April 16, 2024

The Honorable Robert Casey
Chairman
Senate Special Committee on Aging
628 Hart Senate Office Building
Washington, DC 20510

The Honorable Mike Braun
Ranking Member
Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Casey and Ranking Member Braun,

We deeply appreciate your shared leadership and commitment to meeting the care needs of older adults while advocating for innovative policy solutions to sustain the aging services sector. We applaud your continued efforts to bring light to issues impacting aging services and are eager to learn from the upcoming hearing, *The Long-Term Care Workforce: Addressing Shortages and Improving the Profession*.

Chairman Casey, we are particularly appreciative of your bold action to support innovative programs coupled with commensurate financial investment through the *forthcoming Long-Term Care Workforce Support Act* and have included a series of recommendations at the end of these comments regarding this important legislation.

LeadingAge represents more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

Demographic Shift

The population of older adults in the U.S. is growing rapidly. The number of adults over the age of 65 will increase by nearly 50%, from 58 million in 2022 to 83 million in 2050.[1] Projections indicate that we will need an additional 3.5 million workers including 2 million registered nurses in the field of aging services by the year 2030.[2] [3] Many of these older adults will require a combination of care and support services provided by a robust cadre of skilled workers. Yet, the working-age, in the United States, is projected to remain static. Put simply, we do not have the

[1] US Census Bureau. (2023, October 31). *2023 National Population Projections Tables: Main Series*. Census.gov. https://www.census.gov/data/tables/2023/demo/popproj/2023-summary-tables.html

[2] Department of Labor. (n.d.). *Occupational Outlook Handbook - Registered Nurses*. Retrieved March 10, 2024, from https://www.bls.gov/ooh/healthcare/registered-nurses.htm.

[3] Zallman, L., Finnegan, K., Himmelstein, D. U., Touw, S., & Woolhandler, S. (2019). Care for America's elderly and disabled people relies on immigrant labor. *Health Affairs*, *38*(6), 919–926. https://doi.org/10.1377/hlthaff.2018.05514

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

necessary supply of workers to meet the current demand for aging services, and it will become increasingly difficult as the population continues to age. We must act now to prepare, develop, and empower a new generation of healthcare professionals to meet the needs of older adults and people with disabilities.

Mismatched Reimbursement Mechanisms

Our country relies on an ill-fitting patchwork of systems that fund and regulate care and support. They include critical social and safety net services, like those outlined in the Older Americans Act and other federal programs, as well as payment and regulatory systems administered by states and the federal government. This complex network of support and services is most evident in the tangled mix of state and federal funding that pays for the lion's share of Long-Term Support and Services (LTSS) through Medicare and Medicaid. In 2021, these two streams covered 64.1% of LTSS at a cost of $299.68 billion dollars.[4] These covered services range from intensive post-acute rehabilitative care extending to a network of Home and Community Based Services (HCBS) that enable older adults to live and thrive in a setting of their choosing. According to a recent AARP survey, more than 75% of adults over the age of 50 indicated their preference to age in their homes and communities.[5] Our desire to receive care in the home extends to end of life where more Americans are dying at home, due to natural causes, than any other time in the last one hundred years. This is due, in large part, to the contributions of hospice and home care professionals. Yet, both provider types, like the rest of the aging services continuum, struggle to recruit and retain the workforce necessary to meet the needs of older adults. [6]

Despite the importance of this work, low wages persist, causing burnout and high staff turnover, due to inadequate and outdated reimbursement mechanisms. During the Covid-19 pandemic states and the federal government invested in aging services through the American Rescue Plan Act and Provider Relief funds that permitted and encouraged increased flexibility and funding that many providers used to invest in the needs of staff, including raising wages. According to a KFF Report, all fifty states reported that increasing payment rates to providers is the primary mechanism they used to increase the number of workers providing services through HCBS programs. [7] Unfortunately, in the wake of the public health emergency, states

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[4] Congressional Research Service. (2023, September). *Who Pays for Long-Term Services and Supports?* Congressional Research Service Reports. Retrieved April 10, 2024, from https://crsreports.congress.gov/product/pdf/IF/IF10343#:~:text=Public%20sources%20paid%20for%20the,LTSS%20spending%20nationwide%20in%202021

[5] Fetterman, M. (2023, November 10). *The future of aging in place . . . is moving?* AARP. https://www.aarp.org/home-family/your-home/info-2023/future-of-aging-in-place.html#:~:text=And%20in%20a%202021%20AARP,both%20the%20people%20and%20places.

[6] Cross, S. H., & Warraich, H. J. (2019). Changes in the place of death in the United States. *˜the œNew England Journal of Medicine (Print)*, *381*(24), 2369–2370. https://doi.org/10.1056/nejmc1911892

[7] Burns, A., Mohamed, M., & Watts, M. O. (2023, October 24). *Payment rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges | KFF*. KFF. https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/

and federal agencies have rolled back the funding and flexibility that allowed providers to leverage innovative programs that sustained the aging services workforce during the crisis.

Recommendation: **Congress should pass the following bills to stop proposed payment cuts and address inadequate reimbursement mechanisms: Preserving Access to Home Health Act of 2023 (S.2137 / H.R. 5159), HCBS Relief Act (S.311 / H.R. 6267), Better Care Better Jobs Act (S. 100 / H.R. 4131), Expanding Veterans' Options for Long Term Care Act (S.465 / H.R. 1815) and the Expanding Service Coordinators Act (H.R. 5177).**

Education and Training

The current education system for direct care professionals and nurses is heavily dependent on registered and advanced practice nurses to provide program direction and classroom training. Nursing instructors working at the collegiate level, including community college, are often required to have advanced nursing degrees but are paid less than half of what their counterparts earn providing direct care, without advanced degrees.[8] Despite critical shortages, nursing schools across the United States turned away more than 91,000 qualified applicants in 2021 due to staffing shortages, limited classroom space, lack of clinical preceptors and clinical training sites.[9]

We need more nurses and caregivers to meet the increasing demand for care. To train this workforce, we need more nursing and caregiving educators. Yet, the education systems for nurse instructors and direct care nurses are not integrated. A nurse seeking to transition from care to education is required to complete costly training, despite many years of clinical experience that uniquely prepares them to train the next generation of caregivers.

Recommendation: **Congress should pass the the following bills to expand the nurse educator workforce - the Train More Nurses Act (S. 2853) and the Palliative Care and Hospice Education and Training Act (PCHETA) (S.2243).**

Discordant Federal and State Training Requirements

Training requirements for direct care professionals lack consistency; for example, there are federal training minimums for home health aides and certified nursing assistants but no such minimums for personal care aides. States can and do mandate training minimums for various categories of direct care workers, depending upon the service they are providing, in what setting, and to which population. Inconsistent training and certification standards and a lack of

[8] Noguchi, Y. (2021, October 25). The U.S. needs more nurses, but nursing schools don't have enough slots. *NPR*. https://www.npr.org/sections/health-shots/2021/10/25/1047290034/the-u-s-needs-more-nurses-but-nursing-schools-have-too-few-slots

[9] Rosseter, R., American Association of Colleges of Nursing, Bureau of Labor Statistics, Auerbach, D., Institute of Medicine, National Council of State Boards of Nursing, Buerhaus, P., U.S. Census Bureau, Nurse.com, American Nurses Foundation, American Nurses Association, American Association of Critical-Care Nurses, & Aiken, L. (n.d.). *Nursing shortage*. https://www.aacnnursing.org/Portals/0/PDFs/Fact-Sheets/Nursing-Shortage-Factsheet.pdf

stackable credentials obstruct progression and overall career pathways for direct care professionals.

Recommendation: **Congress should consider developing and streamlining federal training requirements for direct care professionals and nurses. This should include an exploration of how Licensed Vocational/Practical Nurses (LVN/LPN) and experienced direct care professionals can assume increased training responsibilities for professional caregivers. This should be done with a focus on developing stackable certifications and opening pathways for aging services staff to engage in a lifetime of career development and learning.**

Limited Clinical Training Sites

Nursing and direct care professional training programs rely heavily on collaborative partnerships with clinical training sites, such as skilled nursing facilities. These locations open their doors to trainees, allowing these caregivers to demonstrate the skills they learned in the classroom in a safe and supervised setting and gain valuable exposure to the rewards of a career in aging services. These locations are foundational links in the nursing and caregiving training system that can simply not be replicated. Clinical training sites are becoming increasingly scarce in part due to the CNA Training Lockout, which, under current law, prohibits nursing homes that receive certain civil monetary penalties from hosting CNA training programs for an arbitrary two years. Restricting training in these settings further impedes our ability to prepare the next generation of the healthcare workforce.

Hospice, home health, home care, and other HCBS programs grapple with the additional complexities of training staff in client's homes, where they often face unexpected challenges, such as hoarding that require a wealth of clinical and interpersonal skills without the infrastructure and staff support available in congregate environments.

Recommendation: **Congress should enact the bipartisan Ensuring Seniors' Access to Quality Care Act that would eliminate the rigid provisions found in the Omnibus Budget Reconciliation Act of 1987 (OBRA) and grant the Centers for Medicare and Medicare Services (CMS) greater flexibility in reinstating valuable CNA training programs.**

Supported Pathways and Services

Training programs are responding to the needs of a diverse set of learners and are deploying a myriad of resources and services to help students complete training programs and join the LTSS workforce. The most successful pathway programs engage students early in their scholastic career and provide support and services to maximize their success. These programs have a proven history of fostering diversity in health professions that will help the country to provide culturally concordant care to an increasingly diverse population of older adults.[10]

[10] AAMC. (2021). *Academic Health Center Best Practices Connecting Pipelines to Pathways for Health Equity*. https://www.aamc.org/media/67211/download

The U.S. workforce is grappling with new and unprecedented challenges, requiring employers to develop creative services and support for trainees and employees, such as housing, food, transportation, and financial support to cover short-term emergencies. Service providers are finding creative ways to meet the needs of their clients and employees. Restrictive reimbursement opportunities often limit these critical programs.

Recommendation: **In addition to the targeted FMAP increase outlined above, we urge Congress to increase reimbursement to allow providers to respond to the unique needs of their workforce. This should include providing support services and emergency assistance to staff, on an as needed basis, to increase recruitment and retention. To address shortages across the aging services continuum we encourage Congress to pass the Supporting Our Direct Care Workforce and Family Caregivers Act (S. 1298).**

Immigration

Foreign born workers have long played a critical role in the U.S. economy, particularly within the healthcare system where they make up 18% of the sector's workforce. [11] A report by the Congressional Budget Office found that the U.S. workforce will grow by 5.2 million workers by 2033 driven, in part because of the contributions of the foreign-born workforce.[12] This is particularly evident in the aging services sector where immigrants comprise a large proportion of staff across the sector, currently accounting for 31% of the home care workforce, 21% of the residential care aide workforce, 21% of the nursing assistant workforce, and 30.3% of the nursing home housekeeping and maintenance workforce. [13][14]

Despite the well-documented positive impact of the foreign-born workforce, there have been no meaningful immigration policy reforms since the 1990's, causing a backlog of trained and well-prepared nurses to wait years to move to the United States due to outdated caps on employment-based visas. In 2023 there were an estimated 10,000 nurses caught in this outdated system.

While the United States immigration system stands still, other countries are actively recruiting internationally trained healthcare professionals through streamlined pathways for nurses and caregivers willing to work in healthcare and aging services. We must work together to develop comprehensive and common-sense pathways for nurses and caregivers seeking to immigrate to the United States.

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[11] Batalova, J. B. J. (2023, April 7). *Immigrant Health-Care workers in the United States*. migrationpolicy.org. https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states#:~:text=Nearly%202.8%20million%20immigrants%20were%20employed%20as,the%20United%20States%20in%20a%20health%2Dcare%20occupation.

[12] Congressional Budget Office. (n.d.). *Budget and economic Outlook: 2024 to 2034*. Retrieved March 10, 2024, from https://www.cbo.gov/publication/59710

[13] *Direct care workers in the United States: Key facts - PHI*. (2023, August 3). PHI. https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/

[14] Zallman, L., Finnegan, K., Himmelstein, D. U., Touw, S., & Woolhandler, S. (2019b). Care for America's elderly and disabled people relies on immigrant labor. *Health Affairs*, *38*(6), 919–926. https://doi.org/10.1377/hlthaff.2018.05514

Recommendations: **Congress should pass legislation that addresses critical gaps in the U.S. immigration system, including significantly increasing caps on employment-based visa programs, prioritizing nurses, and caregiving professionals. We urge Congress to pass the following bills to expand immigration pathways and increase supports for immigrants working in the aging services sector: Asylum Seeker Work Authorization Act (H.R. 1325) and Assisting Seekers in Pursuit of Integration and Rapid Employment (ASPIRE) Act (H.R. 4309 / S. 2175, Healthcare Workforce Resilience Act (S. 3211), Leave No Americans Behind Act (H.R. 6205), and the Immigrants in Nursing and Allied Health Act (H.R. 3731).**

Ensuring Access to Medicaid Services

CMS recently proposed the HCBS Medicaid Access Rule that would require states to ensure that 80% of Medicaid payments for three home and community-based services (home health, home maker and personal care) are directed to wages and benefits for direct care workers. The expressed goal of this provision is to enhance wages and benefits for workers providing direct care. We applaud the intent, though we have grave concerns regarding data infrastructure, clinical supervisory oversight, reporting, and existing rate adequacy, among others.

CMS's proposal does not give providers enough room in their budgets to cover necessary costs – including those important for high-quality care, like training and supervision. If a provider were to remain operational in the face of this requirement, they would likely end up not raising pay to try to achieve compliance but rather reducing investment in other administrative functions that support quality. If this provision is enacted as proposed, more people will go without care and not see the growth in wages that CMS is seeking.

Most critically, a proposal like this cannot be considered without more federal dollars. In the current environment, the math does not work for this proposal – even if a state legislature were to provide substantially more state Medicaid dollars, an 80/20 split as defined by CMS would not be achievable – nor do we feel it has the right incentives considered in its inception. As mission-driven providers of aging services – our members are already teetering on the edge by offering these services through the Medicaid program. This proposal would harm providers and limit care options for older adults.

Recommendations: **Congress should delay the implementation of the 80/20 requirement contained in the proposed HCBS Access Rule until a comprehensive plan is in place to fund a substantive expansion of the aging services workforce that includes affordable and accessible education, increased availability of nurse educators, and a focused FMAP increase to support infrastructure development and ensure competitive wages for all aging services workers.**

Proposed Nursing Home Staffing Standard

Similarly to our concerns regarding the proposed HCBS Access Rule, we are equally aware of the potential negative consequences of the proposed nursing home staffing standard. LeadingAge supports efforts to improve quality and safety in our nation's nursing homes and is committed to ensuring that high-quality nursing home care is available for those who need it. However, the

proposed policies will not be implementable and will effectively limit access to nursing home care, as our mission-driven providers are forced to reduce the number of individuals they serve or to close altogether due to a lack of available workforce to meet these unfounded and unfunded standards.

Recommendation: **Congress should enact the *Protecting American Seniors' Access to Care Act (H.R. 7513)* to stop the implementation of the proposed staffing standard.**

Long-Term Care Workforce Support Act

We are invigorated by the bold vision outlined in the forthcoming *Long-Term Care Workforce Support Act.* If enacted, the investments in the long-term care workforce would help to set our sector on a new, sustainable path that will allow our mission-driven members to meet the full needs of older adults across the country. We look forward to continuing to work with the Chair to address our concerns regarding the forthcoming bill, which are outlined below.

Title I

Creation of a Cliff

With both sections, but particularly Section 102, we are concerned about what happens when federal financial assistance runs out. While we appreciate that the funds are to supplement and not supplant state support, there will still be a time at which the additional federal funds to support enhanced pay are no longer available. Once workers' pay is raised, the new expected wage level must be sustained, and should be sustained.

Recommendation: States submit a plan as to how they propose to sustain and support higher wages once federal funding ends – but that these plans cannot not rest solely on the backs of providers.

Waiting Lists

It appears that a condition of receiving money under Section 101 (page 12, lines 12-13 of the LTC Workforce Support Act draft dated 04-08-2024) is that the State provide assurances they will be utilizing the funds to eliminate waiting lists. In Section 102 (page 17, lines 5-7 of the LTC Workforce Support Act draft dated 04-08-2024), the bill requires that payment rate increases for workers be prioritized toward HCBS workers in states that have a waiting list for HCBS services. Between the two components, a sizeable proportion of the funds could go toward clearing waitlists. While we do not want people in need of services to continue to wait, waitlists have not been found to be a precise indicator of need in each state.[15] From LeadingAge's perspective, if the funds are balanced toward clearing waiting lists, they may not reach older adults or the direct care professionals who serve them. The bills focus on waiting lists may also limit the number of states that are able to take advantage of the money, for example, in a state like Texas whose waitlist comprises 50% of the total waiting list enrollment in the entire

[15] https://www.macpac.gov/wp-content/uploads/2020/08/State-Management-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf

country[16] could command a large portion of dollars while states with no waiting lists but whose workforce still need support may not receive sufficient dollars.

Recommendation: **Please consider dedicating specific funds to clearing waiting lists. These funds should be distinct, ensuring that other potential uses do not get crowded out.**

Passthrough Threshold

Similar to our comments on the proposed HCBS Access Rule, we are supportive of the intent of an 85% passthrough threshold, particularly the fact this applies to the additional funds proposed in the bill. but it is not tenable for LeadingAge members, and we fear unintended consequences, including significant administrative burden should a pass through, as proposed by CMS, that is applicable to the entire Medicaid rate be enacted. All pass throughs regardless of whether imposed on the full rate or funds added to enhance rates fail to account for increasing costs in training, clinical supervision, technology and enabling contracts, among others. No passthrough should be considered without adequate data collection at the provider level to assess any imposed effects.

We recognize two important distinctions between the bill's proposal and the proposed HCBS Access Rule. The first is that you are providing funding. We do not want to minimize this as it is critical, and we appreciate that the Chair realizes that to reach its goals, funding needs to follow. However, the funding is time-limited; therefore, if the funding were to be reauthorized, would the threshold apply in perpetuity?

The second distinction is that, we think, the Chair intends that the threshold elements be designed with stakeholder input. We intuit this from page 16, lines 32-33 (of the LTC Workforce Support Act draft dated 04-08-2024) which refers to page 16, lines 20-27 of the same document. The proposed HCBS Access Rule threshold design did not consider the costs of critical elements like clinical supervision, training, travel, technology, and more. A stakeholder process would allow for these elements to be considered.

Recommendation: **We strongly encourage that the phrase "but may also include" be removed from page 16, line 26 (of the LTC Workforce Support Act draft dated 04-08-2024). Providers must be included both in the rate-setting process and in the formation of any passthrough threshold for which they will be held accountable by their states.**

While we recognize the improvements in the bill's passthrough proposal with regards to financing and the development of the threshold elements, as we commented on the HCBS proposed Access Rule, the infrastructure does not exist to make a passthrough work. As Medicaid programs vary, so too do states' data collection processes. Few states require cost reporting for home and community-based services. Any type of uniform requirement regarding wages must have a universal reporting structure, whether that be in the form of a cost report

[16] https://www.kff.org/medicaid/state-indicator/medicaid-hcbs-waiver-waiting-list-enrollment-by-target-population-and-whether-states-screen-for-eligibility

or some other mechanism. Any data collection infrastructure needs to be inclusive of the information on rates discussed above. We understand this poses generality concerns as uniform data reporting would be tremendously difficult with the unique variability in state Medicaid programs. This is precisely the reason we urge careful consideration of broad payment allocation provisions without adequate and adequately specific data to support the proposal. Some of our state partners do not even think that this type of proposal could be implemented effectively in nursing homes, which do have more intensive reporting structures.

Recommendation: **At a minimum, the thresholds must align with their timelines for implementation and structures for reporting. We urge you to contemplate a delay in the payment adequacy component of the proposed HCBS Access Rule to align with the bill's timelines. We recommend the Chair provide specified funds from the bill to create this infrastructure rather than imposing a passthrough requirement. This could begin with reporting requirements related to these specific dollars and how they are tracked.**

Some providers – homemaker, home health, and personal care – may be subject to two parsing reporting both on total Medicaid rate expenditures, and as a function only of the increase. These conflicting thresholds depending on the source of dollars will be confusing for states and providers, administratively burdensome, and duplicative in reporting nature. How would states track this? How would providers?

Title II

Complex Grant Structure

We applaud the significant financial investment in training and pathway development through education and wrap-around support services such as transportation and childcare. A seismic investment of this kind requires an equally developed infrastructure to ensure these dollars are well spent and accessible to the communities that need them most.

Recommendation: **Where possible, combine the grant funds under one authority, such as the Bureau of Health Workforce within the Health Resources and Services Administration (HRSA). This office would be charged with educating potential grantees on the various streams of funding, providing technical assistance, and ensuring timely and comprehensive reporting and analysis.**

Mental Health Services for Aging Service Professionals

The Aging Services workforce is navigating new and unprecedented challenges in the wake of the Public Health Emergency (PHE), our workforce reporting increasing levels of stress. We welcome additional support for mental health care. However, like the aging services workforce, the healthcare system is experiencing strains and limited staffing. Many of our members report increasingly limited accessibility to counselors and mental health providers. We encourage authorization of additional flexibilities to allow providers to offer virtual counseling across state

lines, as Secretary Beccera supported in his recent comments to the Senate Finance Committee on March 14, 2024.[17]

Recommendation: **We encourage authorization of additional flexibilities to allow providers to offer virtual counseling across state lines, as Secretary Beccera indicated in his recent comments to the Senate Finance Committee on March 14, 2024.**

Scholarships and Stipends
Direct financial supports to aging service workers to advance their career through training and education pathways is imperative. However, 45% of the direct care workforce relies on public assistance programs.[18] We are concerned that any direct cash assistance may cause these workers to lose access to life saving benefits for their families.

Recommendation: **We suggest clarification if these stipends or scholarships will count toward an income threshold and if they will, conducting an analysis of the potential impact on access to benefits.**

Title III
We have a variety of questions and concerns about this Title but will highlight four provisions.

Written Agreement (Subtitle B, Sec. 312):
LeadingAge members work cooperatively with their staff to ensure a shared understanding of the terms, conditions, and expectations of employment, including compensation, benefits, etc. We are concerned that the requirement to establish binding written agreements with all direct care professionals imposes significant administrative burdens for employers, duplicates delivery of information that already is routinely provided, limits the ability of employers to make changes to its employment policies, and potentially could be interpreted to mean that employment arrangements are presumed not to be "at will." We suggest exploration of alternatives, such as evaluation of employer notification requirements, rather than written agreements.

Fair Scheduling Practices (Subtitle B, Sec. 313):
Ensuring that the needs of residents and clients are met in a dynamic care environment is an on-going challenge, and these provisions raise numerous practical concerns. We recognize the importance of predictability and consistency for employees, but note that resident and client need change rapidly, with constant fluctuations in caseloads, care plans, and staff schedules and availability. An employer might need to cancel or shorten a shift, or otherwise adjust work schedules for a variety of reasons; this section's requirement of a 72-hour notice of a shift

[17] *The President's Fiscal Year 2025 Health and Human Services Budget*. (n.d.). https://www.finance.senate.gov/hearings/the-presidents-fiscal-year-2025-health-and-human-services-budget
[18] Staff, N. (2023, October 24). *The direct care workforce*. NASHP. https://nashp.org/the-direct-care-workforce/

changes and related provisions, in many cases, may deprive employers of the flexibility needed to ensure delivery of needed services, and impose additional costs.

Workplace Violence Prevention Standard (Subtitle C):
LeadingAge recognizes and appreciates the importance of protecting workers from acts of violence. We have participated in the work OSHA initiated in 2023 concerning a potential regulatory standard, and we are concerned that the specificity in this subtitle will potentially limit the opportunity for public comment to inform and shape future OSHA rulemaking on this important issue. As we have previously shared in written comments to OSHA, certain key principles are important, including: 1) One size does not fit all. Any OSHA standard relating to workplace violence must reflect the significant diversity of employers that would be covered by it, such as the size of the organization, the services the specific organization provides, the specific characteristics and needs of the population it serves, and the service delivery setting; 2) standards in this area must provide flexibility, not be overly prescriptive, and avoid duplicating requirements that employers already meet under federal certification or state licensing requirements, conditions of payment through state Medicaid programs, or standards applied by accrediting organizations; and 3) it is important that OSHA accurately estimate and consider the costs of complying with such a standard, including the estimated labor burden relating to the framework.

Improving Access to Job Benefits: Paid Sick Leave (Subtitle D):
We agree and recognize that increased benefits are an important part of addressing the ongoing workforce shortages our sector is facing. However, we are deeply concerned about the cost of complying with this mandate absent additional funding. Additional staff will be needed to accommodate the leave provided in the bill, and it's uncertain where those staff will be found. Aging services providers, including our members, are heavily dependent on public healthcare programs to reimburse them for the services they deliver, at rates established by a federal agency or by a state, depending on the program. Unfortunately, Medicaid funding is inadequate to cover the full cost of delivering care for many services and in many states. And while Medicare rates may be higher than Medicaid, they may not be sufficient to fully offset labor and non-labor costs that have risen significantly in recent years. Medicare payment rates for home health care, for example, have been subject to baseline cuts under payment rules CMS has recently finalized for this provider type.

General Comments:

Recommendation: **We request that home health (section 1891) and hospice (section 1814) be added to the definition of long-term care setting (page 9, line 14-25 of the LTC Workforce Support Act draft dated 04-08-2024). They should be eligible for funds through the various grant programs – they use direct care workers, and those workers deserve the same opportunities for professionalization, training, pay, etc. as their counterparts across the long-term care workforce. Home health and hospice are critical services and should be included in these funding opportunities so that they can compete for and afford quality staff.**

Recommendation: **Remove the phrases "As applicable" or "but may also include" in reference to including employers or providers in stakeholder engagement, advisory groups, grant opportunities, etc. in this legislation. If providers, like our members, are not engaged in the process of improving the workforce, the impact is not going to be what the proposed legislation envisions. We want to have well-paid, highly trained, and dedicated staff and want to be engaged in activities that are trying to achieve these goals. Providers' voices are important, and we ask that the bill be clear at every opportunity that providers are a critical stakeholder in these important efforts.**

Chairman Casey and Ranking Member Braun, we appreciate your ongoing commitment to older adults and to supporting a workforce that empowers older adults to age in the setting of their choosing. We look forward to continued partnership and collaboration to develop and sustain a robust aging services workforce.

Thank you for your consideration. Please reach out to Nicole Howell at nhowell@leadingage.org with any questions or to discuss any of the ideas in this letter.

Katie Smith Sloan

President & CEO
LeadingAge