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Long-Term Care: Nursing and Paraprofessional Workforce Issues

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Summary

Currently, about 4.8 million nurses and paraprofessionals provide care to individuals in a range of institutional and community settings. Widespread accounts of problems health care providers have had in attracting and retaining nursing personnel have led to concern within the health care sector and have attracted the attention of lawmakers. There are reports that the demand for registered nurses, licensed practical nurses, nurse aides and other paraprofessional personnel exceeds supply. Health care practitioners, nursing educational institutions and researchers suspect that this problem will worsen. The difficulty attracting and retaining nurses and paraprofessionals may be the result of a variety of factors including competing job opportunities for women, relatively low wages, limited or no benefits, stressful working conditions, and insufficient opportunities for professional development.

The demand for qualified nurses and paraprofessionals is expected to increase as baby-boomers swell the older population. Currently, about 9 million adults age 18 and older receive long-term care services in community settings or in institutions. Registered nurses, licensed practical nurses, and paraprofessionals (home health aides, nursing aides, and personal care and home care aides) provide the majority of long-term care supportive and health services to individuals who have lost some or all capacity to care for themselves. Aging baby-boomers and increased life expectancy will increase the demand for these services and for the nurses and paraprofessionals who provide them.

Medicare and Medicaid are the largest public sources of financing for care provided in nursing facilities and by home health care agencies. The importance of these programs has led policy-makers to evaluate how they can be modified to address inadequate staffing levels.

On August 1, 2002, The Nurse Reinvestment Act (P.L. 107-205) was signed into law, having been passed by the House on December 20, 2001 and by the Senate on July 22, 2002. P.L. 107-205 addresses issues concerning recruitment, training and retention of nurses and paraprofessionals through amendments to the Nursing Workforce Development Act, Title VIII of the Public Health Service Act. The 107th Congress has also considered addressing nurse staffing in a number of other ways. Proposals introduced by Members of Congress included: changing payment rates under Medicare and Medicaid to encourage more nurse training, prohibiting mandatory overtime; expanding tax incentives to encourage family members to act as caregivers; and further facilitating the use of foreign nurses. None of these latter proposals were enacted into law.

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Introduction

The aging of the "baby boom" generation and increasing longevity of the population will affect the demand for long-term care – supportive and health services for persons who have lost some or all capacity for self-care. According to the 1994 National Health Interview Survey, about 3.9 million persons age 65 and older, and 3.4 million persons age 18-64, receive care in home and community-based settings and about 1.6 million persons receive care in nursing facilities. By 2020, estimates predict that the total number of elderly individuals using home care and institutional services will increase by about one-third.[1] The majority of direct care providers include registered nurses (RNs), licensed practical nurses (LPNs) and paraprofessionals (home health aides, nursing aides, personal care and home care aides). As the need for long-term care services grows, policymakers will be faced with pressures to expand long-term care funding, even without changes to current law. At the core of these challenges are issues concerning quality of care and adequacy of the supply of those nurses and paraprofessionals who play a central role in providing long-term care services. Already long-term care providers report an insufficient number of direct service personnel. This problem is projected to worsen in the future.

There have been widespread accounts of hospitals, nursing homes and other facilities having great difficulty attracting and retaining nursing and paraprofessional personnel. This problem may be the result of a variety of factors, including competing job opportunities for women, relatively low wages, limited or no employee benefits, and insufficient opportunities for professional development (such as promotions and training opportunities) offered to paraprofessionals.[2] These problems are especially acute in the long-term care sector where nursing homes and home health agencies play a major role.[3] This report focuses on the care provided by these providers.

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[1] U. S. Department of Health and Human Services. *The Long-Term Care Financing Model*. Prepared by the Lewin Group, Inc. for OASPE, 2000.

[2] President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Quality First: Better Health Care for All Americans, Final Report to the President*, 1999. North Carolina Division of Facility Services. *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers*, September 1999.

[3] Other long-term care providers, whose nurses and paraprofessionals are not regulated under Medicare or Medicaid, include assisted living facilities and other congregate residential facilities.

Inadequate staffing and training of nursing personnel may impact patient health outcomes. The Department of Health and Human Services' (DHHS) Inspector General confirmed that staffing deficiencies and inadequate staff expertise were major factors in many chronic and recurring quality problems in nursing facilities.[4] In contrast, other studies found that adequate numbers of staff led to higher quality of care, such as improvements in residents' functioning, reductions in the likelihood of premature patient death and incontinence and a greater provision of personalized and slower-paced care.[5]

Medicare and Medicaid are the largest public sources of financing for care provided in nursing facilities and by home health agencies, contributing $69 billion in 2000 (Medicare outlays were $18.7 billion and Medicaid outlays were $50.3 billion), over half of the Nation's total spending for long-term care.[6] The important role played by these programs has led some policy-makers and advocacy groups to evaluate how they can be modified to address inadequate staffing levels among nurses and paraprofessionals in the long-term care sector.

Traditionally, Medicare and Medicaid laws have included provisions to establish a framework for staffing and quality standards for care paid for by the programs. The statutory authority pertaining to nursing homes participating in Medicare and Medicaid was comprehensively reformed under the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). Some of the same concepts underlying the nursing home reform law of 1987 were also included as conditions of participation for home health agencies in that same year. Current Medicare and Medicaid regulations provide only limited staffing requirements. In recent years, Congress has explored issues pertaining to long-term care in general, and staffing and quality of service in particular. A series of recent hearings held by the Senate Special Committee on Aging on these topics began in 1998 and have continued through the present day. On August 1, 2002, The Nurse Reinvestment Act (P.L. 107-205) was signed into law, having been passed by the House on December 20, 2001 and by the Senate on July 22, 2002. P.L. 107-205 addresses issues related to recruitment, training and retention of nurses and paraprofessionals through amendments to the Nursing Workforce Development Act, Title VIII of the Public Health Service Act. P.L. 107-205 will provide loans to nursing students with loan forgiveness opportunities for those individuals who retain nurse faculty positions for at least 1 year, grants to

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[4] U.S. Department of Health and Human Services. *Quality of Care in Nursing Homes: An Overview*. Office of Inspector General June Gibbs Brown, March 1999.

[5] Institute of Medicine. *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* Washington, D.C., National Academy Press, 1996. Monroe, D. J. The Influence of Registered Nurse Staffing on the Quality of Nursing Home Care. *Research in Nursing and Health*, v. 13, 1990. p. 263-270. Spector, W.D., and H.A. Takada, Characteristics of Nursing Homes that Affect Resident Outcomes. *Journal of Aging and Health*, v. 3. p. 427-454, 1991. Bowers, Barbara J., Sarah Esmond, and Nora Jacobson. The Relationship Between Staffing and Quality in Long-Term Care Facilities: Exploring the Views of Nurses Aides. *Journal of Nursing Care Quality*, v.14(4), 2000. p. 55-64.

[6] Health Care Financing Administration. Office of the Actuary, National Health Statistics. *Group Table 9. Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Calendar Years 1992-99.*

recruit nursing personnel through public service announcements and local advertising campaigns, career ladder opportunities, among other purposes. An explanation of these requirements, as well as a description of the issues contributing to current and projected inadequacies in the long-term care labor market are presented in this report.

The Long-Term Care Labor Market

At a Congressional hearing in February 2002, experts detailed the current difficulties in meeting the demand for nurses and paraprofessionals and explained that the problem is likely to worsen.[7] The demand for nursing services is growing. As of 2000, there were nearly 2.2 million registered nurses (RNs), and about 700,000 jobs held by licensed practical nurses (LPNs), and about 3.1 million jobs held by paraprofessional workers, including nurse home health, personal care aides and home care aides. These nursing personnel provide a continuum of acute and long-term health care services to elderly individuals across the United States.[8] The Bureau of Labor Statistics has projected 2008 employment numbers for these occupations. The demand for RNs and LPNs is expected to increase 21.7% and 19.7% respectively. Jobs for nurse aides are also expected to grow (by 23.8%) while the employment of personal care and home health aides could grow at a much more rapid rate (58.1%) between 1998 and 2008.[9] (See Figure 1 for more detail.)

The Health Resources and Services Administration (HRSA, DHHS) also estimated future demand for RNs and LPNs. While the HRSA forecast was conducted in 1996 and uses different and earlier data sources than the BLS estimates, it provides an additional perspective on future requirements for nursing personnel in both nursing facilities and home health agencies. The HRSA forecast projects that demand for RNs and LPNs in nursing homes will increase by 44.2% and 47.9%, respectively, between 2000 and 2020. (See Figure 2.) The demand for RNs and LPNs in home health agencies (HHAs) is expected to increase by 43.8% and 53.8%, respectively, during the same period. (See Figure 3.)

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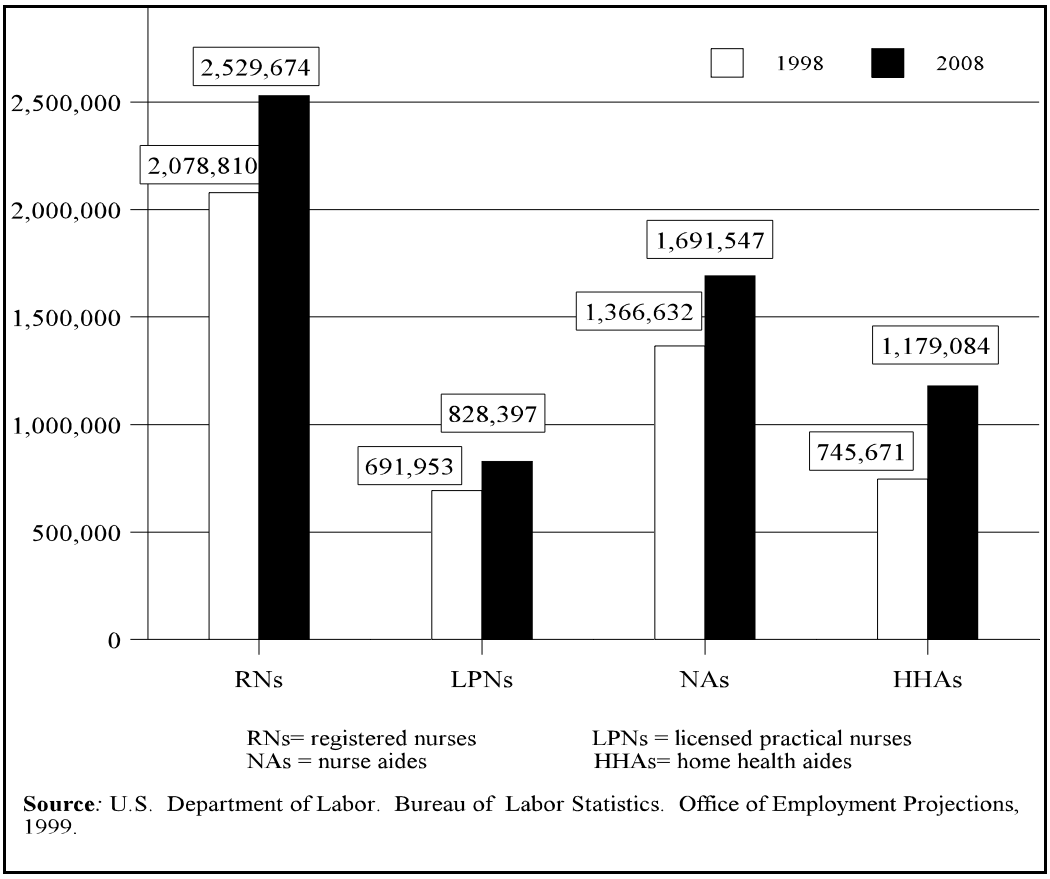
[7] U.S. Congress. Senate. Committee on Health, Education, Labor and Pensions. Subcommittee on Aging. Hearing. *The Nursing Shortage and Its Impact on America's Health Care Delivery System.* February 13, 2001. The General Account Office (GAO) has also responded to congressional concern on this issue. See General Accounting Office Report GAO-01-944, *Nursing Workforce: Emerging Nurse Shortage Due to Multiple Factors* (July 2001) and General Accounting Office Testimony GAO-01-750T, *Nursing Workforce Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern*, Statement of William J. Scalon, Director of Health Care Issues, May 17, 2001.

[8] U.S. Department of Labor. Bureau of Labor Statistics. *Occupational Outlook Handbook (2000-2001 Edition)*, 2001.

[9] U.S. Department of Labor. Bureau of Labor Statistics. Office of Employment Projections. 1999.

Figure 1. Nursing and Paraprofessional Personnel: 1998 Employment and Projected 2008 Employment



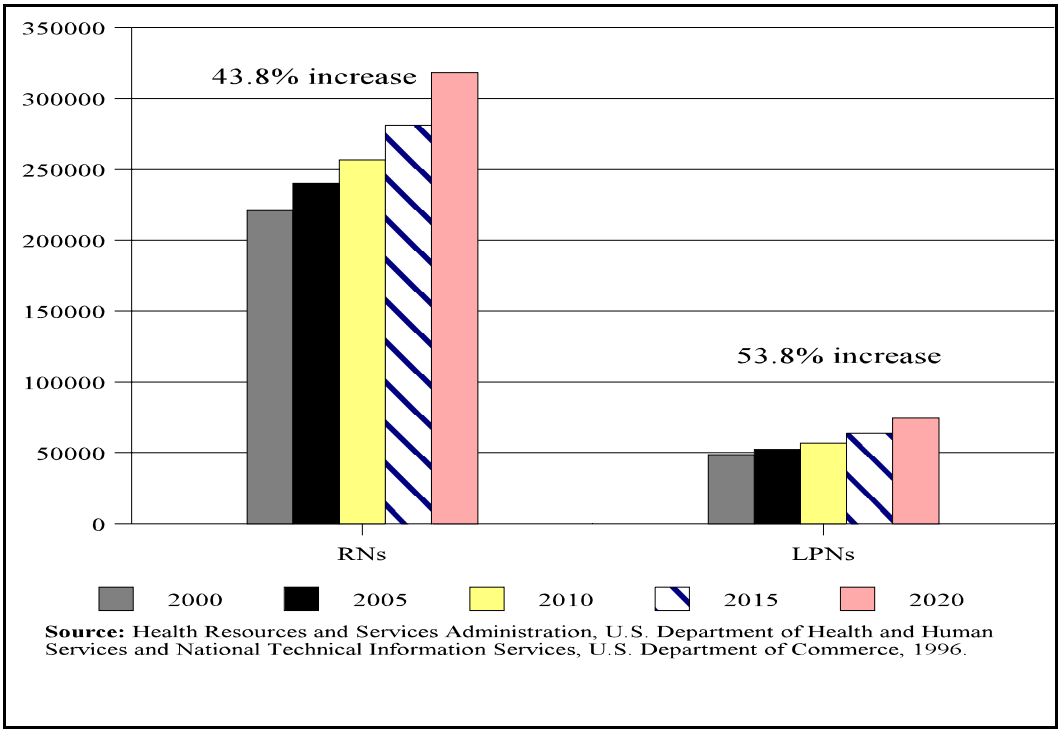
Source: U.S. Department of Labor. Bureau of Labor Statistics. Office of Employment Projections, 1999.

Workforce Issues

A variety of labor market indicators suggests that the health care sector, and especially the long-term care sector, is facing challenges in retaining nursing personnel and in attracting new personnel to the profession. One such indicator is high staff turnover in the long-term care sector. Studies have found that annual turnover rates in nursing facilities range from 55% to 65% for RNs and reach nearly 100% for nursing aides. Home care agencies have annual turnover rates between 40% and 60%.[10] Difficulty in retaining workers is costly for health care providers, consumers, and workers. For health care providers, frequent turnover of staff means high recruitment costs, the use of temporary replacements who are more expensive, and lower profits. High turnover may also cause patients' care to be disrupted, or inadequately provided.

[10] President's Commission on Consumer Protection and Quality in the Health Care Industry. *Quality First: Better Health Care for All Americans, Final Report to the President*. 1999.

Figure 2. Projected Home Health Agency Demand for Nursing Services (2000-2020)



While there is significant variation in work environments, salaries, and employer-sponsored benefit packages across states and long-term care providers, there are some common themes in the problems facing nursing personnel. Possible explanations for the high turnover rates among nursing personnel in the long-term care sector include relatively low wages, limited or no benefits, and greater physical and emotional exertion than is required of many other jobs in the health care sector. Health care workers at all levels have cited the lack of a supportive supervisory environment as another problem. Results of focus groups indicate that many nurses and paraprofessionals do not feel that their knowledge and insights into patients' conditions are respected and valued by their supervisors; they do not feel satisfied with their level of participation in decisions made about care provided to their patients.[11]

Working Conditions. High turnover rates may also lead to poor working conditions. Nurses and paraprofessionals in workplaces with large numbers of vacancies must compensate for the lack of employees. A reduced staff may cause nursing personnel to have less time to spend with each patient since each employee may be responsible for an increased number of patients within each shift. This burden could reduce the quality of care they provide to patients. In addition, health care providers have been requiring mandatory overtime as a means of coping with fewer personnel. These adaptations to staffing shortages may limit the availability of mentors to provide on-the-job training to new nursing personnel and to provide

[11] *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care*. The Aspen Institute, January 2001. p. 6.

continuing education opportunities. All of these factors can lead to increased levels of stress and frustration. The physical health of nurses and paraprofessionals can also be affected.

Some believe that the effect of low morale, combined with complaints of low salaries and increased work demands, has made nursing a less attractive career option both for individuals considering nursing as a profession and for those already in nursing who may leave the field for work in other professions. For example, a common responsibility for home care and personal care aides is assisting patients out of bed. Back injuries, from lifting or moving patients, are the most common types of injury to health care workers. An analysis of injuries in the home health care sector found that the injury rate was 50% higher than the work-related injury rate in hospitals, and 70% higher than the rate for all industries.[12]

Education and Training. The increased use of technology, as well as the more rapid discharge of patients from hospitals, have led to more demands being placed on nursing professionals and paraprofessionals. The changing environment requires the education and skills of nurses to change as well. The Institute of Medicine has recommended that nursing programs focus more on interdisciplinary education and team approaches to care, community-based care, managed care, and home care to respond to the changing needs of patients and the industry.[13]

The National Advisory Council on Nursing Education and Practice has recommended increasing the proportion of nurses with a baccalaureate or higher degree from its current level of 30% to 66% by 2010 to ensure that the nursing workforce is capable and qualified to meet future demands.[14] However, national enrollment in nursing programs has declined 5% over the past 5 years.[15] Explanations for the decline include: a changing image of the nursing profession, expanded employment opportunities for women in other fields, and insufficient financial support (loans, grants, and scholarships) for individuals who enroll in nursing programs.

A related problem is the aging of qualified faculty members at academic institutions and the need to replace them upon their retirement. The average age of nursing school faculty is 52 for full professors and 49 for associate professors. As these faculty members age, schools are concerned about their future ability to

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[12] U.S. Department of Labor. Bureau of Labor Statistics. *Injuries to Caregivers Working in Patient's Homes*. Issues in Labor Statistics. February 1997.

[13] Institute of Medicine. *Adopting New Medical Technology*. Medical Innovation at the Crossroads, v. 4. Washington, DC, National Academy Press, 1994.

[14] U.S. Department of Health and Human Services. Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. National Advisory Council on Nurse Education and Practice. Report to the Secretary of the Department of Health and Human Services on the Basic Registered Nurse Workforce, 1996.

[15] U.S. Congress. Senate. Testimony of Linda C. Hodges, College of Nursing, University of Arkansas before the Senate Committee on Health, Education, Labor and Pensions. February 13, 2001.

produce qualified nurses and nursing personnel in sufficient numbers to meet the increasing need. Already, many educational institutions explain that they have difficulty finding qualified faculty members to fill current vacancies. Some states have reported that they have had to turn away qualified applicants because there are not enough professors within the state to instruct nursing students for nursing degrees. For example, in 1999 Arkansas had to deny enrollment to 153 qualified applicants because the state RN programs did not have sufficient faculty to teach the full capacity of nursing students.[16]

Profile of Nurses and Paraprofessionals

Registered Nurses. As of 2000, there were nearly 2.2 million registered nurses employed in nursing in the United States.[17] Registered nurses are responsible for assisting physicians, administering medications, and helping patients in the convalescence and rehabilitation processes. The average age of employed registered nurses is 45.2 years, and RNs under age 30 represented just 9.1% of the workforce, as of 2000.[18] Most jobs held by RNs are in hospitals, although many work in public/community settings, such as offices and clinics of physicians and other health practioners, home health care agencies, nursing homes, temporary help agencies, schools and government agencies. A small percentage work in nursing education.[19]

Registered nurses can receive formal training through three different routes: 3-year hospital-based diploma programs, 2-year associate degree programs, and 4-year college/university degree programs. In 2000, about 30% received their education in diploma programs, 40% completed associate degree programs, and nearly 29% received baccalaureate degrees in nursing.[20] Each state has specific RN regulations, but all RNs are required to pass the same national licensing examination.

Licensed Practical Nurses. In 2000, there were about 700,000 jobs held by licensed practical nurses (LPNs). LPNs provide routine care (taking vital signs, applying dressings, supervising the care provided by nursing assistants) under the direction of physicians and RNs. They may also help develop care plans. Twenty-nine percent worked in nursing homes, 28% in hospitals, 14% in doctors' offices and clinics, and the remaining 29% worked for a variety of settings, including home

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[16] Ibid.

[17] *The Registered Nurse Population: Findings from The National Sample Survey of Registered Nurses*, March 2000. U.S. Department of Health and Human Services. Bureau of Health Professions. Division of Nursing.

[18] U.S. Department of Health and Human Services. Bureau of Health Professions. Division of Nursing. *Findings from the National Sample Survey of Registered Nurses*, March 2000.

[19] U.S. Department of Labor. Bureau of Labor Statistics. *Occupational Outlook Handbook (2002-2003 Edition)*, 2002.

[20] U.S. Department of Health and Human Services. Bureau of Health Professions. Division of Nursing. *Findings from the National Sample Survey of Registered Nurses*, March 2000.

health agencies, residential care facilities, temporary help agencies, among others.[21] All states require LPNs to participate in a 1- year, state-approved practical training program and to pass a licensing examination.

Paraprofessionals. Long-term care paraprofessionals include home health aides, personal care aides, and nurse aides. They work in a variety of settings and play an important role in the provision of long-term care, providing 8 out of every 10 hours of paid long-term care.[22] In 2000, about 2.1 million jobs were held by nurse aides, more than 615,000 jobs were held by home health aides, and 414,000 jobs were held by personal care and home care aides.[23] These paraprofessionals provided a variety of personal support and health-related services to individuals living in the community, hospitals and nursing homes.

Home health and nurse aides' responsibilities include taking temperatures, assisting individuals with bathing, dressing, eating, toileting and other services under a physician's or nurse's orders. In addition, personal care and nurse aides assist clients with non-health related activities such as housekeeping and monitoring nutrition.[24] A discussion of federal and state requirements for paraprofessionals' training and competency evaluations appears in a later section.

Compared to LPNs and RNs, paraprofessionals are more likely to be older, unmarried, less educated, and work fewer hours per week. A 1995 study found that about 24% of nursing home aides and 38% of home care aides had less than a high school education, while 3% of nursing home aides and 4% of home care aides had 4 years of college education or more. Twenty-seven percent of nursing home aides and 59% of home care aides were over 45 years of age.[25] In its 1999 report, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry emphasized the low wage rates of paraprofessionals. The report estimated that 600,000 of the 2 million health care paraprofessionals earn wages below the poverty line.[26]

Salaries in the long-term care sector vary depending on occupation. The range of salaries within occupations is quite broad. Hospitals tend to provide the highest

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[21] Ibid.

[22] *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care*. The Aspen Institute, January 2001. p. 1.

[23] U.S. Department of Labor. Bureau of Labor Statistics. *Occupational Outlook Handbook (2002-2003 Edition)*, 2002.

[24] *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* Institute of Medicine, 1996. p. 68, and *Improving the Quality of Care in Nursing Outcomes*, p. 52.

[25] Crown, et. al. The Demographic and Employment Characteristics of Home Care Aides: A Comparison with Nursing Home Aides, Hospital Aides, and Other Workers. *The Gerontologist*, v. 35, no. 2, 1995.

[26] President's Commission on Consumer Protection and Quality in the Health Care Industry. *Quality First: Better Health Care for All Americans: Final Report to the President*, 1999, p. 205. Reference to the 1997 written statement by the Home Care Associates Training Institute to the President's Commission.

wages, followed by nursing facilities, and home care agencies. Table 1 provides information on median wages for RNs, LPNs, and aides.

Table 1. Range of Health Care Workers' Salaries (2000)

Occupation	Range of Median Salaries
Registered nurse	Median earnings:$44,840/year Highest 10%: $64,360/year Middle 50%: $37,870-$54,000/year Lowest 10%: $31,890/year
Licensed practical nurse	Median earnings: $29,44/year Highest 10%: $41,800/year Middle 50% : $24,920 to $34,800/year Lowest 10% : $21,520/year
Nursing aides	Median hourly: $8.89/hour Highest 10% : $12.69/hour Middle 50% : $7.51/hour to $10.59/hour Lowest 10%: $6.48/hour
Home health aides	Median hourly: $8.23 Highest 10%: $11.93/hour Middle 50%: $7.13/hour to $9.88/hour Lowest 10%: $6.14/hour
Personal and home care aides	Median hourly: $10.13 Highest 10%: $11.93/hour Middle 50%: $6.43/hour to $8.53/hour Lowest 10%: $5.74/hour

Source: U.S. Department of Labor. Bureau of Labor Statistics. *Occupational Outlook Handbook (2002-2003 Edition)*, 2002.

Federal and State Participation Requirements

Nursing facilities and home health agencies, certified to accept Medicaid and Medicare patients, are subject to broad federal regulations as well as state laws. Both programs pay for the services of nursing and paraprofessional personnel and specify through laws and regulations the specific credentials and level of training these staff must have. These programs also provide general guidelines concerning the number of nursing hours that must be made available to patients in these programs. They do not, however, require specific staff-to-patient ratios nor do they regulate wage and employee benefit levels.

Nursing Homes

Federal Requirements. For the most part, Medicaid and Medicare have identical requirements. Both require participating nursing homes to employ a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Both laws also specify that nursing facility services must provide 24-hour licensed nursing services that are "sufficient" to meet the nursing needs of the nursing facility's residents. Furthermore, nursing and related services must be available to allow residents to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident, as determined by resident assessments and individual plans of care.[27] The fact that "sufficient" is not more specifically defined has created some latitude for providers and confusion for those who monitor nursing home compliance with laws and regulations.[28] Under certain conditions, states have the option of waiving either or both of the RN and license nursing requirements under Medicaid. Under Medicare, waivers must be granted by the Secretary.[29]

Medicaid and Medicare law requires that nursing aides who work on a full-time basis for more than 4 months to complete a training and/or competency evaluation program and be competent to provide care. Nursing homes must also provide regular performance reviews and in-service education (including training for individuals providing nursing and nursing-related services to residents with cognitive impairments) to assure that individuals used as nurse aides are competent to perform services.[30]

Medicaid and Medicare regulations specify training requirements for nurse aides. Regulations require that aides complete a training program lasting no less than 75 clock hours of training, at least 16 hours of which must be supervised practical training.[31]

In addition to these requirements for staffing and training, P.L. 105-277 (October 21, 1998) enabled nursing homes to request the Attorney General to provide the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history of an applicant who would provide direct patient care in a nursing home. The information provided may be used to determine the suitability of the applicant for employment by the facility in a position involved in direct patient care.

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[27] Sections 1919(b)(4) and 1819(b)(4) of the Social Security Act.

[28] Health Care Financing Administration. Report to Congress: *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, summer 2000.

[29] As of March 11, 2000, only 27 out of the 13,200 Medicare and Medicaid certified facilities, 800 Medicare only licensed facilities and 2,300 Medicaid only certified facilities in the Nation received waivers for either RN or LPN coverage requirements, 23 of which were for facilities in Minnesota and Oklahoma.

[30] Sections 1919(b)(5) and 1819(b)(5) of the Social Security Act.

[31] CFR 483.154 and 42 CFR 883.152.

State Requirements. All states have licensing laws that establish requirements that nursing homes must meet in order to operate in the state. These requirements may be very similar to Medicaid and Medicare certification standards and may include additional requirements, such as one staff member to eight residents during the day shift, one staff member to 12 residents in the evening shift and one staff member to 20 residents during the night shift (Maine). With regard to staffing, requirements vary across states and pertain to staff per number of beds, number of staffing hours per patient per day, shifts, etc. A 1999 survey found that 37 states had additional staffing requirements beyond the federal standards while 13 states and the District of Columbia had none. According to the survey, 28 states required nursing homes to determine staffing by the number of hours of nursing care per patient day (e.g., in Florida, nursing homes must have sufficient staff in order to provide an average of 1.7 hours of nurse aide and 0.6 hours of LPN staff time for each resident during a 24 hour period). The survey also reported that 11 states require that staffing be determined by a minimum number of caregivers to resident ratios (e.g., Arkansas required that there be one nurse aide to every seven residents during the day shift). In addition, seven states require that a RN be present 24-hours per day, 7 days a week.[32]

Table 2 describes the range of state staffing requirements, from no requirements beyond federal standards to significantly more demanding requirements. It is important to note that the general nature of federal staffing rules grants states flexibility in interpreting and implementing federal guidelines. There may, therefore, be significant variation in staffing even across those states that have no additional state requirements.

[32] Health Care Financing Administration. *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, summer 2000.

Table 2. Comparison of State Nursing Home Staffing Requirements

No state regulation/law beyond federal standards[a]	Somewhat more demanding requirements than federal standards[b]	Significantly more demanding requirements than federal standards[c]
AL, AZ, DC ,KY ,MO, NE, NH, NM, NY, ND, SD, VT, VA, UT	AK, CO, CT, DE, HI, IN, IA, KS, LA, MD, MN, MT, NC, OH, OK, OR, RI, TN, TX, WA, WY, WV	AR, CA, FL, GA, ID, IL, ME, MA, MI, MS, NV, NJ, PA, SC, WI
Type of nurse staffing requirement[d]		
Number of hours of nursing care per patient day	**Minimum number of caregivers to resident ratio**	**RN 24-hours 7-days a week**
CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, LA, MD, MA, MI, MN, MS, MT, NV, NJ, NC, PA, TN, TX, WA, WV, WI, WY	AR, KS, LA, ME, MI, OH, OK, OR, SC, TX, WV	CA, CO, CT, HI, MD, PA, RI

Source: Health Care Financing Administration, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, summer 2000.

[a] These states do not specify any additional nurse staffing requirements beyond the federal standards.
[b] These states have specified nurse staffing requirements through law and/or regulation, in addition to the federal requirement.
[c] States categorized in this column require more than 2.25 staff hours per resident day or more than one staff member to 9 residents in the day shift, 13 residents in the evening shift, and 22 residents in the night shift.
[d] Some states appear in more than one category because they may have more than one type of requirement.

Home Health Agencies

Federal Requirements. Under Medicaid law, public and private home health agencies or organizations that provide Medicaid home health services must meet the requirements stipulated in Medicare statute and regulations.[33] Staffing rules under Medicare specify the credentials required for nurses and the training required for nurse aides. Registered nurses employed by home health agencies, for example, are required to have graduated from an approved school of professional nursing and be licensed as a registered nurse by a state in which he or she is practicing.[34] Medicare law also states that home health aides can only be used (either on a full-time, temporary, per diem, or other basis) once they have completed certain training

[33] Regulation 42 CFR440.70.

[34] Regulation 42 CFR484.4.

and competency evaluation programs.[35] Federal regulations specify the training and licensing requirements for home health agency (HHA) nurse aides, including a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands on the job.[36] In addition, aide training must be at least 75 hours, 16 hours of which must be classroom training and 16 hours of which must be supervised practical training.

Medicaid also covers home care services under an optional personal care benefit and voluntary home and community-based waivers. Services covered under these options include both licensed nurse and paraprofessional services. Under these options, states define staffing standards.

Finally, in addition to requirements for staffing and training, P.L. 105-277 enabled home health agencies to request the Attorney General to provide the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history corresponding to an applicant who would provide direct patient care for the agency. The information provided may be used to determine the suitability of the applicant for employment by the agency in a position involved in direct patient care.

State Requirements. Some states have licensing laws that establish requirements that home health agencies must meet in order to operate in the state. These requirements may be very similar to Medicaid and Medicare certification standards and may include additional requirements. In addition to licensure laws, most states have laws that enable health agencies to conduct criminal background checks for certain categories of employees. These laws have been passed in response to state policy-makers' concerns about the safety and health of home health beneficiaries. As of April 2000, 32 states had laws that required or allowed agencies to investigate the backgrounds of potential employees for previous criminal activities.[37] In some of these states, laws also cover employees of nursing homes and other long-term care residential facilities.

Payments to Nursing Homes and Home Health Agencies

Combined Medicaid and Medicare expenditures make up the majority of nursing facility and home health spending in the Nation. In 2000, they accounted for 58% of total nursing home care spending (including both nursing homes and intermediate care facilities for the mentally retarded) and 47% of total home health agency spending. Nursing homes and home health agencies also receive funding from individuals who pay out-of-pocket and private health insurance plans that pay

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[35] Section 1891(a) of the Social Security Act.

[36] Regulations 42 CFR484.4 and 42 CFR484.36

[37] For more information on state laws concerning criminal background checks see *Analysis of State Criminal Background Check Laws for Home Health Care Employees.* American Association for Home Care, April 2000.

for both skilled nursing care and other long-term care benefits. Nursing homes and home health agencies use their total funding stream to pay for the cost of patient care, wages and benefits for nursing personnel, and other costs deemed necessary by the providers, such as profits in the case of for-profit nursing facilities or agencies. There are no laws or regulations stipulating how providers must allocate these funds.

Some policy-makers, health care practitioners and advocacy groups have argued that inadequate staffing levels are, in part, due to inadequate Medicaid and/or Medicare payment levels to nursing homes and home health agencies. Others suggest that the problem of a tight labor market for nurses could be addressed by increasing payments from private payers (i.e., out-of-pocket and long-term care insurance). Those who do not support this view attest that these rates are already high. Currently, there is no law that regulates payments by private payers to nursing homes or home health agencies.

Nursing Homes

Medicaid is the largest public payer for nursing home care, making up 48% (about $44 billion) of total spending in 2000 (this amount includes both nursing homes and intermediate care facilities for the mentally retarded). Medicare plays a smaller role, comprising 10% (about $10 billion) of nursing home spending in 2000. Out-of-pocket spending represented 27% of all spending for nursing home care (about $25 billion) and private health insurance represented 8% of the total spending for nursing home care (about $7 billion). The remaining 7% is paid by other federal and state programs as well as some private sources.[38]

Medicaid Payments to Nursing Facilities. Nursing facilities receive Medicaid payments for long-term care services provided to individuals who meet income, asset and categorical eligibility criteria prescribed by federal and state laws. Medicaid is a federal-state means-tested program whose costs are funded by federal and state matching payments.[39]

Within broad federal guidelines, states set payment levels to nursing homes for services provided. Before enactment of a provision known as the Boren amendment in 1980 (Medicare and Medicaid Amendments of 1980, P.L. 96-499), states used Medicare cost-based reimbursement methods to pay nursing home providers. In response to concerns about the growth in spending for these providers, and criticism that cost-based reimbursement offered few incentives for providers to perform efficiently, Congress enacted the Boren amendment. The amendment directed states

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[38] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Bureau of the Census. *Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980-2000.*

[39] The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. The federal matching rates ranged from 50% to 77% of states' expenditures for Medicaid items and services. Overall, the federal government finances about 57% of all Medicaid costs. See Section 1905(b) of the Social Security Act.

to pay rates that were "reasonable and adequate" to cover the cost of "efficiently and economically operated" facilities. Subsequently, a number of courts found that state systems failed to meet the test of "reasonableness" and, as a result, some states were required to increase payments to these providers. In response to growing costs that some argued strained state budgets, the National Governor's Association repeatedly asked Congress for relief from the Boren requirements. The Balanced Budget Act of 1997 (P.L. 105-33) repealed the Boren amendments, giving states greater discretion to determine their payment rates to nursing homes. The provisions allow states to set payment methodologies and determine its own rates for those services provided. States are required to publish their rates as well as the underlying methodologies and justifications for the rates. The Balanced Budget Act of 1997 also required the Secretary to study the effect of states' rate-setting methods on access to, and quality and safety of, services.

Medicare Payments to Skilled Nursing Facilities. Nursing homes participating in Medicare are known as SNFs. They can receive payments for the services they provide to Medicare beneficiaries in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis after hospitalization.

Medicare payments to skilled nursing facilities are determined under a prospective payment system (PPS) which sets payments in advance of a beneficiary's stay according to expected use of resources by a person assessed with certain clinical and other characteristics. Under PPS, nursing facilities receive a fixed payment for each Medicare-covered day a beneficiary spends in the facility. A standard protocol classifies new patients into one of 44 resource utilization groups (RUGs). Each RUG payment covers all costs that, on average, should be sufficient to pay for a beneficiary in that group. These payments are intended to cover all costs for nursing and paraprofessional aide services and each RUG reflects a different mix of skilled nursing and other personal care. RUG payments are adjusted by the Medicare hospital wage index to reflect the costs of labor in a particular geographic area relative to other areas.[40]

Private Sector Payments to Nursing Facilities. Private pay rates charged by nursing facilities vary by state and facility. In some facilities, private pay rates for a day of care include supplemental services such as physical therapy or prescription drugs, and in other facilities they do not. The level of private rates are determined by the provider and the payer.

Private health insurance plans sometimes make payments to nursing facilities on behalf of beneficiaries who require acute and or long-term care benefits. For the most part, employer-sponsored group plans cover only skilled nursing care for acute medical needs and do not cover custodial care.[41] In a HayGroup study of 1,008 U.S. companies in 2000, 98% reported offering skilled nursing home coverage under their

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[40] For more information on Medicare payments to SNFs, see CRS Report RL30859, *Medicare Provisions Enacted in the 106th Congress for Skilled Nursing Facilities; Hospital Outpatient Departments; Hospice; and Home Health Agencies*, by Carolyn L. Merck.

[41] Health Insurance Association of America. *Who Buys Long-Term Care Insurance in 2000? A Decade of Study of Buyers and Nonbuyers*. Washington, DC, October 2000.

employer sponsored health plans for recovery care in lieu of hospitalization. Often other types of long-term care services, such as custodial care, are not covered.

Long-term care policies are available in the individual market or in the employer-sponsored group plan market. A total of about 6 million long-term care policies were sold as of 2000 (includes both the individuals market and employer-sponsored market). As of 1999, there were over 3,000 employers who offered long-term care insurance plans as an optional benefit available to their employees and about 800,000 employees who purchased such plans.[42] A study by Mercer/Foster Higgins found that 15% of employer-sponsored health plans offered long-term care insurance to their active employees, while only 4% provided such coverage to their retirees. In addition, 6% of employers made long-term care insurance coverage available to the parents of their active or retired employees.[43] On September 19, 2000, former President Clinton signed the Long-Term Care Security Act (P.L. 106-265), making private group long-term care insurance available to federal workers, retirees and certain relatives by mid-FY2002. Such long-term care insurance policies cover custodial services, such as nursing home and home health care.[44]

Private long-term care benefits generally include a dollar amount per day of care (e.g., $100 for each day a person is in a nursing home so long as the individual meets eligibility criteria). Payments to nursing homes vary and sometimes the beneficiary is required to pay the difference between the nursing home charge and the insurance payment. Nursing homes use the funds received from private payers toward the cost of patient care, wages and benefits for nursing personnel, administrative and maintenance costs, as well as a variety of other purposes deemed appropriate by the providers.

Home Health Agencies

Medicare payments comprised about 28% (about $9 billion) of total home health care spending in 2000 ($32 billion), while Medicaid payments comprised about 18% ($6 billion). The fact that Medicare pays a greater proportion of home health services can be partly attributed to the fact that Medicare is the primary payer for services covered by both Medicare and Medicaid for those eligible for both programs. Out-of-pocket and private health insurance totaled 20% ($6 billion) and 24% ($8 billion) respectively. The remaining 10% ($3 billion) was paid for by other public and private sources, such as local charities.

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[42] *Who Buys Long-Term Care Insurance in the Workplace? A Study of Employer Long-Term Care Insurance Plans 2000-2001*. Prepared for Health Insurance Association of America by LifePlans, Inc. Washington, D.C. October 2001.

[43] Mercer, William M. *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000*. Report on Survey Findings, New York.

[44] Mercer, William M. *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000*. Report on Survey Findings, New York.

Medicaid Payments to Home Health Agencies. Medicaid pays home health agencies to provide part-time nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home to qualifying Medicaid beneficiaries. States may also chose to provide optional services, such as physical therapy, occupational therapy, speech pathology and audiology services. Medicaid law requires that home health services be prescribed by a physician's written plan of care. Home health services are available to individuals qualifying for Medicaid's general benefit package, as well as to certain individuals who qualify for Medicaid home and community-based waiver program. Just as states receive federal matching funds to pay nursing homes, they also receive federal matching funds to pay home health agencies and for other home care services. States determine the rates they pay for such care.

Medicare Payments to Home Health Agencies. Home health services under Medicare are provided to beneficiaries who need skilled nursing care on an intermittent basis or therapy services and who also meet Medicare's requirements for being homebound. Covered home health services include skilled nursing care, physical therapy, speech-language pathology, occupational therapy and home health aide.

As of October 1, 2000, home health agencies have been paid using a prospective payment system (PPS).[45] Agencies receive a fixed payment for a 60-day episode of care, set in advance of delivery of care. The actual payment received for a specific beneficiary will depend on which of the home health resources groups (HHRGs) the beneficiary is assigned. Those payments are adjusted by the hospital wage index to reflect the relative wage levels in a geographic area.[46]

Private Sector Payments to Home Health Agencies. Private pay rates charged by home health services vary by state and facility. Home health agencies use the funds received from private payers toward patients' cost of care, wages and benefits for nursing personnel, administrative and maintenance costs, as well as a variety of other purposes deemed appropriate by the providers.

Private health insurance plans sometimes make payments to home health agencies on behalf of beneficiaries who require acute and or long-term care benefits. For the most part, employer-sponsored group plans cover only home health for acute medical needs and do not cover custodial care.[47] In a study of 1,008 U.S. companies in 2000, the HayGroup reported that employer sponsored health plans generally cover home health care as recovery care in lieu of hospitalization and do not cover custodial care. For a discussion of long-term care policies see above.

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[45] This change was a result of the Balanced Budget Act of 1997.

[46] For more information on home health services and eligibility, see U.S. Congress. House. Committee on Ways and Means. *2000 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*. 106th Congress, 2nd Session, WMCP:106-14, October 6, 2000.

[47] Health Insurance Association of America. *Who Buys Long-Term Care Insurance in 2000? A Decade of Study of Buyers and Nonbuyers*. Washington, DC, October 2000.

Policy Issues and Legislative Activity

Widespread accounts of problems health care providers have had in attracting and retaining nursing personnel have led to action at the federal level by both the Department of Health and Human Services (DHHS) and Congress. On August 1, 2002, The Nurse Reinvestment Act (P.L. 107-205) was enacted, having been passed by the House on December 20, 2001 and by the Senate on July 22, 2002. P.L. 107-205 addresses issues related to recruitment, training and retention of nurses and paraprofessionals through amendments to the Nursing Workforce Development Act, Title VIII of the Public Health Service Act. For FY2002, Congress also appropriated $10.2 million for the Nursing Education Loan Repayment Program (NELRP) under Title VIII of the Public Health Service Act. Under NELRP, HHS repays the educational loans of clinical care nurses who agree to work for 2 years in facilities that are in areas with nurse shortages. Other funds from HHS appropriations for FY2002 will be used for a variety of activities intended to increase the number of qualified nurses and the quality of nursing services, increase the number of nurses with bachelor's and advanced degrees, diversify the workforce, and prepare more nurses for leadership roles in public health.[48]

Legislation in the 107th Congress

P.L. 107-205 addresses staffing inadequacies by creating programs under the Public Health Service Act that will be targeted on specific goals, such as attracting more people to the professions, providing scholarships for nursing education, and paying education costs. Other proposals have been introduced that would prohibit health care providers from requiring nursing personnel to work overtime, mandate staffing levels, change payment rates under Medicaid and Medicare, facilitate the use of foreign nurses; and enhance the role of family caregivers through tax incentives. The Nurse Reinvestment Act (P.L. 107-205) and other Congressional proposals are described below.

The Nurse Reinvestment Act will

- Establish a National Nurse Service Corps Scholarship Program that provides scholarships to individuals seeking nursing education in exchange for no less than 2 years of service in a health care facility located in critical nursing shortage areas;
- Develop career ladder programs to assist individuals in obtaining education required to enter the nursing profession and advance within the profession;
- Provide student loan assistance of up to $30,000 (indexed for inflation) for certain persons pursuing degrees in nursing. Partial loan forgiveness will apply to those individuals who retain nurse faculty positions for at least 1 year;
- Recruit new nurses through public service announcements developed by the Secretary of Health and Human Services, and through grants to support state

[48] The Nurse Education Act (Title VIII of the Public Health Service Act) is the primary source of federal funding for nurse education programs.

and local advertising campaigns that promote the nursing profession and provide information about financial assistance for nurse education; and

- Require the General Accounting Office to conduct studies of national variations in nursing shortages at hospitals, nursing homes, and other health care providers; the hiring differences among nurses by nonprofit private entities and private entities; the effectiveness in increasing the number of applicants to nursing schools.

Another proposal that was introduced by Representative Holt, The Nursing Home Staffing and Quality Improvement Act of 2001 (H.R.118), would provide grants to nursing facilities that participate in Medicare and Medicaid. The bill, among other things, would authorize the Secretary of the Department of Health and Human Services to provide competitive grants to qualifying states that have skilled nursing facility and nursing facility staff levels sufficient to provide at least 2 hours per day of direct care to residents. The grants could be used to test innovative ways to (1) recruit new staff members to work in nursing homes, (2) increase education and training of nursing staff (including designing or implementing programs to promote the career advancement of certified nurse aides), and (3) provide bonuses to nursing homes that meet state quality standards.

Prohibiting Mandatory Overtime. Some bills were introduced in the House of Representatives that would limit the number of overtime hours employers can require nursing personnel to work. Representative Pete Stark introduced the Safe Nursing and Patient Care Act of 2001 (H.R. 3238). This bill would amend Medicare law to prohibit Medicare providers, such as hospitals or nursing homes, from requiring RNs and LPNs to work in excess of the scheduled work shift or duty period of the nurse; 12 hours in a 24-hour period; and 80 hours in a consecutive 14-day period, except under specific conditions. Representative Tom Lantos introduced the Registered Nurses and Patients Protection Act (H.R. 1289). This bill would amend the Fair Labor Standards Act of 1938 and is slightly more restrictive in the number of allowable hours that nursing personnel can be required to work than H.R. 3238. This bill would prohibit employers from requiring licensed health care employees to work more than 8 hours per day, or 80 hours in any 14-day work period, except under specific conditions. Both bills would prohibit employers from discriminating or taking any other punitive action against employees who refuse to work overtime.

Implementing Minimum Staffing Requirements. A variety of bills were introduced in the House of Representatives that would impose minimum staffing requirements on nursing homes across the country. Representative Waxman introduced the Nursing Home Quality Protection Act of 2001 (H.R. 2677) that would, among other purposes, amend Medicaid statute to require nursing homes to comply with minimum staffing levels determined by the Secretary, or in the absence of the Secretary's determination, require nursing homes to comply with the staffing standards proposed by the Hartford Institute for Geriatric Nursing and the National Citizens Coalition for Nursing Home Reform. The bill would also require nursing homes to conduct criminal background checks, using state and federal records, on employees and all candidates for employment who would provide services in areas where residents are present. Representative Schakowsky introduced a bill entitled Quality Care for Nursing Home Patients Act of 2001 (H.R. 3331), that would require nursing homes to have one licensed nurse per every 15 residents during the day, 20

residents in the evening and 30 residents during the night. It would also require nursing homes to have one paraprofessional for every five residents during the day, every 10 residents during the evening, and every15 residents during the night.

Changes to Payment Mechanisms under Medicaid and Medicare. Proposals intended to bolster the supply of nurses and paraprofessionals by increasing payment levels to nursing homes and home health agencies under Medicaid and Medicare were introduced by Senator John Kerry (S. 706) and Representative Lois Capps (H.R. 1436).[49] These proposals would provide (1) Medicare payments to nonhospital providers, such as rural health clinics, federally qualified health centers and Medicare+Choice organizations that contract with hospitals to provide RN training; (2) Medicare payments to hospice programs and home health agencies that conduct nurse training; and (3) enhanced federal matching payments under Medicaid to nursing facilities for CNA training.

Other Legislation

Senator Harry Reid and Representative Maurice Hinchey introduced companion versions of the Patient Safety Act of 2001 (H.R. 1804 and S. 863) that addressed issues associated with the nurse workforce. The legislation would amend Medicare law to require providers to make public specific information on staffing levels and mix as well as patient outcomes. Mandates would be set for the disclosure of the number of RNs, LPNs and unlicensed personnel providing direct care; the average number of patients per RN providing care; patient mortality rates; the incidence of adverse outcomes; disclosure of complaint information; and methods used for adjusting staffing levels and patient care needs.

In addition to the provisions described above, H.R. 118, introduced by Representative Holt, would also amend Medicare and Medicaid to enable states to pay bonuses to nursing homes that meet state quality standards and/or avoid quality violations. Medicare and Medicaid would also be amended to require skilled nursing facilities and nursing homes to report data on staffing levels to the Secretary of the Department of Health and Human Services.

State Activities

States play a major role in designing, administering, and financing long-term care programs. They have been developing their own plans to address the supply of quality personnel in the long-term care sector. A recent survey found that 42 states considered paraprofessional recruitment and retention a major workforce issue.[50]

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[49] Senator Kerry later introduced a revised version of S. 706, as S. 1597, without provisions amending Medicare and Medicaid laws. The Senate Health Education Labor and Pensions Committee, which reported S. 1597, does not have jurisdiction over Medicare and Medicaid.

[50] *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers*. North Carolina Division of Facility Services, September 1999, p. 3.

In addition to the creation of task forces to examine long-term care workforce issues, states have taken specific policy actions. For example, seven states have established minium wage rates for paraprofessionals that are up to $1.35 higher than the federal minimum wage. Other states have legislated higher reimbursement rates for in-home services provided during night, weekend, and holiday shifts. The reimbursement of travel expenses for home health workers is another issue being considered by states.

A number of states have focused on ways to professionalize the nursing aide and home health aide occupations as a way to decrease turnover. For example, a number of states have introduced legislation to authorize additional funding to train nurse aides. One state has introduced legislation to authorize the creation of a resident attendant category for workers in nursing homes. These workers would provide basic support services to fully trained nurse aides. The use of welfare program training funds is also being considered by a number of states as a way to train welfare recipients to be nurse aides.[51]

States have also been active in addressing problems faced by the registered nurse labor force. In addition to funding studies of the education and training needs of the nursing workforce, some states have required facilities to collect and report data on nursing personnel and establish specific RN to patient ratios in a variety of hospital and community settings.[52]

A related approach requires that some portion of an increase in state Medicaid payments (and other public funding sources) to long-term care providers must be (or intended to be) used to increase wages and or benefits for nursing aides. Typically, "wage pass-through" legislation has either designated some specified dollar amount (e.g., $.50 or $1.00) or designated a certain percentage of the increased state payments be used for wages and or benefits. As of November 2000, 16 states reported having implemented "wage pass-through" legislation. These states are Arkansas, California, Colorado, Illinois, Maine, Massachusetts, Missouri, Michigan, Minnesota, Montana, Oregon, Rhode Island, South Carolina, Texas, Virginia and Washington.

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[51] *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers*. North Carolina Division of Facility Services, September 1999, pp. 4-6.

[52] *Perspectives on the Nursing Shortage: A Blueprint for Action*. American Organization of Nurse Executives. October 2000, p. 67.