Center for Health Care Strategies

Forging a Path Forward to Strengthen Michigan's Direct Care Workforce

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By Courtney Roman and Diana Crumley, Center for Health Care Strategies

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Contents

Introduction 3

Methodology 6

Economic Analysis Highlights 9

Key Themes from Interviews 12

Challenges Facing the Direct Care Workforce in Michigan.................... 12

Policy Objectives to Support DCWs: The Path Forward 15

A Roadmap for Strengthening the Direct Care Workforce 18

1. Focus and organize state-level efforts relating to the direct care workforce.................... 18

2. Use federal funding and flexibilities.................... 20

3. Prioritize DCW-related goals in Medicaid managed care contracts.................... 23

4. Build a centralized training infrastructure. 24

5. Continue plans for building a virtual Michigan Care Career Online Platform. 24

6. Leverage the DCW Advisory Committee.................... 24

7. Talk about the job differently at every opportunity.................... 25

Conclusion 26

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

Introduction

Across the U.S., direct care workers (DCWs) are responsible for most of the hands-on care for older adults and people with disabilities, including those who require personal assistance services. These individuals may have any of the following job titles: certified nurse aides, direct support professionals, home health aides, hospice care aides, personal care assistants, and/or psychiatric aides.[1] DCWs may be employed in home-based settings, adult day centers, and long- term care facilities, among others, and perform tasks such as bathing, dressing, housekeeping, meal preparation, medication management, and more intensive medical care and assistance. These important workers provide essential support for older adults and people with disabilities who may not have family or informal caregivers to provide the day-to-day care they need. The state of Michigan, like many other states, has been grappling for years with challenges to meaningfully support DCWs — many of whom are women, people of color, and living at or near the poverty level.[2] The COVID-19 pandemic only heightened the urgency of developing strategies to attract new workers to the field and strengthening the direct care workforce,[3] especially as more older adults and people with disabilities seek to avoid institutions to live in home- and community-based settings.

The challenges DCWs in Michigan face are significant. First, DCWs are highly underpaid — in part due to low Medicaid reimbursement rates — but also because of a deeply rooted undervaluing of the work within the health care system.[4] Pay is often so low that many Michigan DCWs qualify for publicly funded programs such as SNAP and Medicaid.[5] Due to low wages, long hours, and the demanding nature of the work, there is a high rate of DCW turnover, with many moving on to jobs with fewer hours and higher pay in other industries such as hospitals, retail, and fast food.[6] High turnover was also exacerbated by the COVID-19 pandemic because Michigan DCWs often lacked access to paid time off if they became infected, had to quarantine, or lost reliable child care.[7]

Second, while the state of Michigan cleared a significant hurdle by creating a set of evidence-based core competencies for DCW training[8] and has long advocated for strategies to implement training for DCWs,[9] many employers in Michigan still struggle to find consistent ways to provide comprehensive and flexible training for DCWs. While some employers require a certain number of hours for basic certification, there are few federal training requirements and DCWs are often performing tasks outside their limited training.[10]

Finally, DCWs and the work they provide to individuals in Michigan are essential — but are not always viewed as such by society.[11] Advocacy for DCWs is strong in Michigan, but a concerted culture shift is still needed across the broader health care system and the public in general, where DCWs are valued for the skilled work they perform as health care professionals.

Key stakeholders in Michigan are acutely aware of the challenges the direct care workforce faces and the implications it has for meeting the needs of the growing older adult population. There is still a need, however, for a concrete plan for tackling the issues in a systematic way. Effectively strengthening and sustaining the direct care workforce cannot be addressed piecemeal, but instead needs a comprehensive approach involving state government, advocates, providers, consumers, and DCWs — in addition to a societal cultural shift.

Purpose of Project and Report

With funding from the Michigan Health Endowment Fund, the Center for Health Care Strategies (CHCS) sought to develop considerations and identify concrete next steps to support the state of Michigan in expanding and strengthening its direct care workforce. The work consisted of three elements:

1. **CHCS partnered with the Michigan Department of Health and Human Services (MDHHS), Bureau of Aging, Community Living, and Supports (ACLS Bureau),**[12] **and the ACLS Bureau-led DCW Advisory Committee** to understand the direct care workforce policy landscape in Michigan, the challenges faced by the state, and the ideal path forward to better support the direct care workforce.
2. **CHCS conducted a scan of 11 states to identify examples of legislation related to the direct care workforce, effective training curricula, and ways American Rescue Plan Act (ARPA) funds are supporting DCW improvements**. The purpose of the scan was to offer Michigan concrete examples of what other states have done regarding training and legislation to support DCWs.
3. **Public Sector Consultants (PSC),**[13] **a public policy consulting firm based in Lansing, Michigan, provided an economic analysis of the direct care workforce in Michigan**. Specifically, PSC produced a living wage and turnover cost analysis to paint a more complete picture of the DCW landscape in the state.

Unlike most states, there is tremendous momentum in Michigan to make significant changes regarding the direct care workforce. Stakeholders are aligned and robust efforts are underway to institute permanent wage increases for all DCWs, develop a centralized training hub, professionalize the workforce through a credentialling system, and implement a robust online platform that would allow DCWs and care recipients/employers to build profiles and "match" to each other. CHCS sought to analyze these opportunities — along with key stakeholders' and listening session participants' remarks — and develop considerations for Michigan geared toward moving these activities forward.

This report discusses the three elements of the project and includes:

1. **Methodology**;
2. **Summary of PSC's findings** from its DCW living wage and turnover cost analysis;
3. **Key themes from interviews** and listening sessions with DCWs; and
4. **Considerations for Michigan** as it works to strengthen the direct care workforce.

Methodology

The following section describes the methodology used for the various elements of this project, including attending DCW Advisory Committee meetings, conducting key stakeholder interviews, facilitating DCW listening sessions, performing a state scan research, and developing an economic analysis.

Direct Care Workforce Advisory Committee

From January 2021 through November 2021, CHCS virtually attended monthly DCW Advisory Committee meetings, led by staff at ACLS Bureau. Formed in February 2020, this group of stakeholders, consisting of representatives from state agencies, researchers, academia, advocacy, providers, is working to improve and strengthen the direct care workforce in Michigan. By attending these meetings, CHCS had the opportunity to form relationships with the key players and found the depth of their commitment to strengthening the direct care workforce to be an invaluable asset in Michigan. Much of the momentum around this issue in the state is a direct result of the work of the DCW Advisory Committee (see Exhibit 1, page 8, for a select list of engaged DCW-focused groups in the state).

Key Stakeholder Interviews

In order to develop a rich understanding of the policy and advocacy landscape in Michigan around the direct care workforce, CHCS leveraged relationships with the DCW Advisory Committee and conducted 20 interviews between March and April 2021, ensuring that interviewees were varied in terms of geographic location, race/ethnicity, and agency/organization represented (e.g., DCWs, home care agencies, adult day centers, for- and non-profit associations, state government, advocacy, etc.).[14] During the 60-minute interviews, CHCS and interviewees discussed topics including: general observations of DCW policy in Michigan; recruitment, retention, and workforce shortages; training and credentialing; and pay/wages. Interviewees also offered their perspectives on the future of the direct care workforce in Michigan and the steps that need to be taken to support meaningful improvements in the future.

Listening Sessions

CHCS organized and facilitated three virtual listening sessions in March 2021. Participants included two providers, seven DCWs, and four care recipients. CHCS also held separate calls with three DCWs who were unable to attend any of the scheduled sessions.[15] Participants spoke candidly about the challenges surrounding the direct care workforce from their different perspectives. Providers discussed how difficult it can be to recruit and retain workers. DCWs spoke about the challenging nature of their jobs, the low wages and absence of benefits, and deeply rooted lack of respect for the position. Care recipients shared that their DCWs are a lifeline, but it can be challenging to find DCWs with the necessary training and skills to care for them safely. Hearing from those with lived experience through the listening sessions was an invaluable complement to the policy-focused stakeholder interviews. CHCS was able to note firsthand the frequent disconnects between policy and what is happening on the ground.

Direct Care Workforce State Scan Research

While the state has made meaningful strides toward improving and strengthening the direct care workforce, Michigan was interested in learning from other states, particularly regarding existing legislation that supports DCWs and funding streams for training — two underdeveloped areas in Michigan.

To that end, CHCS conducted a scan of 11 states (Colorado, Illinois, Indiana, Iowa, Massachusetts, Minnesota, Nevada, New Jersey, Tennessee, Washington State, and Wisconsin) that are using legislation to support DCWs and/or fund DCW training. During the scan research, the ARPA passed, and states began releasing budget plans. Realizing this could be an important opportunity to use federal funds to support the direct care workforce, CHCS expanded its work to include DCW ARPA funding examples in the scan, ***Strengthening the Direct Care Workforce: Scan of State Strategies***.

Economic Analysis

The final component of this project was an analysis of the DCW living wage and cost of turnover in Michigan, conducted by PSC. For more information, see the report, ***Michigan's Direct Care Workforce Living Wage and Turnover Cost Analysis***.

Exhibit 1. Overview of Michigan DCW-Focused Groups

MICHIGAN DCW-FOCUSED GROUP	DATE FORMED	PURPOSE
DCW Advisory Committee	2020	Led by ACLS Bureau, the DCW Advisory Committee provides insight and direction into development of policies, programs, and procedures to address the direct care workforce shortage in Michigan. The group consists of both Advisor members and Consultants, including representatives from state agencies, researchers, academia, advocacy, providers, associations, and DCWs.
IMPART Alliance	2016	IMPART Alliance is a coalition of researchers, DCWs, care recipients, and agencies working together to develop a competent direct care workforce, improve the lives of DCWs and the individuals they serve, and be a model for the nation.[16] The goals of the coalition are to: (a) develop direct care work as a profession with respected training; (b) promote a standardized program with universal training (Building Training...Building Quality); (c) increase respect and value for the DCW profession; and (d) provide avenues for information exchange for everyone committed to this goal and ways to mobilize rapidly to lobby legislators and raise public awareness.
Essential Jobs, Essential Care	2020	A multi-state initiative led by PHI, Coalition partners in Michigan (IMPART Alliance), New Mexico (New Mexico Caregivers Association), and North Carolina (North Carolina Coalition on Aging), are focused on advancing policy solutions for DCWs across three areas: (1) increasing wages and reimbursement rates; (2) promoting workforce innovations; and (3) improving data collection. PHI provides strategic advocacy guidance, coordination, and technical assistance to support coalition partners in working toward their goals.[17]
Incompass Michigan	1974	Incompass Michigan is a statewide network of mission driven organizations promoting community access and inclusion for people with disabilities and other barriers. Incompass Michigan members serve individuals with intellectual and developmental disabilities, at risk youth, veterans, experiencing homeless, etc. Incompass Michigan and IMPART Alliance have formed a partnership to pilot IMPART Alliance training sessions to DCWs who serve Incompass Michigan members' clients.
Michigan Direct Care Workforce Wage Coalition	2016	A coalition committed to improving wages for DCWs, especially those providing behavioral health services. Members include: Association for Children's Mental Health, Autism Alliance of Michigan, Community Living Services, Community Mental Health Association of Michigan, Disability Rights Michigan, Incompass Michigan, Mental Health Association in Michigan, Michigan Assisted Living Association, Michigan Developmental Disabilities Institute, Michigan Disability Rights Coalition, National Alliance on Mental Health Michigan, and The Arc Michigan. The Wage Coalition commissioned a study that demonstrated — for the first time — a return on investment for the state of Michigan if it were to increase wages for DCWs in behavioral health settings.[18]

Economic Analysis Highlights

The economic analysis conducted by PSC helped provide a more comprehensive view of Michigan's DCW landscape. The study: (1) assessed the size and characteristics of the direct care workforce in Michigan; (2) compared hourly DCW wages to estimated living wages and competitor occupation wages; and (3) assessed the costs of DCW turnover rates. PSC used 2020 Bureau of Labor Statistics data and a living wage methodology from the Massachusetts Institute of Technology (MIT) to support findings.

Key Findings

- **Direct care workforce size and demographics:** Approximately 165,000 individuals are employed in Michigan's direct care workforce, equivalent to four percent of total employment in the state. The direct care workforce is overwhelmingly female, primarily has a high school diploma (34%) or some college (39%) and is mostly white (63%) and Black/African American (29%). The workforce, however, is disproportionately Black/African American compared to Michigan's general population.

- **Wages by DCW occupation in 2020:** Hourly wages for the direct care workforce vary by specific occupation. Certified nursing assistants ($15.18) have higher hourly wages than home health and personal care aides ($11.85) and direct support professionals ($12.43). Individual caregivers under Michigan's Home Help program[19] have the lowest wages ($9.90 without premium pay, $12.25 with premium pay).[20] (See below sidebar for a description of "premium pay.")

Recent Updates: The "Premium Pay" Increase

On April 1, 2020, DCWs received a $2.00 wage increase in the wake of the COVID-19 pandemic, often referred to in Michigan as "premium pay." The premium pay increase was then extended for services provided — March 1, 2021 through September 30, 2021 — to a $2.25 per hour increase above March 1, 2020 DCW wages.

CHCS conducted interviews around the time of the March 2021 premium pay extension, and many interviewees hoped that the pay increase would become "permanent." Starting October 1, 2021, that wage increase is now $2.35 above rates paid March 1, 2020. The wage increase currently only applies to fiscal year 2022 rates.

- **Living wages in 2020:** The MIT living wage methodology considers a "living wage" to be a self-sufficiency wage, meaning the worker does not rely on public assistance, such as Medicaid, but is not high enough to produce savings for retirement or home purchase. As a result, a living wage is largely a paycheck-to-paycheck wage for which the worker can only afford common household expenses. PSC found that in 2020, whether a DCW has a living wage or not depends on the specific occupation and the presence of children. Most DCWs who do not have a child maintain a living wage, particularly if there is another working adult in the household. For DCWs with children, though, very few maintain a living wage. PSC noted these results are consistent with demographic data on the direct care workforce, which indicates that approximately 50 percent rely on public assistance and nearly half have at least one child in their household.[21]
    - ***Certified Nursing Assistants (CNAs):*** PSC found that CNA wages meet or exceed living wage estimates more often than other DCW occupations. While most CNAs without children maintain a living wage, few can if they have children in the home.
    - ***Home Health Aides and Personal Care Aides:*** Only when home health aides and personal care aides have another working adult in the household and no children are they able to maintain a living wage. Few maintain a living wage as a single adult with no children, and almost none maintain a living wage with children.
    - ***Direct Support Professionals (DSPs):*** While PSC found detailed wage data on DSPs to be unavailable, wage data obtained from surveys indicate that DSPs face a very similar dynamic as home health aides and personal care aides.
    - ***Individual Caregivers under the Home Help program:*** Without premium pay, no individual caregivers under the Home Help program would have a living wage regardless of family status. Even with premium pay extended, individual caregivers would face a similar dynamic as home health aides and personal care aides.
- **Competitor wages:** In 2020, PSC found that hourly wages for DCWs were similar to other occupations that DCWs consider as alternative employment, such as fast-food workers, retail salespersons, and cashiers. But, in the wake of the COVID-19 pandemic, select large companies in retail sales and other sectors are offering significantly higher minimum wages than most DCW wages in Michigan, putting competitive pressure on the direct care workforce. While state-level, DCW occupational data is not yet available for 2021, national hourly wages for many low-wage occupations have increased, including DCWs. Inflation has increased as well, offsetting wage gains. However, it is difficult to confirm whether competitive wage dynamics have shifted in Michigan in 2021. According to PSC, anecdotal evidence in

2021 indicates that DCW employers in Michigan are struggling to recruit and maintain workers, in part due to higher wages in alternative occupations. This is acutely concerning given the essential medical and non-medical services DCWs provide to older adults and individuals with disabilities.

- **Turnover costs:** PSC primarily focused on employer turnover costs in its research, which included direct costs, such as separation, vacancy, replacement, training, and worker injury costs, and indirect costs, such as lost productivity, reduced service quality, lost client revenues, lost clients to other agencies, and a decline in employee morale. Estimated employer total (direct and indirect) turnover costs range from $6,160 to $7,893 per turnover occurrence depending on occupation and estimated statewide costs are $684 million per year. Although the focus was on employer turnover costs, PSC identified a direct and indirect cost framework that may still be applicable to other stakeholders, including Michigan (see ***Michigan's Direct Care Workforce Living Wage and Turnover Cost Analysis*** for more details).

PSC's full report offers concrete quantitative evidence of the current state of DCW wages and high cost of turnover, and in turn, what that means for the future of the workforce and profession. CHCS heard important points during interviews that are valuable to note. First, while PSC found that *some* DCWs maintain a living wage (but only if they did not have children in their home), it is important to reiterate that the term "living wage" places DCWs in a paycheck-to-paycheck lifestyle, with limited ability to save or afford items beyond household essentials. Per feedback from some interviewees, hearing that some DCWs earn a "living wage" sounds as if they are paid a fair wage, which all stakeholders in Michigan (including PSC) agree is not the case.

Furthermore, some interviewees and stakeholders have pushed back on the idea of "competitive" or "comparable" professions (terms that are used often in Bureau of Labor Statistics data). While data illustrates that DCWs do leave their jobs for positions in retail, fast food, and hospitals, the concept of "competitive" or "comparable" is perhaps misleading. Compared to those other sectors, the work of a DCW is more demanding, as they often provide care for individuals who have complex care needs, challenging family dynamics, etc. Additionally, the nationwide increase in hourly wages, particularly in the retail and service industries, in a post-pandemic environment may have left DCW wages lagging even farther behind. In October 2021, a DCW in Michigan shared that two fast-food chains and a retail store in her area were offering $14-17 per hour for starting workers, significantly higher than the $12 per hour she is receiving — even with the recent DCW wage increase that was added to the FY22 state budget (i.e., $2.35 per hour above the rates paid on March 1, 2020).[22]

Key Themes from Interviews

In spring 2021, CHCS conducted interviews and listening sessions with DCWs, provider agencies, consumers, advocates, state agency representatives, and other stakeholders to better understand the current environment and how to strengthen DCW supports in Michigan. Interviewees shared stories of love and loss, struggle, and resilience. Care recipients and their family members reflected on how DCWs allowed them to live independently and with dignity. DCWs and provider agencies shared stories of relentless commitment to clients, despite low wages. Interviewees were often emotional and expressed frustration and exhaustion. Over and over, CHCS heard similar themes, under one central core tenet: ***Michigan must act to better support the critically important direct care workforce***.

CHCS' takeaways from these interviews resonate with prior analyses regarding the Michigan DCW context.[23,24,25] Unlike these prior reports, however, CHCS' interviews took place in spring 2021 — about a year into the COVID-19 pandemic. This timing added an *urgency* to these topics, as well as a *hopefulness* — a sense that, *perhaps finally*, change is on its way. Interviewees reflected on the potential for headway, given pandemic experiences, federal attention, and state legislative breakthroughs relating to premium pay. COVID-19 exacerbated longstanding workforce shortages; underscored the essential lifeline DCWs provide, particularly for those who experience social isolation; and further highlighted longstanding gender and racial inequities for DCWs.[26]

Following are key themes and quotes from interviews, organized by: (1) challenges facing the direct care workforce; and (2) key policy objectives for the path forward.

Challenges Facing the Direct Care Workforce in Michigan

- ### Michigan needs more DCWs.

  Workforce shortages are dire and require urgent solutions, otherwise Michiganders will go without care or receive substandard care. Provider agencies and facilities will be short-staffed. These conditions will inevitably lead to mistakes, injuries, and burnout. For example, a 2021 survey of Home Help[27] agency providers found 49 percent do not have enough caregivers to meet the needs of clients, with one provider noting that 40 percent of staff are working overtime to meet client needs.

We knew we had workforce shortages, but COVID amplified it. COVID also revealed the challenge of a known deficiency in a particular facility or region and filling that hole. You can't insert a DCW on the drop of a dime. You're begging and borrowing from other organizations that have "half capacity" and they don't have capacity.

- **DCWs are commonly characterized as "unskilled" workers, despite the breadth of skills required for the position.**

  DCWs have essential, specialized skills and know-how. Experienced DCWs have developed their skills through on-the-job experience, and in partnership with their clients and clients' families. For some DCWs, health plans, employers, and federal regulations require extensive training, such as in the case of home health aides, certified nursing assistants, and direct support professionals caring for clients with intellectual and developmental disabilities and/or behavioral health needs. The DCW Advisory Committee has taken important first steps by defining core competencies.

We want people to understand that this is a complicated job. It's hard work. Our staff get about twice as much training as a certified nursing assistant. It's a highly sophisticated job that takes a lot of effort and supervision. And, the general community doesn't tend to recognize that.

- **DCWs should have higher wages and better benefits.**

  DCW wages and benefit packages are not commensurate with the breadth of skills that these jobs require, nor the psychological and physical toll they take. DCWs that participated in interviews and listening sessions often shared how they used their "whole body" in their work, as well as their whole heart — physically lifting their clients, caring for them with empathy, and mourning those that pass. DCWs can often make more money in non-specialized, entry-level jobs, or by collecting unemployment. Low pay, persistent poverty, and personal health concerns can drive turnover.[28]

You pay your babysitter more than this. You've got to talk about the wages and benefits. This is really intimate, person-centered work. You want to attract people who see it as a career. It starts with being able to feed your family and getting benefits.

- **Low Medicaid and Medicare reimbursement rates hamstring employers' ability to attract and retain workers.**

  Provider agencies often feel their hands are tied and find it difficult — if not impossible — to compete with other employers like Amazon and Target, which have much higher base wages. Higher Medicaid and Medicare rates could enable higher wages, provided appropriate accountability measures were put into place (such as those tested through recent COVID-19 "premium pay" increases).

In many cases, the solution is raising wages, and raising wages forces public policy change. This is not sustainable. In our view, we need to look at it from the standpoint of how do we raise reimbursement for services to address the issue of professionalizing the industry and making sure that we're able to pay living wages.

- **DCWs do not always receive support and respect.**

  Interviewees described factors influencing turnover, including conflicts with supervisors, inconsistent hours, inadequate benefits, injuries, and poverty and related disruptions. A more supportive work environment — small notes of appreciation, supportive supervisors, rides to work when personal cars break down, mileage and training and/or tuition reimbursement, consistent hours, and robust benefit packages — can help keep DCWs engaged but can only go so far.

Even before, but especially now with the virus and pandemic, these people are basically trying to survive and work at the same time. They've been taken advantage of and devalued for so long. It's hard to let them know: 'Listen, you are important. You are essential.' This is a job. The fight is not there anymore.

- **DCWs serve individuals in a patchwork of siloed programs.**

  DCWs provide services to individuals affiliated with many different programs and can specialize in serving individuals with varying needs (e.g., individuals with disabilities or with behavioral health needs, older adults, etc.). This patchwork of programs and eligibility criteria complicates opportunities to strengthen supports for DCWs. Michigan needs big-picture, large-scale efforts to tackle this complex problem.

The other issue is in the funding streams and how services are paid for, because they're all different. It's almost like you have to meet a certain eligibility loop to get support at all.

Policy Objectives to Support DCWs: The Path Forward

Interviewees across all stakeholder groups generally agreed on five major policy objectives, which are summarized below.

- ### Increase wages and improve benefits.

  CHCS repeatedly heard variations of the same theme: Make recent legislatively mandated wage increases (i.e., "premium pay") permanent, but do not stop there. Ensure that DCWs receive a strong, competitive wage, and that employers receive Medicaid reimbursement rates that can support those higher wages now and in the long term.

  Some interviewees warned that other strategies, such as training and certification programs, may be ineffective or counterproductive without first increasing wages — especially as a growing number of large employers raise starting wages for non-specialized, entry-level positions.

  The immediate impact of wage increases on recruitment and retention (or the most appropriate size of the wage increase, given low starting levels) is not yet known. In a 2021 survey of Home Help agency providers, 77 percent used increased wage offerings as an incentive to recruit new Home Help caregivers, with 24 percent of agencies using sign-on bonuses and 24 percent using benefits (sick leave and vacation time) as incentives for new employees. Nonetheless, roughly half of agency providers reported an insufficient number of DCWs to serve client needs. Wage increases were likely limited by the level of Medicaid payment to Home Help agency providers ($18.71 per hour in fiscal year 2022, which includes administrative overhead).

- ### Design training and certification programs that empower DCWs.

  Training programs should foster a sense of purpose and accomplishment, as well as continuous career development opportunities. They should be inherently flexible and avoid imposing barriers to entry into the workforce.

  Interviewees warned against an unfunded mandate for training and unnecessary fragmentation across DCW training programs.

The idea of a Universal DCW is important — one that meets all competency standards for work with any population, program, setting, etc. We need to get away from a siloed, fractured system and toward one that is more portable, coordinated, standardized, and based on professionalism and efficiency.

They voiced support for dedicated, sustainable funding for this training, as well as a certification that can "follow" DCWs from job to job. Interviewees often cited Medicaid funding as a potential resource for training but noted that there have been efforts to think beyond Medicaid. In the absence of substantial, dedicated funding from the legislature, one interviewee noted that agencies providing home- and community-based services (HCBS) can nonetheless dedicate portions of incremental rate increases to training — for example, as a quality improvement activity for the MI Choice Waiver Program.

Recent Updates: IMPART Alliance Proposals for ARPA Funds

In July 2021, IMPART Alliance developed a proposal to use ARPA funds to develop a multi-level training infrastructure.[29] The proposal suggests using ARPA funds to infuse one-time startup costs into building infrastructure, which over time will create sustainability as training and support leads to job satisfaction, retention, and career pathways. By the end of 2022, IMPART Alliance suggests that the state create a centralized recruitment and training center, with regional hubs and outreach programs to widen the pipeline.

Additionally, the recruitment and training center would include both a training arm and credentialing arm to ensure DCWs receive stackable, client-centered training and credentials to further their careers. The proposal has received support in initial meetings with key stakeholders at Michigan and Health and Human Services and appears to be on the right path forward.

- **Recruit and retain more DCWs.**

  Interviewees uniformly expressed the need to recruit and retain more DCWs. As noted in a recent report from Altarum and PHI, there are 36 home care workers for every 100 likely consumers statewide, with the lowest home care workforce ratio in the rural Upper Peninsula (23 workers for every 100 likely consumers).[30]

- **Develop ways for DCWs to connect with each other and with potential clients.**

  Interviewees often shared personal stories of caring for family members and noted how important it is for DCWs and family caregivers to feel supported and connected. Interviewees noted that IMPART Alliance's DCW directory and DCW forum[31] seeks to develop this support network. Interviewees also noted difficulties finding qualified DCWs and described the benefits of an online platform to connect DCWs and those who need DCW services.

- **Start a culture change campaign and connect investments in the direct care workforce to broader state health care goals.**

  Interviewees reflected on how society unjustly diminishes DCWs and people who need their services. Interviewees frequently cited the need for a broad culture shift, and a deeper understanding and appreciation of how valuable, essential, and "skilled" the role is of DCWs.

  At a personal level, those who received support from DCWs characterized that support as indispensable, and integral to maintaining their quality of life. At a more macro policy level, interviewees noted how a robust direct care workforce can enable better, more value-based care. For example, several interviewees noted DCWs were essential to a statewide strategy to reduce health care costs and keep individuals at home and in the community (and out of high-cost nursing facilities and emergency departments). DCWs help facilitate access to preventive care and represent essential lifelines for those experiencing social isolation.

Preventive care is not just medicine, it's also the social services and long-term support services that are so needed. Often, some of the only contact these people have is their DCW. So that makes them feel like, 'Somebody sees me.' That DCW not only provides a service that's tangible, but also an intangible service by sitting and listening.

A Roadmap for Strengthening the Direct Care Workforce

There is tremendous momentum at the state level around the need to better support the vital direct care workforce. Michigan is in a unique place and time to make lasting change. The following considerations may support the policy objectives in the previous section and help guide the state toward growing, strengthening, and sustaining the direct care workforce:

1. Focus and organize state-level efforts relating to the direct care workforce.

Over the last five years, Michigan stakeholders have come together to discuss issues facing the direct care workforce — such as wages, training, and professionalizing the workforce — creating groups such as: the DCW Advisory Committee; IMPART Alliance; PHI's "Essential Jobs, Essential Care" initiative; and Direct Care Worker Wage Coalition. These efforts have made significant headway in identifying issues affecting the direct care workforce across programs and populations served.

Reflecting on the work that remains to be done, several interviewees noted the need for legislative champions and specific legislative authority to explore and pursue multi-agency, multi-program initiatives to address the direct care workforce shortage. Following are opportunities to focus these state-level efforts on the direct care workforce and support the policy objectives in the previous section (i.e., relating to wages, training, recruitment and retention, DCW-to-DCW and DCW-to-client communications, and culture change campaigns).

1a. Leverage the new bipartisan legislative Care Caucus.

DCW shortages are a complex problem in need of urgent solutions. To tackle this crisis, interviewees expressed the need for a bipartisan group of state legislators to focus on issues affecting the direct care workforce. At the time of this writing, a new legislative "Care Caucus" has formed, made up of legislators committed to improving health care in the state. Members of the DCW Advisory Committee could aim to meet consistently with the Care Caucus to ensure the issues surrounding the direct care workforce are a priority and can work together to create legislation designed to strengthen long-term services and supports with a focus on DCWs and family caregivers.

1b. Develop a state-level task force or response team.

DCWs serve a diverse population with varying needs across various state programs. A state-level task force or response team could help inform state strategies and bring the perspectives of various agencies. These agencies could include: the Department of Labor and Economic Opportunity; the Michigan Long-Term Care Ombudsman; and representatives from the Health and Aging Services Administration and the Behavioral Health and Developmental Disabilities Administration at the Michigan Department of Health and Human Services.[32,33] This task force can come together to determine strategic priorities and establish a cohesive strategy for state and federal funds that can be used to support the direct care workforce. For example, see the Special Task Force on Direct Care Workforce Retention and Recruitment in New Jersey.[34]

1c. Ensure that state agencies have adequate authority and resources to tackle this complex problem.

Several interviewees noted that Michigan needs a better way to quantify and communicate with DCWs, and to establish training standards and core competencies. One interviewee noted the difficulties in disseminating information about personal protective equipment during the COVID-19 pandemic since there is no centralized data on DCWs and their current placements. Another interviewee noted the state currently has limited avenues to require training because it does not license home health agencies (which commonly employ DCWs). Interviewees also reflected on difficulties identifying and connecting funding sources for centralized training resources, absent specific legislative direction given the many programs under which DCWs provide services.

To take on this work, administrative agencies will need specific legislative authority to track and measure impact of policies to strengthen the direct care workforce, as well as dedicated full-time employees for state operations. Specific legislative authority can also empower agencies to braid and — if appropriate — blend funding streams to support training efforts, increase wages, and track effects of different policies on workforce recruitment and retention. It can also provide direction and cohesion to state DCW policy, allowing payment increases and recruitment and retention policies to be tested at scale, instead of piecemeal (i.e., in every relevant waiver, state plan, and Medicaid managed care program and across programs for older adults, individuals with intellectual and developmental disabilities, and

individuals with behavioral health needs). The newly formed legislative Care Caucus could potentially support some of this work.

1d. Prioritize higher wages as a mechanism for growing and stabilizing the direct care workforce.

This report includes an economic analysis using 2020 data — the most current available. Through our interviews and touchpoints with the DCW Advisory Committee, provider agencies shared acute DCW recruitment and retention problems across the state, as large employers are increasing starting hourly wages. (Interviewees often shared anecdotal reports from employers such as Amazon, Target, McDonald's, Wendy's, and Hobby Lobby.) DCWs interviewed described hard decisions they had to make, balancing commitment to their clients and a substantially higher wage elsewhere.

There's a sequence here. It's important to get the wages and fringes better before you demand certification for DCWs because you don't have to be certified to work at McDonald's or Target. So, the employee says, 'The job's hard, it's thankless, it's got crazy hours. The pay is terrible, and you're going to make me get certified to keep it. I'm going to go do something else.'

Interviewees uniformly stressed the importance of training initiatives, but a subset of interviewees warned that prioritizing training and certification efforts over wage increases may backfire and exacerbate the recruitment and retention crisis. To address these concerns, the state could ideally increase wages (and, relatedly, Medicaid reimbursement rates) in tandem with or before the rollout of certification programs.

2. Use federal funding and flexibilities.

The federal government has shown an interest in supporting the direct care workforce.[35] Michigan can take advantage of existing and emerging flexibilities and funding to test strategies to strengthen and support the direct care workforce.

2a. Refine DCW initiatives in later iterations of the HCBS Spending Plan.

ARPA, which passed in 2021, allowed states to tap into enhanced federal funding to support the direct care workforce. Potential activities include: creating financial incentives to recruit and retain DCWs; supporting training; increasing rates to support increased compensation for DCWs; providing leave benefits; and providing specialized payments, including hazard pay, overtime pay, and shift differential pay.

For Michigan, this enhanced federal funding is equal to $61,593,450, and can be spent through March 31, 2024.[36] Michigan's HCBS Spending Plan, submitted in summer 2021, included initial Phase 1 investments, and noted possible Phase 2 and Phase 3 investments, pending additional development and discussions with stakeholders. Specifically, the plan listed several preliminary Phase 2 and Phase 3 initiatives relating to the direct care workforce, including the extension of premium pay, bonuses and hiring incentives, and a statewide database of credentialed DCWs (see Exhibit 2, below). At the time of this writing, Michigan's Medicaid (now Health and Aging Services) director was coordinating with IMPART Alliance, among other stakeholders, to refine these potential spending priorities for Phase 2 and Phase 3. Michigan could draw from examples in state spending plans, such as recruitment and conversion bonuses in the District of Columbia and organized training efforts in California.[37,38] For more examples, see ***Strengthening the Direct Care Workforce: Scan of State Strategies***.

Exhibit 2. HCBS Workforce Development, Phase 2 and 3: Michigan Initial HCBS Spending Plan[39]

CATEGORY	PRELIMINARY LIST OF INITIATIVES
Wages	• Extend Direct Service Provider (DSP) premium pay authorized through this fiscal year. • Enable HCBS recipients and providers who hire DSPs for HCBS service delivery to offer bonuses or hiring incentives to DSPs.
Training and Credentialing	• Establish a statewide training and credentialing system for Community Living Supports providers (like what is done for nursing home aids) with reciprocity requirements. • Establish a statewide database of credentialed DCWs. • Identify and codify Supports Coordinator core competencies, the use of Independent Facilitation, Supports Brokering, and Support Coordinator Assistance; and create uniform statewide online core competency training.

2b. Plan for a cohesive DCW spending strategy if additional federal funding streams become available.

At the time of this writing, members of Congress are negotiating the parameters of an infrastructure bill that includes initiatives to strengthen the direct care workforce. The version of the bill passed by the House includes a section dedicated to recruitment, education, training, retention, and career advancements for the direct care workforce, including: $1.48 billion for direct care workforce grants, and $130 million for HCBS Improvement Planning Grants, which would include an

assessment of payment rates affecting the direct care workforce, among other factors.[40]

To prepare for future federal funding dedicated to the direct care workforce and potential flexibility with existing COVID-19 relief funds, the state can ensure that strategic planning is well underway, in coordination with any established task force and relevant state agencies.

2c. Use Medicaid payments to facilitate access to benefits and skill training for DCWs.

DCWs who participated in our interviews and listening sessions noted poor access to benefits, such as health insurance and retirement. In addition, DCW interviewees noted difficulties in locating potential funding for training and certification programs — despite significant headway in developing a core curriculum via Building Training…Building Quality[41] among other initiatives.

In response to similar concerns across the nation, the Centers for Medicare & Medicaid Services (CMS) recently proposed a rule that would allow state Medicaid agencies to make payments to third parties to facilitate access to benefits such as health insurance and skills training.[42] In press releases and the proposed rule, CMS noted how this rule can be used to strengthen the HCBS workforce, particularly home care workers.[43] Once this rule is approved, Michigan could use this payment flexibility to support access to health insurance and training and certification programs. This step would ideally be in tandem with a rate or wage increase, given that payments would be deductions from existing provider payments.

2d. Embed travel costs (as reasonable costs) into Medicaid rates.

Interviewees noted significant travel time and costs associated with direct care work. As suggested in state Medicaid guidance, overtime costs and compensable travel time costs that are incurred by DCWs cannot be considered administrative costs in the Medicaid program. However, the cost of compensable travel time under the Fair Labor Standards Act can be allocated as a reasonable cost of delivering a covered Medicaid service.[44] This rate setting approach, if not already employed for agencies that employ DCWs, can help build out Medicaid rates that would reflect the true costs of services provided by DCWs.

3. Prioritize DCW-related goals in Medicaid managed care contracts.

Michigan has three types of Medicaid managed care programs. Medicaid managed care organizations (MCOs) arrange for home health services, among other physical health services. Prepaid inpatient health plans (PIHPs) manage specialty mental health and substance use disorder treatment benefits, and often represent community mental health. Prepaid ambulatory health plans (PAHPs), more commonly referred to as waiver agencies, provide services for the MI Choice Waiver program and often represent Area Agencies on Aging. Michigan could work toward embedding DCW-related goals into these contracts in the following ways.

3a. Require minimum enrollee to DCW ratios and tie bonus payments to progressive improvements.

Michigan has required managed care entities to maintain and expand access to certain types of providers. For example, MCOs must maintain a community health worker (CHW) to enrollee ratio (i.e., 1 full time CHW per 5,000 managed care enrollees), and meet network adequacy requirements for a range of Medicaid providers (e.g., 1 to 500 provider-to-enrollee ratio for adult and pediatric primary care providers).[45] Michigan could consider building on this experience to develop a minimum DCW-to-enrollee ratio and incent managed care entities (including PIHPs and PAHPs) to increase this ratio over time, experimenting with strategies such as sign-on and retention bonuses. This trend is consistent with several proposals in state HCBS spending plans, such as New Hampshire's[46] support of sign-on bonuses, retention bonuses, ladder advancement stipends, and competency/training, and a related directed payment program in the context of its managed care program.

3b. Integrate DCW-related strategies into quality improvement efforts.

MDHHS could require that MCOs, PIHPs, and PAHPs test recruitment and retention strategies, and report back on successful models. In particular, these entities could note which wage levels, bonuses, and benefits appeared to be most effective for attracting DCWs, and how these entities used similar strategies to improve retention.

3c. Require managed care entities to participate in statewide or regional collaborations.

These collaborative activities could help increase the number of DCWs and keep managed care entities apprised of related state initiatives for training, certification,

and recruitment. The state could ensure that network providers are aware of workforce development programs, as well as any emerging registries, training hubs, and Department of Labor and Economic Opportunity-affiliated apprenticeship programs (e.g., Registered Apprenticeship Programs and Michigan Industry Cluster Approach (MICA), Going Pro).

4. Build a centralized training infrastructure.

As noted earlier, IMPART Alliance has put forth a thoughtful proposal to use ARPA funds to develop a multi-level training infrastructure. If approved, ensuring DCWs are front and center in all planning and design teams will be important. DCWs' expertise will be critical in ensuring the recruitment and training center is truly accessible, comprehensive, and addresses their unique needs.

5. Continue plans for building a virtual Michigan Care Career Online Platform.

ACLS Bureau and other stakeholders are in the process of building a virtual Michigan Care Career platform (MI Care Career) to connect DCWs and employers/care recipients to each other. While prior programs have been used at various points in Michigan, the current model would operate similarly to Care.com,[47] where DCWs, employers, and care recipients could develop profiles and be "matched" based on care needs, skills, completed trainings, location, work hours, etc. Leaders at ACLS Bureau consulted with stakeholders in Minnesota where a similar model was successfully implemented and considered lessons and best practices in shaping the MI Care Career platform. During CHCS' listening sessions with DCWs, the concept of the MI Care Career platform was well received by participants.

6. Leverage the DCW Advisory Committee.

The significant amount of progress made in Michigan toward strengthening the direct care workforce is a direct result of the DCW Advisory Committee that is convened by ACLS Bureau. The wide range of stakeholders working together to advance their goals is notable and should serve as an exemplar to other states that are trying to develop similar workgroups. The Advisory Committee was formed at the start of the COVID-19 pandemic and has gotten stronger despite the competing priorities the pandemic brought and a change in leadership at ACLS Bureau, which is a testament to the members' level of dedication and commitment. The DCW Advisory Committee has a unique opportunity to take on any of the ideas proposed in this report and continue to

move them forward. Existing workgroups could shift to more current priorities and others could be added. The current Personal Protective Equipment/COVID-19 vaccine workgroup, for example, could eventually pivot to support the new Michigan Care Career platform and additional workgroups could be formed around the legislative caucus, ARPA funds, the new potential training hub, and/or the focus on federal funding and flexibilities. (The latter is particularly relevant given the recent announcement that AASA and the Medical Services Administration have come together under one umbrella agency, Michigan's Health and Aging Services Administration).[48]

7. Talk about the job differently at every opportunity.

In discussing the challenge around culture change with stakeholders, the issue seemed to stem from a fundamental stigma around the work, where it is considered "just" work in the home. Across the nation, work in the home is not consistently valued or thought of as essential, so the work DCWs perform is at a significant disadvantage right from the start. What CHCS heard from stakeholders is the need to talk about this profession differently at every available opportunity. If the pendulum can swing on how this profession is viewed, it would go a long way toward making lasting changes.

In terms of talking about this profession differently, Michigan can consider the following opportunities:

7a. Talk about the value and importance of direct care work.

This can be done at career fairs, high school, and college job fairs, and in mass mailings and communications, among other opportunities.

7b. Use the Legislative Caucus and Governor's task force.

The task force can be leveraged to reframe the messaging around this profession to Executive and Legislative branch leaders so they deeply understand the importance of the direct care workforce. Regardless of political affiliation, everyone will need care at some point over the course of their lives — the need for high-quality, well-trained, and dedicated DCWs will only increase in the coming years.

7c. Hire and train DCW trainers who are committed to advancing the direct care workforce themselves.

Trainers play a critical role in conveying the value and dignity of the position.

7d. Partner closely with DCWs and care recipients to craft and test messages for how to talk about the profession.

DCWs and individuals who receive care from DCWs will be the absolute best source of ideas on how to frame the messaging around the work, its importance, and value.

Conclusion

Observing the work of DCWs, the ACLS Bureau, the DCW Advisory Committee, and the many other stakeholders who participated in interviews and listening sessions over the course of this work demonstrated to CHCS how dedicated Michigan is to strengthening and improving the direct care workforce. Michigan is uniquely positioned to make meaningful improvements given the current momentum in the state.

The DCW Advisory Committee, ARPA funds, attention of the Governor in approving a wage increase for DCWs in the FY22 budget, and the formation of the Health and Aging Services Administration all are levers for change.

The suggestions set forth in this report — coupled with the examples in the state scan and the findings in the economic analysis — could help the state continue making progress and lead to significant and lasting changes to the direct care workforce.

ENDNOTES

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[12] The Bureau of Aging, Community Living, and Supports (ACLS Bureau) was formerly the Aging & Adult Service Agency (AASA).

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[14] Complete list of key stakeholder interviewees: Altarum, ARC Michigan, Community Mental Health Association of MI, Compassionate Care MI, Detroit AAA, Disability Network of Mid-Michigan, Evergreen Commons, Hillside Senior Center, IMPART Alliance, Michigan Assisted Living Association (, Michigan Commission on Services to the Aging, Michigan Department of Health and Human Services (MDHHS) ACLS Bureau, Home Help Program, Michigan Elder Justice Initiative, Michigan HomeCare & Hospice Association, Michigan Medicaid, Perennial Park at Hillsdale County Senior Services Center, Personal Care Aide (PCA) Association, Residential Opportunities, Inc., Wind Beneath Your Wings. Interview domains included: Organization and DCW Advisory Committee Overview; General Observations of DCW Policy in Michigan; Recruitment, Retention, and Workforce Shortages; Training and Credentialing; and Pay. Interviewees received questions from CHCS in advance and each interview was recorded, transcribed for accuracy, and summarized for internal purposes.

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