation of the annual median wage is flawed. In part, the number of weekly hours for a PCA is governed by their clients' plan of care.

But as representatives from Nevada-based home care agencies explained to our team, pursuant to Nevada Revised Statutes (NRS) 608.018, employees only can work an eight-hour "rolling workday" before overtime rules apply.[150] A "rolling workday" is one in which overtime begins to accrue when eight total hours is exceeded over a period of 24 consecutive hours. For care work, which may necessitate, for example, a four-hour shift that begins late on one day and a five-hour shift that begins early the next day, this would equal one hour of overtime, even though the PCA worked fewer than eight hours on each *actual* day. In theory, the law offers protections for workers, such that employers must pay 1 ½ times an employee's regular wage rate if he or she works more than eight hours in a day (or ten hours per day for four calendar days by mutual agreement). In practice, this means that agencies typically do not schedule personal care aides for work hours that exceed the daily maximum, lest they incur costly overtime expenses. This leads to irregular–and fewer–work hours for personal care aides.

It also should be noted that many of Nevada's personal care aides pay out-of-pocket for supplies that are necessary for their clients' health and safety, such as surgical masks, gloves, and other protective equipment.[151] Home care agencies in Nevada are not required to provide supplies to PCAs, though it appears that all do. However, logistics, such as working around a client's plan of care, and transportation costs tend to create informal barriers that inhibit personal care aides from acquiring supplies through their employer agencies.

The next section examines public financing of personal care services, first from the vantage point of state expenditures and then with a close look at Medicaid reimbursement rates, which may be the driver of depressed wages for personal care aides.

## Public Financing of Personal Care Services

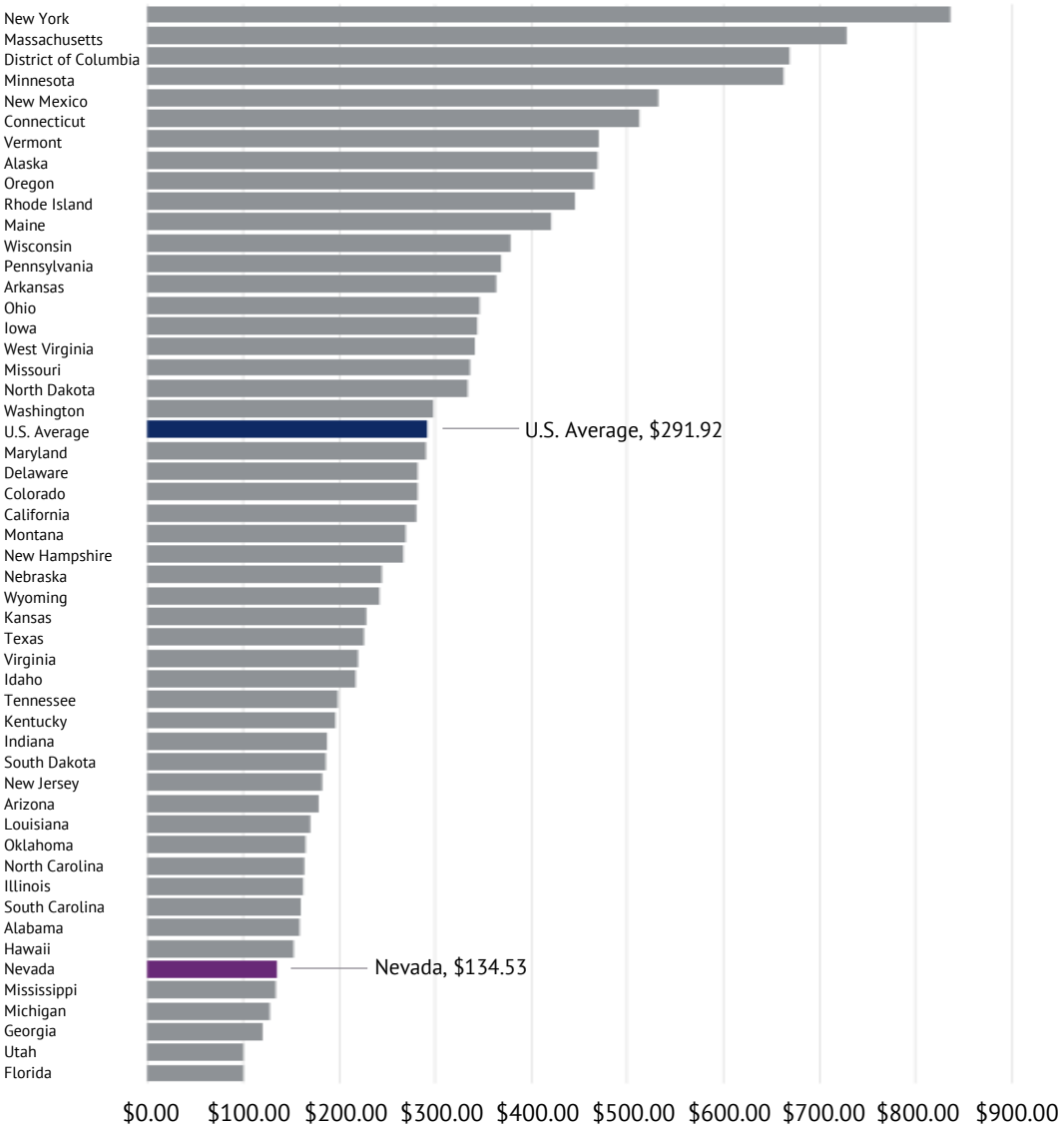
As we noted in the second section, Medicaid is the primary payer for long-term care services nationwide.[152] In Nevada, Medicaid spending on home and community-based services (HCBS), which are part of long-term services and supports (LTSS), totaled $258 million in federal Fiscal Year (FFY) 2018 in Nevada, accounting for 43.5 percent of total LTSS.[153] Nevada ranked 36th among states in HCBS as a percentage of LTSS in FFY 2018.

States are required to report Medicaid expenditures in CMS-64 reports to claim federal matching funds.[154] While it is possible to extract expenditures for personal care services (offered as a state plan option), 1915(c) waivers, 1915(k) state optional services (Community First Choice), and 1915(j) state optional services (Self-Directed Personal Assistance Services offered through a state plan option or 1915(c) waiver) from the CMS-64 reports, it is not clear that this would reflect total spending on personal care services (PCS), by state, accurately. As previously discussed, for example, 1915(c) waivers can be tailored for specific populations within states, and some may not include personal care services.

To place spending on personal care services per capita in comparative context, we instead use expenditures for home and community-based services HCBS per resident. Home and community-based services includes "a wide range of services including personal care services provided in a home or residential care setting, supported employment, non-medical transportation, and home-delivered meals."[155] It is an imperfect proxy, as HCBS encompasses more than personal care services, as well. But given the uniformity of reporting requirements in the CMS-64s and operating under the assumption that PCS is not distributed unevenly across states, Figure 14 displays HCBS per resident for federal Fiscal Year (FFY) 2016.[156]

Nevada's expenditures on HCBS per resident in FFY 2016 were $134.53, ranking it 46th in the nation. The Silver State is followed only by Mississippi, Michigan, Georgia, Utah, and Florida (ranked lowest, with spending of $99.81 per capita). New York had the highest HCBS expenditures per resident in FFY 2016, at $836.27. That is more than six times higher than spending in Nevada, for which expenditures were also below the U.S. average of $291.92. On a population-adjusted basis, Nevada's spending on home and community-based services falls short of the majority of its peers, but a considerable amount of money may be required to elevate spending levels that would bring Nevada more in line with other states.

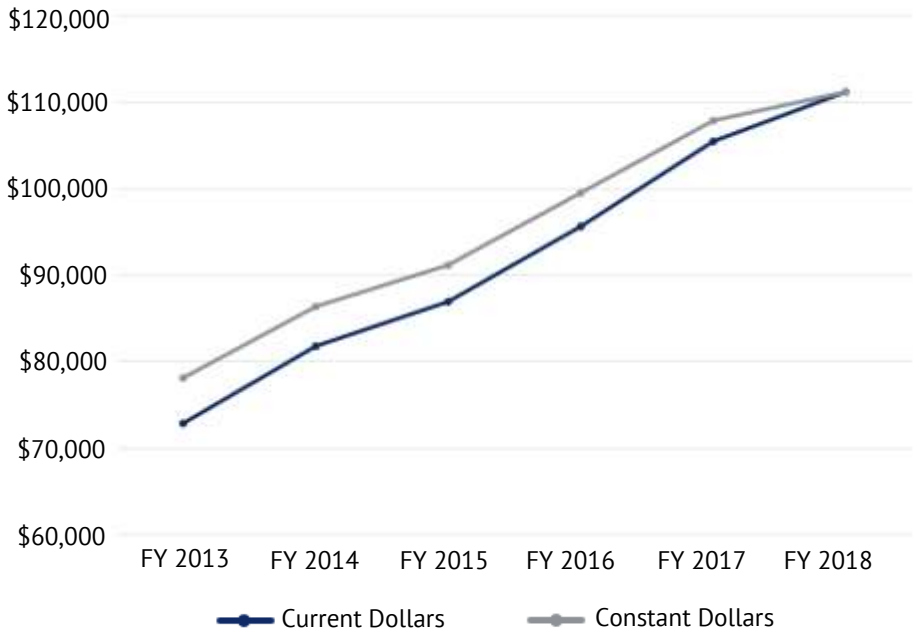
Figure 14. Total HCBS Expenditures per Resident, FFY 2016




While Figure 14 indicates that Nevada's spending on HCBS is comparatively low, Figure 15 shows that State expenditures for Medicaid-reimbursable personal care

services have been increasing over time, both in current and constant (inflation-adjusted) dollars.[157]

Figure 15. Total Cost of Coverage in Nevada: PCS Provider Agencies and Intermediary Service Organizations, FY 2013 – FY 2018




Amounts in Figure 15 are for total Medicaid reimbursements to full-service agencies for PCS and to Intermediary Service Organizations (ISOs) for employment-related services related to self-directed PCS under the State Plan option. Personal care services offered through 1915(c) waivers are excluded for the reasons detailed above. Note that precise dollar amounts for State spending on personal care services cannot be obtained from budgetary data. As one official from the Nevada Department of Health and Human Services explained to the Guinn Center, "Our base budget is split into buckets for the different eligibility categories[,] not into amounts for specific services. For example, there is no specific amount for PCS or any other provider type or service, but there is a line item for Aged, Blind, and Disabled recipients that includes the costs for all of the services they are expected to receive. When we ask for a[n] enhancement like a rate increase, it is in a separate decision unit....Note that this money isn't 'set aside' for PCS services, but it [is] lumped in the different buckets based on eligibility groups."

In State Fiscal Year (FY) 2018, Medicaid reimbursements to full-service agencies and ISOs ("total reimbursements") were more than 1.5 times higher than they were in FY 2013 in current dollars. In FY 2013, total reimbursements amounted to $72,848,445, while by FY 2018, the current dollar amount increased to $111,218,459. Each year in between witnessed an increase over the previous year.

The greatest year-over-year increase was between FY 2013 and FY 2014, at 12.2 percent. The graph also suggests that Nevada's expenditures for personal care services under the State Plan option have kept apace of inflation, as the slope of the gray line evinces steady year-over-year increases. Between FY 2013 and FY 2018, total reimbursements increased by 42.4 percent in real dollars. In sum, Nevada's expenditures per capita on HCBS are relatively low compared to other states, but the State has increased spending consistently for personal care services offered through its State Plan option. However, as one PCA workforce policy expert shared with the Guinn Center, "PCS spending increases have been driven by increased utilization, not investment in the workforce."[158]

Given the growth in PCS employment and higher demand for services that is expected only to increase exponentially over time, coupled with the commitment of additional resources by the State to meet needs, the comparatively low annual median wage initially may appear something of a puzzle. (See Section V for more on employment, demand for services, and annual median wage.) But there is an explanation: Medicaid reimbursement rates. Each state establishes its own provider reimbursement rates, and these vary widely across states, and even within states, depending on payment methodology (e.g., state plan optional services versus 1915(c) waivers).

Reimbursement rates establish the ceiling for what personal care aides can be paid under Medicaid and have an effect on the private pay market, as well. Moreover, rates established for the Personal Assistance Services (PAS) Program, the Community Service Options Program for the Elderly (COPE), and the Homemaker Program historically have been aligned with Medicaid's rates "for consistency and ease of administration," though there has been a recent exception, as discussed below.[159]

In Nevada, the reimbursement rate may cover wages, workers' compensation, State taxes (e.g., the Modified Business Tax, or MBT, which is a payroll tax), liability and bonding on behalf of the PCA, employee insurance, compliance with State statutes, rent, training, additional annual education, and federal regulations.[160] The Administrator for the Nevada Department of Health and Human Services' Division of Health Care Financing and Policy, the Director of the Nevada Department of Health and Human Services, and the Governor's Finance Office review and approve Medicaid reimbursement rates that are authorized by the Nevada Legislature.[161]

In October 2003, the personal care aide reimbursement rate was established at $4.25 per service unit (15 minutes) or $17.00 per hour. That rate was increased by four percent as of July 2006 to $4.44 per service unit ($17.76 per hour). It increased again by four percent as of July 2007 to $4.63 per service unit ($18.52 per hour) but decreased by eight percent as of July 2009 to $4.25 per service unit ($17.00 per hour), which returned it to the rate established in October 2003. This rate

remained in effect through December 2019.[162] In 2019, the Nevada Legislature passed a 3.3 percent increase for personal care service providers (effective January 1, 2020) to $4.39 per service unit or $17.56 per hour.[163] Even with the increase, the January 2020 rate was below the $18.52 per hour that was in place as of June 30, 2009, and it had not been restored to the July 2006 rate of $17.76 per hour.

Confronted with a State General Fund shortfall of approximately $1.2 billion in FY 2021 in the wake of the COVID-19 pandemic, the governor convened a special session of the Nevada Legislature to close the budget gap.[164] Assembly Bill (AB) 3, which reduced appropriations for many State-level agencies, was enacted in the 31st (2020) Special Session. The legislation included a six percent across-the-board reduction in reimbursement rates for all Nevada Medicaid providers in FY 2021; this reduction applies to PCS provided through State Plan optional services (both agency and self-directed) and 1915(c) waivers (both agency and self-directed).[165] The new rate is $4.13 per service unit ($16.52 per hour), which went into effect on August 15, 2020.[166] Thus, the increased reimbursement rate following the 80th (2019) Legislative Session was only in effect for 7 ½ months. The August 2020 rate of $16.52 per hour is not only less than the previous rate of $17.00 per hour but is the lowest reimbursement rate for Medicaid-reimbursable PCS in Nevada since 2003. Had the reimbursement rate set in October 2003 kept pace with inflation, it would have increased to $23.81 per hour in July 2020.[167]

The reimbursement rate for each the Personal Assistance Services (PAS) Program, the Community Service Options Program for the Elderly (COPE), and the Homemaker Program will remain at $4.39 per service unit ($17.56 per hour): AB 3 required reductions only in the fee schedules for Medicaid providers, and these are not Medicaid programs (see Section II).[168] Thus, the FY 2021 reimbursement rates for PAS, COPE, and the Homemaker Program are not aligned with Medicaid's rates for PCS, as historically has been the case.[169]

Even prior to the COVID-19 pandemic, representatives from Nevada-based home care agencies shared some concerns regarding reimbursement rates with the Guinn Center: (1) after expenses, the entire reimbursement rate for Medicaid-reimbursable PCS nets to zero; (2) agencies are not non-profits, and they operate on very thin profit margins; and (3) the low reimbursement rate means that some agencies do not take on Medicaid recipients as clients, while others may have a few but offset their costs by increasing the rate for private pay clients.

It is difficult to draw conclusions about reimbursement rates for personal care services in comparative context. The most complete source of state-level data on state plan optional services PCS reimbursement rates is available from the Kaiser Family Foundation (KFF) and is shown in Table 3.[170] As we discuss below, the information should be interpreted with caution, though we present it for the sake of reference.

As the table shows, the data is inconsistent within states (e.g., decreases from federal Fiscal Year [FFY] 2017 to FFY 2018, when they are known to have instituted rate increases), and some are entirely incorrect. KFF's data on reimbursement rates is based on its Medicaid State Plan Personal Care Program Survey, and it is incumbent upon respondents in the states to report accurate information. Individuals that receive the survey may not understand the distinction between state plan optional services and 1915(c) waivers, for example, and a great deal of complexity attends reimbursement rates. This may explain the discrepancies in reported reimbursement rates.

Our team contacted all 50 states, plus the District of Columbia, to obtain more accurate information, but most officials ranged from uncertain to non-responsive. Representatives from state, with whom we had extensive conversations but who wished to remain anonymous, stated that the reimbursement rates reported for FFY 2017 and FFY 2018 were incorrect. The FFY 2017 reimbursement rate is for its 1915(c) Elderly, Blind, and Disabled waiver (i.e., not the State Plan option), and its FFY 2018 reimbursement rate was deemed "egregiously inaccurate for any personal care services provided in [state]."

To the extent that inferences are possible, we would observe that, in FFY 2018, Nevada had an agency provider PCA reimbursement rate ($17.00 per hour) that was just below the median of $17.20 per hour (excluding Colorado, for which the FFY 2018 provider rates appear to be inaccurate). Nebraska had the lowest agency provider PCA reimbursement rate ($9.20 per hour), while North Dakota had the highest ($27.96 per hour).

The data also can mask differences in how personal care aides' wages are structured. We detailed the items included within Nevada's reimbursement rate, above, and it should be noted that agencies have discretion over allocation of amounts. Massachusetts serves as a distinct counterexample. The Commonwealth offers only independent providers, which means that their personal care services are entirely self-directed.[171] For FY 2018 (beginning July 1, 2017), the hourly PCA rate was $16.52.[172] (Note that this differs from the information compiled in Table 3.) Of the hourly PCA rate, $14.56 was allocated to the PCA gross wage component, while $1.96 was allocated to the employer expense component.[173] The former is the "portion of the PCA rate designated as the PCA's gross hourly wage," while the latter is the "portion of the PCA rate designated as reimbursement to members for their mandated employer's share of social security, federal and state taxes, unemployment insurance taxes, Medicare, and worker's compensation premiums."[174] That is, a personal care aide received $14.56 per hour in gross wages, while a fiscal intermediary (FI) received a separate portion in the amount of $1.96 per hour to manage employer-required tasks (e.g., filing taxes, paying unemployment taxes, preparing payroll, etc.).[175]

Table 3. Personal Care Services Provider Reimbursement Rates (per Hour)

| | FFY 2017 | | | FFY 2018 | |
|---|---|---|---|---|---|
| State | Agency | Provider | | Agency | Provider |
| Alaska | $24.40 | | | $24.40 | |
| Arkansas | | | | $18.00 | |
| California | | $14.00 | | | $11.25 |
| Colorado | $19.28 | | | $60.66 | $60.66 |
| District of Columbia | $20.08 | | | $20.08 | $13.84 |
| Florida | $15.00 | $15.00 | | $15.00 | $15.00 |
| Idaho | $15.76 | | | $15.76 | |
| Kansas | | | | NR | NR |
| Louisiana | $11.40 | | | $11.40 | |
| Maine | $20.12 | | | $20.12 | |
| Maryland | $16.99 | | | $16.99 | |
| Massachusetts | | $16.52 | | | $15.00 |
| Michigan | $14.25 | $9.95 | | $14.50 | $9.25 |
| Minnesota | $17.40 | | | $17.40 | |
| Missouri | $17.22 | | | $18.12 | $15.76 |
| Montana | $19.44 | | | $19.44 | |
| Nebraska | $9.78 | $9.78 | | $9.20 | $9.20 |
| Nevada | $17.00 | | | $17.00 | $17.00 |
| New Hampshire | | | | NR | NR |
| New Jersey | $41.83 | $38.28 | | $15.00 | $15.00 |
| New Mexico | | | | NR | NR |
| New York | | | | NR | NR |
| North Carolina | $15.60 | | | $15.60 | |
| North Dakota | $37.10 | $29.52 | | $27.96 | $20.36 |
| Oklahoma | $15.68 | | | NR | NR |
| Oregon | $22.32 | $15.00 | | $24.61 | $14.65 |
| Rhode Island | | | | NR | NR |
| South Dakota | $37.38 | | | $25.24 | |
| Texas | $13.22 | $10.43 | | $12.44 | $12.44 |
| Utah | $19.08 | $11.64 | | $19.08 | $11.64 |
| Vermont | | | | N/A | N/A |
| Washington | $26.32 | $13.58 | | $26.86 | $17.91 |
| West Virginia | $16.00 | | | $16.00 | |
| Wisconsin | $43.02 | | | $16.72 | |

*Note*: Provider reimbursement rates apply to optional State Plan services (i.e., not waivers). "No Personal Care Program" should be interpreted to mean as not being offered as a State Plan option; it does not mean that the state does not provide PCS at all but rather that it may do so under a different authority, such as waivers. In FY 2017, 16 states reported having no Personal Care Program (AL, AZ, CT, GA, HI, IL, IN, IA, KY, MS, OH, PA, SC, TN, VA, and WY). Responses for DE were blank for provider reimbursement rates; it did not complete the survey, as these services were included in its Section 1115 capitated managed care waiver. In FY 2018, 17 states reported having no Personal Care Program; they are the same states as FY 2017, plus DE, which discontinued its personal care State Plan benefit in FY 2018 (instead, it covers them under its home health state plan benefit).
NR = no response. N/A = VT's program is entirely self-directed. Blank = state does not elect policy option.

This suggests that even though Nevada's personal care aide reimbursement rate may appear higher than that of Massachusetts for FFY 2018–$17.00 per hour versus $16.52 per hour–the amount that PCAs receive likely is higher in the Commonwealth. According to the Personal Care Association of Nevada (PCAN), many agencies pay caregivers approximately $12.75 per hour to remain competitive.[176] That is lower than the $14.56 per hour personal care aides received in Massachusetts through its PCA gross wage component. And it should be noted

that, as Table 2 (page 34) indicates, the hourly mean (average) wage actually received by PCAs in Nevada may be less than $12.75 per hour. Data from the U.S. Bureau of Labor Statistics (BLS) shows an average of $11.34 per hour, and a Nevada-based worker survey reveals an average of $10.88 per hour.

The reimbursement rate structure in Massachusetts is what is known as a wage pass-through, which "require agencies providing long-term care services spend a certain percentage or specific dollar amount of their Medicaid reimbursement on frontline worker wages or benefits."[177] Other states with wage pass-throughs or floors (which are minimum levels of compensation that employees must receive) for Medicaid-funded home care workers employed by agencies are Alaska, Illinois, Minnesota, New York, and Texas.[178] It appears that Colorado recently enacted a limited wage pass-through, while the District of Columbia has implemented a wage floor.[179]

In Nevada's 80th (2019) Legislative Session, a pass-through wage for personal care aides was considered through the introduction of Senate Bill (SB) 446. In its initial iteration, it would have required the following: "An agency to provide personal care services in the home that enters into a contract with Medicaid must agree to pay its employees who provide personal care services at least 75 percent of the reimbursements paid to the agency under Medicaid for personal care services."[180] However, the language was eliminated in the 1st reprint.[181]

Institutional changes at the State level may compel Nevada to reevaluate its reimbursement rate for personal care aides. In 2017, Assembly Bill (AB) 108 required a rate review for every Medicaid provider type every four years.[182] It does not guarantee that the rate will be revised but does ensure that it will be taken under consideration.[183] According to an official with the Nevada Department of Health and Human Services, "For the quadrennial budget reviews required by AB 108, we survey providers regarding their costs for providing different services. This part of the analysis is required by AB 108. We have also opted to research the rates paid by Medicare and other state Medicaid agencies for these services. This allows additional comparison to determine if our rates are appropriate[.]..the analysis is in progress." The rate review for personal care aides (both provider agencies and Intermediary Service Organizations) began in the second quarter of 2019.[184]

And pursuant to AB 456 of the 80th (2019) Legislative Session, Nevada's minimum wage is required to increase gradually (i.e., by 75 cents each July 1) until 2024, when the minimum wage reaches $12.00 per hour for those without health benefits and $11.00 per hour for those with health benefits.[185] Ensuring that agencies are able to comply with the implementation of a new statewide wage floor, while still covering overhead and employer-required tasks but not shifting the cost burden to private pay clients, could entail a reimbursement rate increase for personal care aides.

# Conclusion

Personal care aides provide some of the most essential services in Nevada. They care for the Silver State's most vulnerable residents, including seniors and individuals with disabilities. Their work affords dignity and privacy to individuals who need support and prefer to receive it in the comfort of their home rather than in an institutionalized setting. The career, while rewarding to so many personal care aides, can be physically taxing and emotionally exhausting. Moreover, home care continues to offer poor-quality, low-paying jobs that lead to high turnover and widespread vacancies.

This report has found that nearly half of all PCAs are aged 45 to 64. It is a predominantly female workforce, and women of color are overrepresented. Almost 20 percent of PCAs are uninsured, while 32.0 percent depend on Medicaid for health insurance coverage, much like the population they serve.

Research shows that training is important for a number of reasons, including the development and maintenance of appropriate skill sets to ensure client well-being, higher job quality and satisfaction, and better wages. However, Nevada requires minimal training standards. It lags behind several other states in comprehensiveness and rigor, and the training requirements do not provide the necessary foundation to establish a career pathway into other occupations within the direct care workforce, such as home health aides and certified nursing assistants.

Between 2010 and 2018, Nevada witnessed a 198.4 percent growth in its personal care aide workforce, but this trend is not expected to continue. After adjusting for population, the PCA workforce is expected to remain flat through 2026. Nevada's aging population has driven demand, and while the proportion of the population aged 65 and over is expected to grow in the coming decades–in fact, Nevada is ranked first in the percent change of this age cohort through 2040–experts are predicting shortfalls in workforce supply. Simultaneously, as of 2028, PCAs will be the fourth most in-demand job sector nationwide. If demand for personal care services were to outstrip supply of personal care aides, then Nevada would confront a "care gap."

There are structural reasons underlying a potential care gap, most notably the demographics of labor force participation. And these effects may be fairly pronounced in Nevada. As noted above, personal care aides are mostly women (83.7 percent) and individuals in older middle age (48.7 percent). Projected attrition in the female labor pool, coupled with the potential transition of those from caregiving roles into recipients of care, means that the most heavily concentrated shares of the PCA workforce could exit, attenuating supply.

Occupational attributes may diminish the appeal of personal care aide work, as well. It is one of the lowest paid occupations in the country. Median wages for personal care aides in Nevada have remained flat over time. In 2018, Nevada was ranked 31st in the nation with an annual median PCA wage of $23,020, which is below the national annual median PCA wage of $24,020.

To put the annual median wage of $23,020 for a personal care aide in Nevada in perspective, our team assessed this wage against cost-of-living expenses using the Economic Policy Institute's Family Budget Calculator. For a personal care aide residing in the Las Vegas/Henderson/Paradise metro area who is single and has no children, his or her annual costs would amount to $32,410, or $9,390 more than the annual median wage. In order to make up the difference, the PCA would need to work more than 56 hours per week or earn $15.58 per hour.

Nevada's expenditures for personal care services has been increasing over time, both in current and constant (inflation-adjusted) dollars. In State Fiscal Year (FY) 2018, Medicaid reimbursements were more than 1.5 times higher than they were in FY 2013 in current dollars. Given the growth in PCS employment and higher demand for services that is expected only to increase exponentially over time, coupled with the commitment of additional resources by the State to meet needs, the comparatively low annual median wage initially may seem inherently contradictory. But there is an explanation: Medicaid reimbursement rates.

Medicaid is the primary public payer for long-term care services nationwide, and each state sets its own provider reimbursement rates under Medicaid. Reimbursement rates thus establish the ceiling for what personal care aides can be paid under Medicaid, which explains some of the variation in median wages across states.

In October 2003, the personal care aide reimbursement rate in Nevada was set at $17.00 per hour. Although the rate increased twice in subsequent years, it was returned to the 2003 rate as of July 2009 and remained in effect through December 2019. In 2019, the Nevada Legislature passed a 3.3 percent increase for personal care service providers (effective January 1, 2020) to $17.56 per hour. However, that rate subsequently was decreased to $16.52 per hour in August 2020 as part of a package of direct spending cuts implemented to close Nevada's $1.2 billion budget gap that arose from the COVID-19 pandemic. It is the lowest reimbursement rate for Medicaid-reimbursable PCS in Nevada since 2003. Had the reimbursement rate set in October 2003 kept pace with inflation, it would have increased to $23.81 per hour in July 2020.

Few, if any, would describe the personal care aide workforce in Nevada as resilient. Low-paying jobs that are depressed by a Medicaid reimbursement rate that has not kept up with inflation are contributing to a shrinking pool of available workers who can find more lucrative positions in leisure/hospitality or

distribution/fulfillment centers. The ever-increasing cost of living in Nevada may be accelerating this development. Concurrently, demand for personal care services is expected to grow at exponential rates in the coming years. The mismatch of supply and demand suggests that the market wage rate is in disequilibrium, likely as a function of the Medicaid reimbursement rate establishing a ceiling on wages.

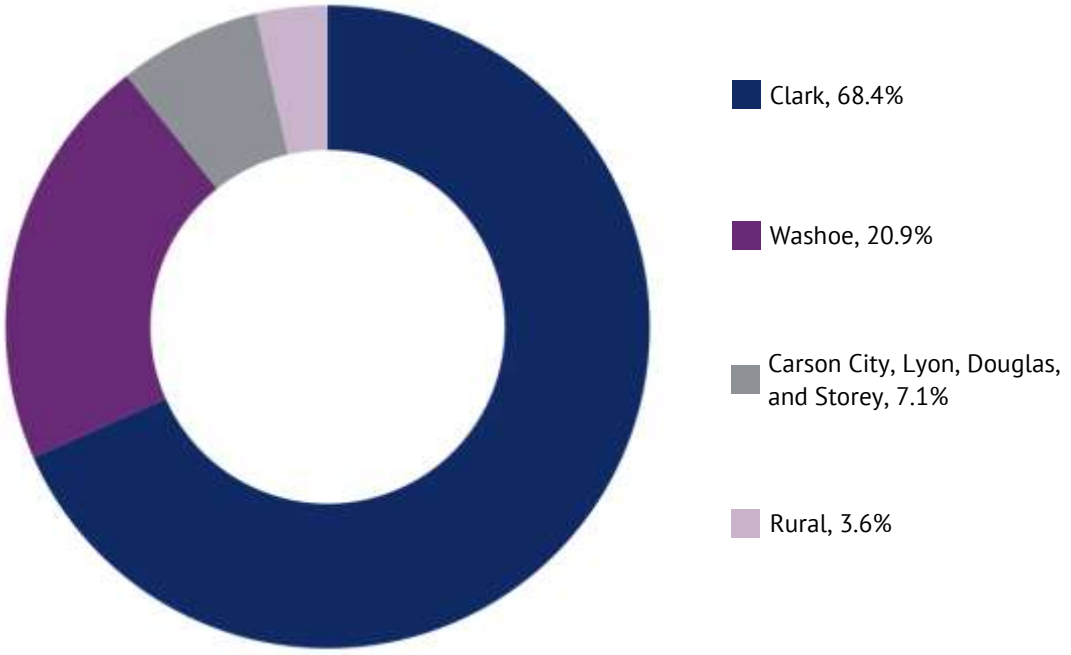
Most recently, the coronavirus pandemic has reinforced preexisting occupational challenges for PCAs, while exposing emerging issues. Minimal training standards have left many personal care aides ill-equipped to meet clients' needs and lacking effective approaches to coronavirus-specific infection control. Limited access to personal protective equipment (PPE) is endemic to the field, but supply shortages have exacerbated the problem. PCAs are on the frontline of the crisis but may be last in the order of priority as PPE needs have become acute for medical professionals who are responding to the infection directly.

And yet, personal care aides work with some of Nevada's most vulnerable populations, such as the elderly and individuals with disabilities. Their exposure to infection is heightened, especially given that hygiene and sanitation is not uniform across home-based settings, and their physical proximity to clients mitigates implementation of best practices on which individuals in other occupations can rely, such as social distancing. However, reports of concentrated coronavirus-related outbreaks in long-term care facilities have only highlighted the value of personal care services and the critical role they play in supporting vulnerable people to remain in their homes rather than institutions.

While PCAs perhaps are best suited to lead in preemption efforts, collectively, inadequate emergency preparedness training, insufficient supplies, two-way risk exposure, and limited worker support could have downstream consequences. It could mean increased spread, which would deepen the strain on medical resources. And, over the long term, the personal care aide workforce could shrink, reinforcing shortages and the potential forthcoming care gap.

A healthy, robust, and resilient personal care aide workforce in Nevada is imperative. It is incumbent upon decision makers to consider policies that strengthen the personal care aide workforce in Nevada and ensure that the care gap is not realized.

## Appendix A. Personal Care Aides in Nevada, by Geography, 2018[186]



## Appendix B. State Occupational Employment and Wage Estimates for Personal Care Aides (Ranked), 2018[187]

| State | Total Employment | Per 1,000 Jobs | Hourly Median Wage | Annual Median Wage | Rank |
|---|---|---|---|---|---|
| Alaska | 5,390 | 17.1 | $15.94 | $33,160 | 1 |
| North Dakota | 6,090 | 14.6 | $15.54 | $32,320 | 2 |
| District of Columbia | 4,730 | 6.6 | $14.21 | $29,550 | 3 |
| Massachusetts | 76,850 | 21.5 | $13.88 | $28,870 | 4 |
| New Jersey | 14,470 | 3.6 | $13.87 | $28,840 | 5 |
| Washington | 47,240 | 14.5 | $13.77 | $28,650 | 6 |
| Vermont | 6,730 | 22.0 | $13.24 | $27,550 | 7 |
| Hawaii | 4,650 | 7.2 | $13.16 | $27,380 | 8 |
| Rhode Island | 5,860 | 12.2 | $12.93 | $26,890 | 9 |
| New Hampshire | 8,600 | 13.2 | $12.73 | $26,470 | 10 |
| Oregon | 31,510 | 16.7 | $12.68 | $26,370 | 11 |
| New York | 199,060 | 21.2 | $12.49 | $25,990 | 12 |
| Connecticut | 26,360 | 15.9 | $12.48 | $25,950 | 13 |
| Wyoming | 2,420 | 9.0 | $12.42 | $25,840 | 14 |
| Minnesota | 75,830 | 26.4 | $12.38 | $25,750 | 15 |
| Maryland | 19,580 | 7.3 | $12.36 | $25,700 | 16 |
| Nebraska | 7,720 | 7.9 | $11.88 | $24,710 | 17 |
| Maine | 14,880 | 24.6 | $11.85 | $24,650 | 18 |
| California | 558,350 | 32.8 | $11.80 | $24,550 | 19 |
| Utah | 9,850 | 6.8 | $11.70 | $24,340 | 20 |
| Colorado | 27,310 | 10.4 | $11.68 | $24,290 | 21 |
| Pennsylvania | 121,300 | 20.7 | $11.62 | $24,180 | 22 |
| Iowa | 18,520 | 12.0 | $11.57 | $24,060 | 23 |
| South Dakota | 2,860 | 6.8 | $11.46 | $23,840 | 24 |
| Wisconsin | 63,270 | 22.2 | $11.43 | $23,780 | 25 |
| Arizona | 47,610 | 17.1 | $11.39 | $23,700 | 26 |
| Kentucky | 16,690 | 8.8 | $11.38 | $23,660 | 27 |
| Montana | 5,110 | 11.0 | $11.36 | $23,640 | 28 |
| Illinois | 50,970 | 8.5 | $11.31 | $23,520 | 29 |
| Delaware | 4,930 | 11.0 | $11.16 | $23,220 | 30 |
| **Nevada** | **13,130** | **9.7** | **$11.07** | **$23,020** | **31** |
| Michigan | 39,740 | 9.2 | $11.06 | $23,000 | 32 |
| Ohio | 42,590 | 7.9 | $10.94 | $22,750 | 33 |
| Indiana | 28,420 | 9.3 | $10.84 | $22,550 | 34 |
| Idaho | 12,130 | 17.2 | $10.73 | $22,320 | 35 |
| Missouri | 60,330 | 21.5 | $10.71 | $22,280 | 36 |
| Florida | 36,810 | 4.3 | $10.68 | $22,210 | 37 |
| Kansas | 21,450 | 15.6 | $10.54 | $21,920 | 38 |
| Georgia | 29,080 | 6.6 | $10.25 | $21,310 | 39 |
| North Carolina | 30,170 | 6.9 | $10.10 | $21,010 | 40 |
| Mississippi | 9,610 | 8.6 | $9.96 | $20,720 | 41 |
| South Carolina | 18,040 | 8.7 | $9.91 | $20,620 | 42 |
| Tennessee | 21,100 | 7.1 | $9.84 | $20,470 | 43 |
| Arkansas | 16,820 | 13.9 | $9.83 | $20,440 | 44 |
| New Mexico | 27,300 | 33.6 | $9.57 | $19,910 | 45 |
| West Virginia | 12,500 | 17.9 | $9.57 | $19,910 | 46 |
| Virginia | 39,030 | 10.2 | $9.47 | $19,700 | 47 |
| Texas | 206,240 | 17.0 | $9.30 | $19,340 | 48 |
| Oklahoma | 13,820 | 8.7 | $9.27 | $19,280 | 49 |
| Alabama | 14,310 | 7.4 | $8.98 | $18,680 | 50 |
| Louisiana | 34,590 | 18.1 | $8.96 | $18,640 | 51 |
| United States | 2,211,950 | – | $11.55 | $24,020 | – |

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Guinn CENTER | DATA-DRIVEN INDEPENDENT

**About the Guinn Center**

The Guinn Center is a 501(c)(3) nonprofit, nonpartisan, independent policy center that seeks to advance evidence-based policy solutions for Nevada through research, public engagement, and partnerships.



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