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Addressing the Direct Care Workforce Shortage: A Bipartisan Call to Action

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DISCLAIMER

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Executive Summary

For over two decades, the United States has had a long-standing shortage of direct care workers.[1] These workers include personal care aides, certified nursing assistants, home health aides, residential care aides, psychiatric aides, and other occupations. This worker shortage is straining the health care system, harming care access and quality for the millions of adults and children in the United States with long-term care needs, and contributing to potentially avoidable federal and state spending.

Federal agencies have warned of the urgent need to address the problem soon, as the aging of the baby boomers will only exacerbate it.[2] Although the number of direct care workers more than doubled from 2.2 million in 2000 to 5.1 million in 2022, the supply of direct care workers will fall short of the demand associated with 8.9 million projected job openings from 2022-2032.[3,4,5] The COVID-19 pandemic widened that gap, as many health care workers left their employment—due to such factors as risk of infection or lack of child care—and many did not return.[6] The overall U.S. labor force has rebounded since the beginning of the public health emergency (PHE) in February 2020, but direct care employers still struggle to recruit and retain workers.[7]

Fifty-four percent of nursing homes surveyed in 2023 had to limit new patient admissions, while home health care providers said they turned away over 25% of referred patients because of staffing shortages.[8,9,10] Accordingly, hospitals and health systems report increased delays discharging patients for post-acute care.[11] For example, from 2019-2022, the average length-of-stay increased 20% for those hospital patients being discharged to skilled nursing facilities and almost 13% for those being discharged to home health agencies.[12] These delays not only increase the strain on hospital capacity and resources, they are also associated with poor health outcomes for patients, including increased risk of mortality, hospital-acquired infections, depression, and reductions in patients' mobility and activities of daily living (ADLs).[13,14]

The number of people who need long-term services and supports (LTSS) is a helpful indicator of national reliance on, and demand for, direct care workers. The most recently available data indicates that almost 23 million adults in the United States reported significant difficulty with at least one of six domains of functioning—including seeing, hearing, mobility, communication, cognition, or self-care—in 2019.[15] Among those adults, close to half, or 10.2 million, were age 65 or older.[16] Many children with disabilities or functional limitations also rely on LTSS. From 2019-2020, about 3.6 million children experienced functional limitations.[17]

Direct care workers help address these needs by providing hands-on assistance with daily tasks and other LTSS in a variety of care settings. Although Medicaid is the primary payer for LTSS delivered by direct care workers, Medicare and private payers (including private long-term care insurance and out-of-pocket spending) also finance these services.[18] Total LTSS spending in the United States reached $467.4 billion in 2021, the most recent year for which data were available.[19] Because many individuals prefer to receive care in their homes from family members or friends, unpaid caregivers play a major role in alleviating demand for paid direct care workers. According to recent estimates, about 38 million caregivers in 2021 were unpaid, and the estimated economic value of their care reached approximately $600 billion.[20]

There is increasing bipartisan interest in addressing the direct care workforce shortage. Members of Congress across the aisle have recently held hearings, solicited stakeholder feedback, and introduced bipartisan legislation to resolve this crisis. The Biden administration and Congress have also taken important but limited steps to help expand the direct care workforce (see Looking Ahead). However, further comprehensive federal policy reforms are necessary to address the long-standing, deeply rooted challenges to recruiting and retaining direct care workers.

BPC has an extensive track record of working to improve care for individuals with chronic conditions and has released several reports with federal policy recommendations to improve access to LTSS for older adults and individuals with disabilities.[a] In recent years, BPC produced a mounting body of work with federal policy solutions to address worsening shortages of health care providers, including behavioral health, nursing, and rural health providers.[b,c] In this report, BPC builds on that prior work to address the shortage of direct care workers across institutional and home and community-based care settings.

Through research, interviews with stakeholders and federal policy experts, and a private roundtable discussion, BPC identified key challenges to expanding the direct care workforce and federal policy reforms to address those challenges. Specifically, we identified three major challenges to recruiting and retaining direct care workers:

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a See BPC's reports: *An Updated Policy Roadmap: Caring for Those with Complex Needs*, March 2022, available at: https://bipartisanpolicy.org/report/a-policy-roadmap-caring-for-those-with-complex-needs/; *Improving Access to and Enrollment in Programs of All-Inclusive Care for the Elderly (PACE)*, October 2022, available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/10/BPC_PACE_Report_Final.pdf; and *Improving the Medicaid Buy-in for Workers with Disabilities*, December 2022, available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/12/BPC_Health-MBI-Report_RV4.pdf.

b See BPC's report, *Filling the Gaps in the Behavioral Health Workforce*, January 2023. Available at: https://bipartisanpolaicy.org/download/?file=/wp-content/uploads/2023/01/BPC_2022_Behavioral-Health-Integration-Report_RV6Final.pdf.

c See BPC's report, *Confronting Rural America's Health Care Crisis*, April 2020. Available at: https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/.

1. work environments that do not effectively support workers' needs and contribute to feeling undervalued, largely due to inadequate and stagnant wages and benefits, limited access to training, and a lack of career lattices for professional advancement;
2. domestic workforce programs that predominantly target more medicalized or credentialed professions and an immigration system that is not structured to ensure adequate visa and green card pathways exist for foreign-born workers who desire to help fill unmet demand for direct care workers;[d] and
3. the absence of standardized data collection and publicly available data on the volume, stability, compensation, and profile of the direct care workforce to better measure the effects of federal policy reforms to expand the workforce and inform evidence-based policymaking.

Addressing these challenges is critical to not only ensuring a robust direct care workforce, but also to promoting gender and racial equity, as the current workforce is comprised disproportionately of women (86%), people of color (60%), and immigrants (25%).[21] Comprehensive federal policy reforms can help to stabilize the direct care workforce and close the care gap for those with LTSS needs. This moment also presents an important opportunity for federal policymakers to improve care access and quality while making progress in fully integrating individuals with disabilities into the community, as required by the Supreme Court in *Olmstead v. L.C.*[22,e]

This report includes bipartisan legislative and administrative federal policy solutions to (1) promote retention of direct care workers through reforms that encourage more supportive work environments, including assisting unpaid caregivers who incur significant financial burdens while relieving pressure on the paid workforce; (2) increase the number of workers through domestic and immigration policy reforms; and (3) improve standardized data collection and publicly available data on the direct care workforce to measure the effects of these efforts and inform evidence-based policymaking.[f]

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d See BPC's reports: *The Demographic Transition: An Overview of America's Aging Population and Immigration's Mediating Role*, September 2023, available at: https://bipartisanpolicy.org/report/demographic-transition/; and *Filling the Gaps in the Behavioral Health Workforce*, January 2023, available at: https://bipartisanpolicy.org/report/filling-gaps-in-behavioral-health/.

e Olmstead v. L.C., 527 U.S. 581 (1999). In this 1999 opinion written by Justice Ruth Bader Ginsburg, the Supreme Court held that states must provide community-based services to those with a mental disability when: 1) treatment professionals have determined that community placement is appropriate; 2) the individual does not oppose a community-based setting; and 3) community-based care can be reasonably accommodated, considering the state's resources and the needs of others with mental disabilities.

f In this report, recommendations relating to state Medicaid programs apply to all the relevant political jurisdictions, including the 50 states, the District of Columbia, and the U.S. territories administering Medicaid programs.

Direct care workers are critical to ongoing federal and state efforts to promote high-value care for individuals with complex needs, and the shortage of these workers is likely to have negative effects on health care spending over the long term. Undervaluing and underinvestment in the direct care workforce through the years has led to the need for significant federal policy reforms. Some of the reforms will now require upfront federal and state investment to achieve potential long-term cost-savings—such as savings from better health outcomes, fewer avoidable hospitalizations, or workers' reduced reliance on public benefits—and tax revenue from new workers entering the labor force (see The Direct Care Workforce Shortage and Its Effects; Challenges to Recruiting and Retaining Direct Care). Federal policymakers should aim to offset the federal costs associated with the policy recommendations in this report to achieve budget neutrality. Some of our recommendations, such as a caregiver tax credit for LTSS-related expenses (which has a budgetary cost that is well above those associated with the other recommendations), can be adapted as necessary to match the available offsets by modifying design features, such as qualifying criteria for the tax credit or that of their care recipients.

Recommendations

I. Ensure Supportive Environments to Increase Worker Retention

A. The Centers for Medicare & Medicaid Services (CMS) and Congress should strengthen transparency and oversight of states' Medicaid provider payment rates for certain LTSS and direct care workers' compensation as an initial step toward ensuring adequate Medicaid provider payment rates and competitive compensation for direct care workers.

i. **Building on its recently proposed rules, CMS should require states to annually publish select LTSS Medicaid provider payment rates and the percentage spent on direct care workers' compensation in a standard format across both home and community-based and institutional settings.**

ii. **CMS should require states to establish a direct care workforce compensation advisory group to advise the state on proposed provider payment rate changes and appropriate wages for direct care workers.**

iii. **Congress should appropriate a maximum total of $1 million to each state for conducting at least a total of two market rates analyses: one within three fiscal years and another within**

six fiscal years after the enacting legislation becomes law. The analyses should compare the state's median Medicaid hourly wages for direct care workers delivering select LTSS to median hourly wages for private market direct care workers. States' analyses should also examine how direct care workers' compensation compares to that of occupations with similar entry requirements in the state.

iv. Congress should require states to create, submit to CMS, and publicly publish strategies outlining the state's provider rate-setting methodology for select LTSS. The strategies should also detail the state's plans for monitoring provider payment rates and direct care worker compensation. States should publish their strategies within four fiscal years after the enacting legislation becomes law. Congress should require that states not meeting certain standards following the sixth fiscal year conduct one additional rate study analysis and update their strategies.

B. Congress should direct the Department of Health and Human Services (HHS) to conduct a national study and provide a report to Congress on the relationship between the increased Federal Medical Assistance Percentage provided by the American Rescue Plan Act (ARPA) and its effects on the direct care workforce, associated costs, and quality of care. Within the study, HHS should:

- collect and analyze qualitative data and, when available, quantitative data;
- identify the state-level workforce investments that improved direct care worker recruitment or retention, reductions in federal and state costs, and enhancements in quality of care; and
- describe how states modified training requirements for and compensation to direct care workers, including payments to family caregivers under the consumer-directed services model.

C. The Administration for Community Living (ACL), through its National Technical Assistance and Resource Center, should assist states in developing and implementing recruitment and retention initiatives that address direct care worker shortages, including (1) developing career lattices for direct care workers and (2) establishing or improving direct care worker training programs, which should allow workers to self-direct their career trajectory through continuing education opportunities and should be available in multiple languages.

D. The Center for Medicare and Medicaid Innovation (CMMI)

should conduct a demonstration program, considering lessons learned from Kansas' PEAK 2.0 Program and Minnesota's Value-Based Reimbursement Program, across several states; this program should test a new value-based demonstration for Medicaid payments, where Medicaid provides incentive payments to nursing facility providers that meet certain quality standards and benchmarks for workforce development and staff satisfaction.

E. Congress should appropriate $4 million for the National Health Care Workforce Commission in FY2025 to perform a comprehensive evaluation of the health care workforce, including the direct care workforce landscape. The commission should deliver a report to Congress within three years of receiving the appropriation, describing findings of the evaluation and providing policy recommendations to strengthen the impact of federal education and training programs on mitigating the workforce shortage. It should also offer strategic partnership to HHS, the departments of Labor, Veterans Affairs, and Homeland Security, as well as other federal agencies administering federal workforce programs, to ensure the programs address health care labor shortages.

F. As part of a larger update to tax policy required in 2025 due to many expiring provisions, Congress should establish a refundable tax credit for caregivers to help with out-of-pocket costs for paid LTSS-related care, allowing those with qualifying incomes to claim up to a maximum $3,000 credit for each qualifying family member. Congress should scale this credit as needed, consistent with a full tax plan that strengthens the overall fiscal outlook.

II. Grow the Number of New Workers via Domestic and Targeted Immigration Reforms

Domestic reforms to increase the number of direct care workers

A. The Labor Department and Congress should strengthen registered apprenticeship programs.

i. Congress should provide statutory authority for the Labor Department's Office of Apprenticeship, the National Advisory Committee on Apprenticeship, and state-level administrative units.

ii. The Labor Department should approve personal care aides as a registered occupation within its Registered Apprenticeship programs.

B. Congress should reauthorize federal workforce development programs under the Workforce Innovation and Opportunity Act (WIOA) and career and technical education programs under the Carl D. Perkins Career and Technical Education Act through FY2030.

C. Congress should establish a grant program and appropriate $225 million to support up to 75 grantees with awards of up to $3 million over three fiscal years to develop and carry out projects that reduce barriers to recruiting direct care workers and match prospective workers with direct care employers. The Health Resources & Services Administration (HRSA) should administer the grant program and set aside at least 10 of these grants for applicants helping immigrants enter direct care occupations.

Targeted immigration reforms to supplement the number of direct care workers

D. Congress should amend the Immigration and Nationality Act (INA) to recapture permanent employment-based visas (i.e., green cards) previously unused for FY1992 through FY2021 to increase the number of employment-based visas, up to 65,000 visas, available for FY2024 or any subsequent fiscal year to fill health care workforce shortages. Congress should reserve 25,000 of these visas for direct care workers. Congress should not count visas for certain family members to accompany the principal beneficiary of these permanent employment-based visas against the 65,000 cap.

E. Congress should direct the Labor Department to classify direct care professions as Schedule A shortage occupations for at least five fiscal years, allowing streamlined and simplified visa processing.

F. The State Department should modify the J-1 Visa Exchange Visitor Program's au pair category to increase cultural exchange and to permit qualifying migrants to work legally in caregiving professions for older adults. The State Department should also establish separate training requirements for J-1 au pair recipients working with older adults and improve oversight of the J-1 Visa Exchange Visitor Program.

G. Congress should amend the INA to establish a four-year nonimmigrant employment-based visa classification (i.e., temporary work visa) for low-skill health care workers. The new category would be capped at no more than 15,000 visas each fiscal year starting FY2025 through FY2027. Starting in FY2028 and ending in FY2030, Congress should modify this cap based on the National Health Care Workforce

Commission's comprehensive evaluation of the direct care workforce. Congress should also require the petitioning facility to complete a labor certification process, including an attempt to recruit U.S. citizens for these positions.

H. To address the urgent direct care workforce shortage and ensure quality of care for individuals with LTSS needs, Congress should establish a legalization program for qualifying foreign-born workers who will help relieve the country's direct care workforce shortage. This program should be available to eligible foreign-born workers who currently reside in the United States and should provide them with the proper authorization necessary to legally remain in the country, work, and pay taxes. Key program details include:

- *Eligibility*: Individuals who apply within an 18-month application period, are present in the United States as of the legislation's date of enactment, have performed at least 180 days of direct caregiving labor over the past two years, and are otherwise admissible.
- *Certified Direct Care Worker (CDCW) status:* Eligible individuals should receive CDCW status, valid for five years and renewable indefinitely, provided that the CDCW holder continued to work in direct care for at least 100 days per year. Congress should allow long-term CDCW holders to adjust to lawful permanent resident (LPR) status by engaging in additional direct care work and paying a $1,000 fine.
- *Protections:* Congress should establish safeguards for individuals (and their spouses and minor children) applying and participating in this program.
- *Reporting:* Congress should direct the secretary of Labor and the secretary of HHS to submit a report evaluating the impact of the program within three years after enactment of the legislation and every three years thereafter.

I. Congress should appropriate additional resources to the Labor Department, USCIS, and other agencies involved in immigration processing needed to implement the policy reforms in this report.

III. Improve Data on Workforce Characteristics to Measure Progress on Enlarging the Workforce

A. CMS should create and implement a standardized set of data measures for the direct care workforce based on the Recommended State Minimum Dataset on Workforce for Long-term Care Systems Change previously developed by the agency's Direct Service Workforce Resource Center. The dataset should capture the volume, stability, compensation, and profile of the direct care workforce.

B. CMS should require collection and reporting of standardized direct care workforce data (outlined in III.A.) across settings and programs and allow voluntary submission of other measures.

i. **CMS should require skilled nursing facilities and nursing homes to report standardized direct care workforce data (outlined in III.A.) as a condition of program participation in Medicare and Medicaid.**

ii. **Through the Home Health Quality Reporting Program, CMS should require Medicare-certified home health agencies to report standardized direct care workforce data as a condition of program participation.**

iii. **CMS should require states to collect, and report standardized direct care workforce data (outlined in III.A.) for home and community-based services provided through Sections 1915(c), 1915(i), 1915(j), and 1915(k) authorities, and Section 1115 demonstrations.**

iv. **CMS should publish standardized direct care workforce data collected from Medicare and Medicaid programs in an easily accessible and understandable format. Congress should appropriate the additional resources CMS needs to regularly publish standardized direct care workforce data.**

C. The U.S. Census Bureau should include questions on paid and unpaid caregiving in the American Community Survey.

D. The Office of Management and Budget should update the 2018 Standard Occupational Classification Manual to create an independent Standard Occupational Classification (SOC) code for direct support professionals that can be utilized by states and federal agencies.

E. The Labor Department should instruct the Bureau of Labor Statistics to publish standardized data on home health aides (31-1121) and personal care aides (31-1122) separately.

Background

WHO ARE DIRECT CARE WORKERS?

Direct care workers assist older adults and individuals with functional limitations—typically due to physical, cognitive, or intellectual/developmental disability—by providing essential, hands-on assistance with daily tasks or other long-term services and supports (LTSS) across care settings.[23,24] The Bureau of Labor Statistics groups direct care workers in three categories: personal care aides and home health aides; certified nurse aides; and psychiatric aides (see Appendix A). Direct support professionals represent another important part of the direct care workforce, but they are not currently classified and regulated by federal agencies in the same way as other direct care occupations (see Appendix A). All direct care workers provide a wide variety of essential long-term services to patients, from helping with daily tasks such as dressing and bathing, to some clinical services, including wound care and blood pressure readings (see Figure 1). Direct support professionals focus more broadly on helping people with disabilities lead independent lives, live in integrated settings, and pursue competitive integrated employment.[25]

Direct care workers provide services in home and community-based settings, including private and community group homes, as well as institutional settings such as skilled nursing facilities and nursing homes, rehabilitation centers, and hospitals, among others. Similarly, they can be employed by a range of providers, including home health agencies and facilities, or hired directly by care recipients or their representatives.

However, paid workers in these settings do not constitute the entire direct care workforce. Other individuals often informally take on the role of these workers, providing LTSS to supplement or replace formal paid caregiving for a variety of reasons. Family caregivers and providers in the "gray market"—those hired directly by consumers outside of government programs—constitute a significant portion of the direct care workforce. Although this report focuses primarily on the paid workforce, it is imperative that policymakers understand the spectrum of caregiving relationships and recognize how the shortage of paid direct care workers has led to an increased reliance on unpaid, and potentially uncertified, individuals in these roles.

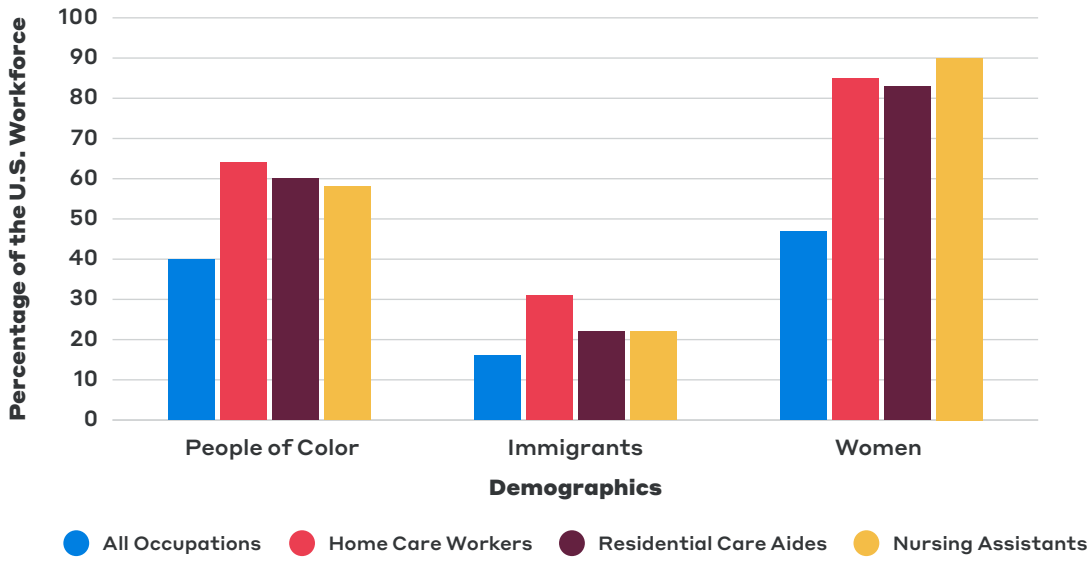
Figure 1: Interdisciplinary Services Provided by Direct Care Workers

Source: Idaho Office of Performance Evaluations

Together, nursing assistants, home health aides, and personal care aides represent the largest occupation in the United States. As of May 2022, more than 5 million jobs were held by these direct care workers.[26] This is likely a conservative estimate, as the data collected by the Bureau of Labor Statistics is based on estimates from employers and is not able to capture providers hired independently by consumers.

Compared with the entire civilian U.S. workforce, direct care workers are predominantly or disproportionately people of color, immigrants, and women.[27] People of color make up 40% of the nationwide workforce, but they account for 64% of home care workers, 60% of residential care aides, and 58% of nursing assistants in nursing homes.[28] Immigrants constitute only 16% of the total U.S. workforce but 31% of home care workers, 22% of residential care aides, and 22% of nursing assistants in nursing homes.[29] The large majority of direct care workers are also women: They are 85% of home care workers, 83% of residential care aides, and 90% of nursing assistants in nursing homes (See Figure 2).[30]

Figure 2: Demographics of the U.S. Workforce Compared with Direct Care Workers, 2022



Source: PHI
Note: "Immigrants" refers both to foreign-born individuals who are naturalized U.S. citizens and to individuals who are in the U.S. workforce but are not naturalized.

DEMAND FOR DIRECT CARE SERVICES

Current estimates and projections of LTSS need are helpful indicators of the nation's reliance on, and demand for, direct care services.

Millions of adults and children in the United States need LTSS, and demand for those services is projected to increase concomitant with the rapid growth of the older adult population. The most recently available data indicates that almost 23 million adults reported significant difficulty with at least one of six domains of functioning—including seeing, hearing, mobility, communication, cognition, or self-care—in 2019.[31] Among those adults, close to half, or 10.2 million, were age 65 or older.[32] Many children with disabilities or functional limitations also rely on LTSS. From 2019-2020, about 3.6 million children in the United States experienced functional limitations, suggesting a potential need for LTSS.[33]

Old age highly correlates with functional limitations and chronic disability, and more than half of older adults (57%), regardless of their lifetime earnings, are projected to experience serious LTSS needs and will need to use some paid LTSS after turning 65.[34] About 1 in 5 older adults will require LTSS for five years or more.[35] Significant projected demand for LTSS is largely due to the aging baby boomer population, the last of whom will turn 65 by 2029.[36] Moreover, the population of adults ages 65 and older will nearly double from 49.2 million to 94.7 million between 2016 and 2060, while the number of adults ages 85 and older will nearly triple during the same period from 6.4 million to 19 million.[37]

Demand for direct care services is likely somewhat greater in rural versus urban counties, given data on the populations of older adults and individuals with disabilities in those areas. For example, the population of adults ages 65 and older is about 18% in rural counties but only 14% in urban counties.[38] Older adults in rural counties are also slightly more likely (39%) to have disabilities compared with those in urban counties (about 35%).[39] Health and economic disparities in rural counties, such as greater prevalence of adults with multiple chronic conditions and higher poverty rates than urban counties, further indicate that rural communities will have relatively significant demand for direct care workers.[40,41]

Last, projected demographic changes among the older adult population underscore the increasing need for direct care workers who are trained to provide culturally competent care. Between 2019 and 2040, the population of racial and ethnic minorities ages 65 and older is projected to increase by 115%, whereas the population of white, non-Hispanic older adults is expected to increase by only 29%.[42] A workforce prepared to provide culturally competent care to diverse populations—including individuals of different races or ethnicities, religions, sexual orientation, gender, disability status, and other characteristics affecting individuals' needs and preferences—will be critical to reducing health disparities and ensuring patient-centered care.

HOW INDIVIDUALS ACCESS DIRECT CARE SERVICES AND UNPAID CARE

Individuals with LTSS needs access paid and unpaid direct care services through a variety of formal and informal caregiving arrangements. Direct care services are financed through public and private payers (including private insurance and out-of-pocket payments). Medicaid is the predominant payer for LTSS. Of the $467.4 billion spent on LTSS in the United States in 2021, Medicare accounted for $93 billion (or 20%), private pay accounted for $134 billion (29%), and Medicaid accounted for $207 billion (44%).[43] Based on national health expenditure projections, LTSS spending for 2022-2031 will continue increasing each year, on average, about 7.2% for home health care, 4.6% for nursing care facilities and continuing care retirement communities, and 5.2% for other health, residential, and personal care; spending for those categories in total will increase from $559.8 billion in 2022 to $905.1 billion in 2031.[g,44]

Unpaid caregivers, typically family or friends of care recipients, provide a significant portion of LTSS in the United States. One estimate found that more than half of people ages 65 and over receiving LTSS relied on unpaid care only.[45] According to recent estimates, unpaid caregivers totaled about 38 million in

g For more information on LTSS financing, see BPC's report, *Bipartisan Solutions to Improve the Availability of Long-term Care*, September 2021. Available at: https://bipartisanpolicy.org/report/improving-ltc/.

2021 and the estimated economic value of their care reached approximately $600 billion.[46]

Medicare

Although Medicare delivers health care to adults ages 65 and older and individuals under 65 with certain disabilities, it does not offer comprehensive coverage of LTSS. Medicare only covers limited skilled nursing facility care or home health services for qualifying beneficiaries. Specifically, Medicare generally covers up to 100 days of post-acute care in a skilled nursing facility after a three-day qualifying inpatient hospital stay for a beneficiary when (1) a physician certifies the beneficiary needs skilled nursing facility care and (2) the beneficiary requires skilled nursing or skilled rehabilitation services, or both, daily.[h,47,48] Medicare generally covers home health services by a Medicare-certified home health agency when (1) a physician or authorized practitioner establishes and periodically reviews a plan of care for furnishing the services, (2) the beneficiary is confined to the home, and (3) the beneficiary needs skilled care as described in federal rules.[49] Approximately 3 million people received Medicare home health services in 2020, although it is unclear how many of these visits included LTSS (see Appendix B).[50]

Medicaid

Due in part to Medicare's limited coverage of LTSS, as well as a recent shift toward delivering more LTSS in home and community-based settings, Medicaid is the primary payer of LTSS in the country (see Figure 3).[51] In 2020, Medicaid accounted for 44% of LTSS spending nationwide and covered services for about 1.4 million beneficiaries in nursing homes.[i,52] Medicaid also provided home and community-based services (HCBS) to more than 4 million individuals in 2020 (see Appendix B), reflecting their increasing desire to receive LTSS in home and community-based settings.[53]

However, federal Medicaid rules only require states to cover LTSS in institutional settings while states generally have the option to cover HCBS. Home health is the only HCBS that states must cover, but almost all states cover additional HCBS.[54] Eligibility requirements, covered benefits, and access to direct care services provided in home and community-based settings vary widely by state and Medicaid authority.[55] As a means-tested program designed to provide health care to low-income individuals, Medicaid requires those with LTSS needs to meet income eligibility requirements and functional needs

h In response to the COVID-19 PHE, CMS waived several Medicare requirements, including the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility stay. These waivers were in effect through the end of the emergency declaration. For more information, see: https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf.

i This figure likely contains some individuals covered by Medicare as well. Because most nursing homes are certified to serve as both skilled nursing facilities under Medicare and long-term care facilities under Medicaid, this enrollment data is not broken down by payer. For more information, see: https://oig.hhs.gov/reports-and-publications/featured-topics/nursing-homes/.

criteria set by the state to qualify for LTSS assistance. Individuals with LTSS needs often end up qualifying for Medicaid after spending down their savings to pay for LTSS.

Importantly, Medicaid HCBS programs cover self-directed services in addition to traditional home care agency-delivered care. Self-direction allows Medicaid participants, or their representatives, to make decisions and have authority over care services, such as hiring and managing their own home health or personal care aide.[56] All 50 states and Washington, DC, offer at least one HCBS program with the option for enrollees to self-direct their services. As of 2022, 48 states allow legally responsible relatives, such as spouses or parents of minors, to be paid caregivers—an increase from 36 states in 2020—while non-legally responsible relatives can be hired as caregivers under all Medicaid HCBS authorities.[57,58] In 2020, more than 2.5 million people received Medicaid HCBS through state plan services and waivers that allow for self-direction (see Appendix B).[j,59]

States' strategies for delivering Medicaid LTSS vary dramatically across the country and affect how payments are set for providers, including direct care workers and agencies or facilities employing those workers. States can choose to use fee-for-service, managed care, or a combination of both to deliver Medicaid LTSS.[60] Although state Medicaid programs increasingly use managed care to deliver LTSS, about half of all states did not contract with managed care entities to deliver long-term services in 2021.[61] Under fee-for-service, states generally set provider payment rates for Medicaid services and pay providers directly for rendered services.[62] Under managed care, states generally make a capitated, risk-adjusted payment to a Medicaid managed care entity to cover the total cost of care for a population.[63] Medicaid managed care entities typically have flexibility to set payment rates for providers in their network unless the state receives CMS approval to implement certain payment methodologies, such as minimum or maximum provider fee schedules, uniform rate increases, or value-based payment models.[64] Those payment methodologies represent examples of supplemental payments that states can make to providers that are separate from and in addition to payments for services rendered to Medicaid beneficiaries.[65]

Private Pay and Unpaid Caregiving

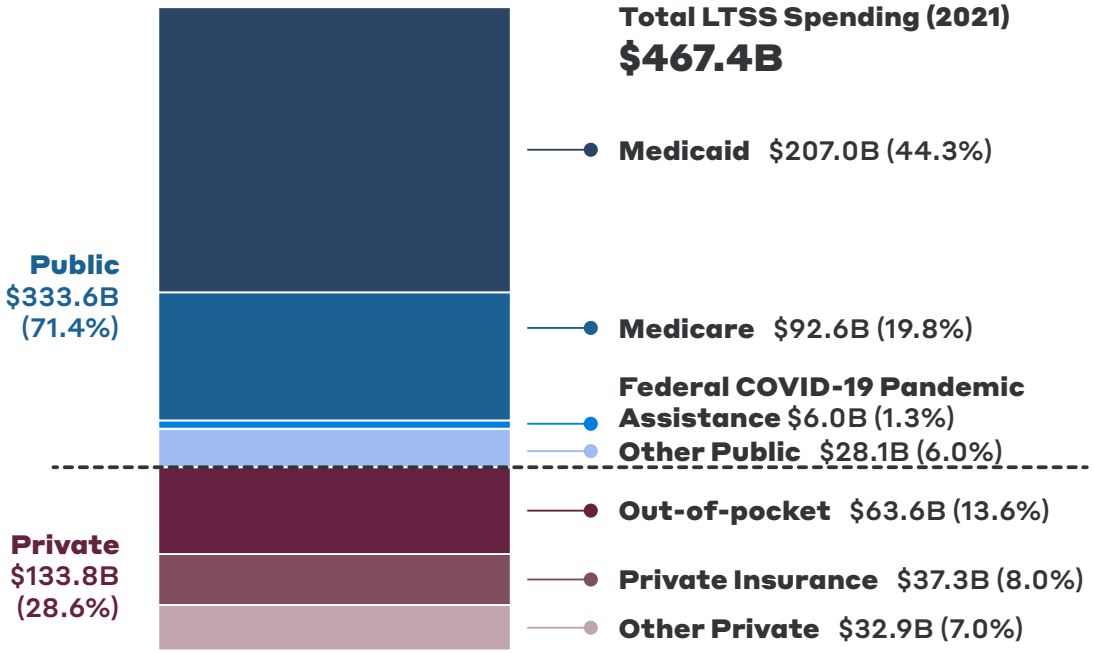
Individuals with LTSS needs who do not qualify for Medicaid must often rely on private funding—either long-term-care insurance or paying out of pocket for care. Although limited private long-term care insurance might cover additional LTSS expenses, the policies are unaffordable for most Americans, and the

j This number includes enrollment in 1915(i) and 1915(k) state plan options, and 1915(c) waivers. While 1915(j)—the Self-Directed Personal Assistance Services State Plan Option—is a dedicated self-direction authority, data on enrollment is not publicly available. As of 2017, only eight states were approved to use this authority. For more information, see: https://www.appliedselfdirection.com/sites/default/files/Self%20Direction%20under%201915j%20and%20k%20Slides_0.pdf.

number of policies sold has decreased by more than 80% since 2002.[66] Some individuals directly hire providers outside of Medicare, Medicaid, or a regulated agency (i.e., under the table). This is often referred to as the "gray market." Although data is limited, gray market care represents a sizable portion of paid LTSS. In one recent study, nearly one-third of respondents (31%) who sought paid care for family members or friends with dementia hired gray market providers. Notably, respondents living in rural areas were almost five times more likely to arrange gray market care than their urban counterparts.[67]

Finally, data suggests that most individuals receive at least some LTSS from family members or friends. One estimate found that more than half of people ages 65 and over receiving LTSS received unpaid care only.[68] In addition to paid family members who act as employees through self-directed Medicaid programs, nearly 38 million adults provided unpaid care to an adult with functional limitations in 2021, according to AARP.[69] This is likely due to a myriad of reasons, including preference for a familiar caretaker, COVID-19 pandemic safety precautions, strict financial eligibility requirements for Medicaid services, and increased demand for LTSS as the population rapidly ages. The estimated economic value of the care provided by unpaid caregivers reached approximately $600 billion in 2021.[70] However, the share of potential family caregivers is projected to shrink, which will likely create even more demand for formal caregiving arrangements. By 2034, adults over age 65 will outnumber children under 18 for the first time in U.S. history.[71]

Figure 3: LTSS Spending by Payer, 2021



Source: Congressional Research Service analysis of National Health Expenditure Account data from CMS, November 2022

THE DIRECT CARE WORKFORCE SHORTAGE AND ITS EFFECTS

Before the COVID-19 pandemic, a pressing nationwide shortage of direct care workers had emerged, largely due to low wages and a rapidly expanding older adult population that is outpacing the growth of the workforce (other factors are detailed in Challenges to Recruiting and Retaining Direct Care Workers below).[72] Although the number of direct care workers more than doubled from 2.2 million in 2000 to 5.1 million in 2022, the supply of direct care workers will fall short of the demand associated with 8.9 million projected job openings from 2022-2032.[73,74,75] The Bureau of Labor Statistics projects that 6 million individuals will be working in home health aide, personal care aide, nursing assistant, and psychiatric aide jobs nationwide in 2032, an increase of more than 860,000 from today.[76]

The pandemic exacerbated existing shortages, because direct care workers often experienced challenges such as limited access to personal protective equipment and vaccines, as well as inadequate support from employers in high-risk settings. And if workers became infected, they often had to take unpaid leave owing to the absence of paid sick time. At the time of publication of this report, more than 1.6 million cases of COVID-19 just among nursing home staff have been confirmed.[77] As more direct care workers left their jobs, remaining workers in nursing homes, home health, and home care agencies were forced to work longer hours, take on bigger caseloads, and face greater risk of COVID-19 infection.[78]

Although the overall U.S. labor force has rebounded since the beginning of the public health emergency (PHE) in February 2020, direct care employers still struggle to recruit and retain workers.[79] Despite steadily growing, nationwide employment for nursing and residential care facility staff in September 2023 still remains 5% below where it was in February 2020.[80] As of January 2023, 84% of nursing homes were facing moderate to high levels of staffing shortages.[81] All but 10 states and the District of Columbia had nursing home staff turnover rates equal to or greater than 50%—meaning that in most states, at least half of direct care workers working in nursing homes in January 2022 left their jobs by January 2023.[82] Outside of institutional settings, 49 state Medicaid programs identified workforce shortages as the pandemic's primary impact on HCBS offerings.[83] Nationwide estimates suggest that direct care workers across settings are transitioning to other occupations at higher rates today than before the pandemic and are more than twice as likely to exit the health workforce as registered nurses and physicians.[84]

Individual case studies from states also reveal a worsening care gap for individuals with LTSS needs. In Wisconsin, 1 in 4 caregiver positions is vacant, and the state projects it will need 20,000 additional home care workers by 2024.[85] North Carolina's direct care workforce shrank by more than 9% from

2016-2021, even as direct care workers represent the most needed health care job in the state by 2030.[86] In Colorado, which is projected to be the third fastest-aging state in the country, the number of older adults is projected to reach 1.2 million by 2030, but Colorado will have only 84,000 direct care workers by 2028.[87] A conservative estimate by the Idaho Legislature found that the state would need 3,000, or 13% more, direct care workers just to meet national average staffing levels. Idaho, like Colorado and Minnesota, also reported a pronounced shortage of workers in rural areas and among consumer populations dependent on Medicaid for LTSS.[88, 89]

These shortages are straining the health care system and harming care access, quality, and costs.

In 2021, 656,000 individuals were on waiting lists for Medicaid HCBS nationwide, and some research suggests that the long waiting lists might be partially attributable to the shortage of direct care workers who provide the majority of home and community-based services.[90] For instance, more than 4,000 Ohioans were on the waiting list for personal care services under one of Ohio's Medicaid HCBS waivers, the PASSPORT program, in 2022 due to a shortage of direct care workers.[91]

Direct care worker shortages also contribute to providers not being able to accept referred patients and, in some cases, closing. Due to insufficient staffing, 83% of direct support professional providers surveyed last year turned away or stopped accepting new referrals, while 63% had to discontinue programs or services.[92] Similarly, over half (54%) of nursing homes surveyed in 2023 had to limit new patient admissions while home health care providers reported turning away more than 25% of referred patients, due to staffing shortages.[93, 94, 95] Over 450 nursing homes have closed since the beginning of the pandemic, displacing over 18,000 residents.[96] In 2022, 44 states reported the permanent closure of at least one Medicaid HCBS provider, such as home care agencies.[97]

Accordingly, hospitals and health systems report increased delays discharging patients for post-acute care.[98] For example, from 2019-2022, average length-of-stay increased 20% for hospital patients being discharged to skilled nursing facilities and almost 13% for those being discharged to home health agencies.[99] These delays not only increase strain on hospital capacity and resources but they are also associated with poor health outcomes for patients, including increased risk of mortality, hospital-acquired infections, depression, and reductions in patients' mobility and activities of daily living (ADLs).[100,101]

Direct care workers are critical to broader efforts to promote high quality, cost-effective care for individuals with complex needs, and a shortage of these workers is likely to have negative effects on health care spending in the long term.

Because hospital care represents the largest component of U.S. health care expenditures, LTSS provided by direct care workers represents an opportunity to reduce avoidable adverse hospitalizations and costs. In 2017, chronic conditions accounted for the large majority (77%) of potentially avoidable hospitalizations among adults.[102] The three most prevalent conditions—congestive heart failure, chronic obstructive pulmonary disease, and diabetes—lead to more than 1.5 million of these potentially avoidable hospitalizations and cost the health care system nearly $26 billion. Notably, Medicare and Medicaid were the primary payer for 79% of these hospitalizations.[103] Certified nursing assistants and home health aides can help individuals monitor blood pressure, exercise, take medication, and perform other tasks to effectively manage all three conditions in non-acute settings.[104] In nursing homes, lower turnover rates among direct care staff have been shown to reduce the incidence of patients' costly infections and resulting hospitalizations, such as pressure ulcers and urinary tract infections.[105] A robust direct care workforce therefore has the potential to reduce spending on avoidable hospitalizations among individuals with chronic conditions.

Direct care workers are also essential to states' efforts to rebalance care, and the savings associated with providing LTSS primarily in home and community-based settings compared to institutional settings. Medicaid in 2020 spent an average of $36,275 per person for people who used HCBS and $47,279 per person for people who used institutional LTSS.[106] These savings are especially important considering that most individuals receive LTSS through Medicaid HCBS waivers and programs: 4 million Medicaid enrollees used only HCBS in 2020, compared with 1.4 million who used only institutional care (another 200,000 used both).[107] Research suggests that shifting spending from institutional care to HCBS can reduce overall state spending by about 15% over 10 years.[108] To realize these savings, an adequate number of direct care workers for HCBS must be available.

Consumers paying out of pocket for LTSS are likely to spend down their savings more quickly if direct care workers are unable to meet the demand for HCBS. The average annual costs of LTSS provided through assisted living facilities ($54,000), homemaker services ($59,488), and home health aides ($61,776) are significantly lower than care delivered in nursing facilities ($94,900 for a private room and $108,405 for a private room).[109] Wide availability of direct care workers in home and community-based settings can help consumers save money and thereby delay or avoid Medicaid enrollment.

CHALLENGES TO RECRUITING AND RETAINING DIRECT CARE WORKERS

Through research, interviews, and a private roundtable discussion with stakeholders and policy experts, BPC identified three primary challenges to recruiting and retaining direct care workers: 1) inadequate support for

INADEQUATE SUPPORT FOR DIRECT CARE WORKERS

A variety of factors are contributing to the unsupportive environment for direct care workers, such as:

- low wages;
- inadequate benefits;
- insufficient staffing;
- inconsistent training opportunities;
- unclear career pathways; and
- persistent devaluing of direct care.

workers; 2) domestic workforce programs and immigration pathways that do not effectively target direct care occupations; and 3) insufficient publicly available workforce data to measure the effects of policy reforms on the workforce.

1. Inadequate support for workers.

The level of support for direct care workers is not commensurate with the highly demanding and crucial nature of their work. Limited compensation, inadequate training and career advancement opportunities, and persistent devaluing of domestic work are some of the many factors that contribute to inadequate support for these workers. Other factors include inadequate staffing, which contributes to worker burnout, and difficult working conditions.[110] With insufficient support, prospective workers are disincentivized to join and remain in the workforce. Additionally, inadequate support for workers has a ripple effect throughout the economy. For example, the combination of low wages and a lack of benefits can lead direct care workers to rely on government programs such as Medicaid.[111] Based on BPC's interviews, it is evident that ensuring sufficient support is a necessary step to address the shortage. However, improving support for workers alone falls short of addressing the broader workforce crisis.

Limited compensation. Inadequate compensation, including wages, salary, and benefits, is consistently cited as the biggest factor causing direct care workers to leave the field.[k,112] Despite the high demand for these workers, wages across sectors—but especially in home and community-based settings—are extremely low. The median pay for home health and personal care aides was $14.51 per hour, or $30,180 a year, in 2022, and even lower for direct support professionals.[113,114] Median pay for nursing assistants was only slightly higher at $17.18 per hour, or $35,740 a year, in 2022.[115] As the *median* figure, it is important to note that wages vary significantly across the country, and many direct care workers earn even less. In 2019, the median hourly wage for home health and personal care aides ranged from a high of $16.43 in Alaska to a low of $9.03 in Louisiana.[116]

Even when entry requirements are similar, compensation is often greater for other roles in health care and non-health care industries compared with direct care occupations. Median wages of home health and personal care aides were

k This report defines compensation to include salary, wages, other remuneration as defined by the Fair Labor Standards Act, benefits, and the employer share of payroll taxes for direct care workers delivering services under Section 1915(c) waivers.

lower than wages of other entry-level jobs in all 50 states and Washington, DC, with an average difference of $3.15 per hour, while median wages for nursing assistants were lower than wages of other entry-level jobs in 40 states and DC.[117] For instance, social and human service assistants, an occupation with similar entry requirements, earned a median income of $18.52 per hour, or $38,520 per year in 2022.[118] Also, many stakeholders BPC interviewed mentioned significant competition from fast-food and retail industries. These jobs usually offer better pay and hours, and are generally less physically and emotionally demanding than direct care. Although employers can usually increase wages or provide other incentives to stay competitive with industries seeking the same, limited number of workers, employers of direct care workers are restricted in their ability to do this because federal and state payment rates for these services are not as responsive to the market. In fact, wages for direct care workers have stagnated over the past decade despite inflation; the median hourly wages for home health and personal care aides were $9.89 and $9.44 in 2010, or $13.64 and $13.02 when adjusted for inflation.[119]

Low compensation also means that many direct care workers struggle financially and work multiple jobs. As a result, many rely on public assistance, and few qualify to receive comprehensive benefits through their employer because they work part time. Just 15% of direct care workers nationwide received retirement benefits from their employers in 2019.[120] That same year, only 45% of direct care workers had health insurance through their employers, and 15% were not covered at all.[121] Today, 40% of direct care workers live in low-income households, with 43% relying on public assistance, such as Medicaid or the Supplemental Nutrition Assistance Program (SNAP).[122] According to one estimate, if direct care workers received at least a living wage, almost 17% of these workers would no longer receive public assistance. Total savings across public programs and tax credits (i.e., free and reduced-price lunches, Medicaid, SNAP, earned income tax credit, and housing subsidy) would total $1.6 billion in 2022; these savings would help offset the estimated $9.4 billion cost of the wage increase.[123]

Inadequate training and career advancement opportunities. Only nursing assistants and home health aides are federally required to receive specific training and meet certification requirements.[l,124] States can impose training requirements for personal care aides, direct support professionals, and psychiatric aides, but these rules vary widely. For example, seven states do not regulate training for personal care aides at all, while Washington state requires that agency-employed personal care aides receive up to 75 hours of training.[125] Colorado does not even use the "home health aide" designation; it instead requires all workers providing home health care to be certified nursing

l Although BPC considered a policy option to establish federal training requirements for personal care aides, we are not recommending this at this time. Stakeholders expressed concerns about potential barriers to the profession, as well as the limited federal data available on Medicaid rates and wages for personal care aides.

assistants.[126]

Many workers also seek opportunities to transition to higher-level positions within their field or related fields by continuously acquiring relevant skills, such as specialized care, first aid, and meal preparation. Some states have established core competencies and certifications for direct care occupations that can incentivize job training, but structures for professional development in the direct care field are not standardized or widely available.[127] This can make it difficult for workers to translate work experience and on-the-job training into higher wages or new job opportunities, and it disincentivizes long-term workforce participation.[128]

Devaluing domestic work. Direct care work allows millions of individuals to maintain independence and access health services in the community every year, yet the workforce continues to earn low compensation in high-risk settings. Given that direct care work is largely publicly financed (see Figure 3), wages and working conditions are significantly affected by political decisions, reflecting long-standing biases against a workforce predominantly composed of women and disproportionately consisting of Black, Hispanic, and immigrant individuals.[129]

Most home care workers were excluded from standard minimum wage and overtime protections under the Fair Labor Standards Act until 2015.[130] During the PHE, the majority of state designations prioritizing the distribution of personal protective equipment included hospital workers but often not direct care workers in nursing home and home and community-based settings.[131] Finally, even though home care workers have had some of the highest occupational injury rates in the country, the National Institute for Occupational Safety and Health has not issued guidance on best practices for them since 1993.[132] Direct care workers feel the effects of these policy decisions, with stakeholders reporting that these workers often feel undervalued in their roles.

2. Domestic workforce programs and immigration pathways that do not effectively target direct care occupations.

There is a scarcity of qualified and willing workers to fill the substantial demand for direct care positions. An inadequate system for domestic direct care workforce recruitment and development, along with an inefficient immigration system, widens the gap between the number of job openings and the availability of skilled and willing personnel.

As previously discussed, a disproportionate portion of the direct care workforce consists of immigrants, partially due to a shortage of native-born workers in the United States to meet the demand.[133] Recent record-low population growth rate during the COVID-19 pandemic has further heightened this demand.[134] Given these circumstances, immigration presents a crucial opportunity to bridge the workforce gap and generate favorable economic impacts, including revenue from federal and state tax contributions.[135,136] However, the United States'

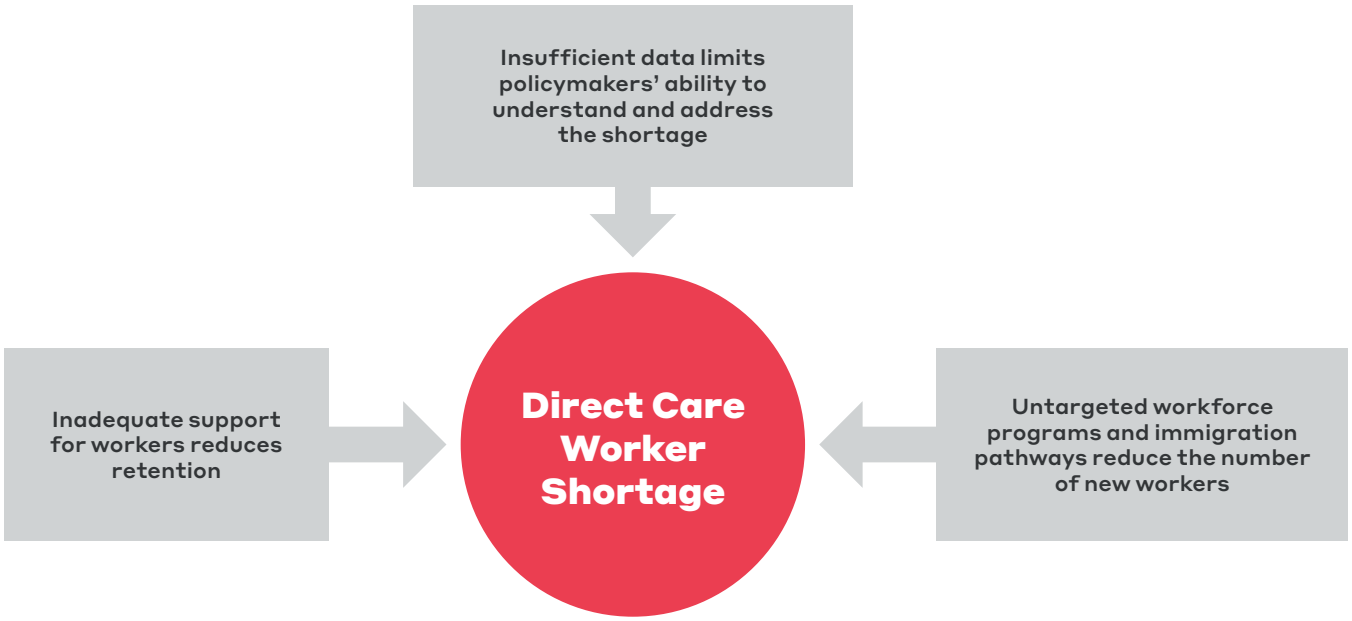
immigration system is not designed to effectively maintain population growth and address the direct care workforce shortage. The system is fragmented and inefficient, lacking a structured approach to ensure adequate visa and green card pathways exist for foreign-born workers who want to help fill unmet demand for direct care workers.

Without increasing the pool of new workers, employers in the direct care industry will find it increasingly difficult to fill job openings. Consequently, individuals requiring direct care services risk losing access to care. To address the shortage of workers, federal policymakers should enhance recruitment efforts for direct care workers on both the national and global stage.

3. Insufficient publicly available workforce data to measure the effects of policy reforms on the workforce.

Inadequate federal and state data make it difficult to understand, mitigate, and prevent direct care workforce challenges. Data on workforce volume, stability, and compensation is limited, and available data is not often disaggregated by direct care profession. Previous experiences in addressing workforce shortages emphasize the importance of data. For instance, statistics on nurse-to-patient ratios helped identify staffing deficiencies in nursing homes and prompted policy changes, including federal grant programs to facilitate entry into nursing fields and proposed minimum staffing requirements.[137,138] Improving the quantity and quality of data on the direct care workforce can help employers and policymakers understand the magnitude of the shortage, develop initiatives to improve recruitment and retention, and anticipate and address future shortages. Policymakers should improve data collection and reporting requirements to address the direct care worker shortage.

Figure 4: Existing Structures Driving the Direct Care Worker Shortage



Looking Ahead

Under increasing pressure to address the crisis, members of Congress are pursuing legislation to alleviate the shortage.[m] For example, two key congressional committees held hearings related to the direct care workforce shortage earlier this year. The Senate Aging Committee hearing focused on informing policies to address recruitment and retention challenges within the direct care workforce, while the Senate Health, Education, Labor and Pensions (HELP) Committee took a broader look at workforce shortages.[139,140] Senate HELP Committee Chair Bernie Sanders (I-VT) and Ranking Member Bill Cassidy (R-LA) also requested stakeholders' feedback on the causes and potential policy solutions to the health care workforce shortages.[141] In the House, Energy and Commerce Committee Chair Cathy McMorris Rodgers (R-WA) and Subcommittee on Health Chair Brett Guthrie (R-KY) held a subcommittee hearing on the long-term care workforce and CMS' proposed regulations on nursing home staffing ratios.[142] House Energy and Commerce Committee Chair Rodgers also sought input on strengthening access to HCBS for people with disabilities, which will require a strong direct care workforce.[143]

Several members of the 118th Congress have introduced legislation to address the shortage. For example, Rep. Guthrie introduced the bipartisan Building America's Health Care Workforce Act (H.R. 468), which would extend COVID-19 flexibilities for training and competency requirements for nurse aides in certain settings for a specified duration. The bill would also permit any hours worked by a nurse aide during the COVID-19 PHE to count toward meeting the federal training requirement. Rep. Ron Estes (R-KS) and Sen. Mark Warner (D-VA) introduced another bipartisan bill, Ensuring Seniors' Access to Quality Care Act (H.R. 3227 / S. 1749), in the House and Senate. This legislation would allow nursing homes, which had to temporarily suspend their certified nurse aide education programs due to quality-related penalties, to resume these programs once they meet quality standards.

Lawmakers have also proposed bipartisan bills to strengthen the home-based care workforce. Rep. Adrian Smith (R-NE), along with three Democratic co-sponsors, introduced the Expanding Care in Home Act (H.R. 2853). The legislation would provide grants to organizations shifting medical personnel from facility-based care to home-based care, offering training for those entering home care, and recruiting medical staff for in-home care and support. Although not limited to the direct care workforce, this legislation could improve recruitment and retention for direct care workers in residential settings.

m The actions and proposals highlighted in this section are focused narrowly on the direct care workforce. However, there are additional measures and proposals that aim to strengthen long-term care more broadly, which might indirectly alleviate the shortage of direct care workers.

Both Democrats and Republicans are interested in enhancing data collection on the direct care workforce. Policymakers seek reforms to further disaggregate labor workforce data by direct care occupation, thereby improving states' and employers' understanding of workforce trends. Thirty members of Congress from across the aisle signed a letter urging the Bureau of Labor Statistics to create a Standard Occupational Classification (SOC) code specific to direct support professionals.[144] The Recognizing the Role of Direct Support Professional Act (S.1332), introduced by Sens. Maggie Hassan (D-NH) and Susan Collins (R-ME), directs the Office of Management and Budget to establish an SOC code for direct support professionals. The Senate Committee on Homeland Security and Governmental Affairs favorably reported this act out of committee in July 2023; Reps. Brian Fitzpatrick (R-PA) and Joseph Morelle (D-NY) introduced a House version of the bill (H.R. 2941).[145]

Democrats have also introduced partisan legislation to alleviate the direct care workforce shortage. Rep. Debbie Dingell (D-MI) and Sen. Robert Casey (D-PA) introduced the Better Care Better Jobs Act (H.R. 547 / S. 100) which, among other provisions, would permanently increase the Federal Medical Assistance Percentage (FMAP) for HCBS by 10% and develop training opportunities for the direct care workforce. Rep. Seth Magaziner's (D-RI) Healthcare Worker Retention Act (H.R. 1215) would establish a refundable tax credit of $1,000 to eligible individuals who work in health care settings, such as direct care workers. Other Democratic legislation, such as the Direct Creation, Advancement, and Retention of Employment Opportunity Act of 2023 (H.R. 4720), the HCBS Access Act (S.762 / H.R. 1493), and the Supporting Our Direct Care Workforce and Family Caregivers Act (S.1298), would create grants for the recruitment, retention, and advancement of direct care workers.

The Biden administration has prioritized increasing access to LTSS, which involves strengthening the direct care workforce responsible for delivering these services. In his 2024 budget, the president proposed $150 billion over 10 years to improve and expand Medicaid HCBS.[146] In April 2023, President Biden directed the Department of Health and Human Services (HHS) to issue regulations and guidance to improve working conditions and job quality for long-term care workers.[147]

CMS and the Administration for Community Living (ACL) have taken steps to alleviate the direct care worker shortage. CMS issued a proposed rule on September 6, 2023, that, if finalized, would establish minimum staffing level requirements for certified nurse aides in long-term care facilities. Among other requirements, the proposed rule would require states to report the percentage of Medicaid payments for certain Medicaid-covered institutional services that are spent to compensate direct care workers. CMS also released a proposed rule on May 5, 2023, that would enhance transparency and oversight of compensation for direct care workers delivering Medicaid HCBS. The rule proposes requiring that at least 80% of Medicaid payments for select LTSS be spent on compensation for direct care workers. ACL is also building a national

technical assistance and resource center to expand and strengthen the direct care workforce. Once established, ACL's Direct Care Workforce Capacity Center will serve as a national hub of resources and best practices for retaining and recruiting direct care workers.[148]

Although many states have acted recently to strengthen their direct care workforces, questions surround how states will sustain these actions after temporary federal funding expires and what, if any, role the federal government should play in shoring up the direct care workforce over the long term. Through the American Rescue Plan Act (ARPA), President Biden and Congress provided to states a 10-percenage-point increase in the FMAP for Medicaid HCBS from April 1, 2021, through March 21, 2022.[149] Because states have until March 31, 2025, to spend the extra funds, federal policymakers are analyzing state efforts and federal opportunities to address the direct care worker shortage.

While most of the proposed federal changes focus on the direct care workforce itself, experts see the increased adoption of technology as a pressing need in long-term care. Some experts suggest that addressing technology will, in turn, help address the shortage of direct care workers. Long-term care facilities were largely ineligible for financial incentives from the Health Information Technology for Economic and Clinical Health Act, resulting in slow technology adoption. Now, experts are exploring how technology, such as scheduling software, can reduce staff turnover.[150] Looking ahead, technology, including artificial intelligence, will likely play a larger role in solving the direct care worker shortage through increased remote patient monitoring, better scheduling, and improved communication between medical teams, patients, and their families and caregivers.

Recommendations

I. Ensure Supportive Environments to Increase Worker Retention

To tackle the shortage of direct care workers and enhance retention, policymakers should implement a series of administrative and legislative reforms. BPC's recommendations focus on creating supportive work environments for direct care workers, with a priority on feasible changes that that can be implemented in the current political landscape. BPC explored options with more immediate outcomes, such as an enhanced federal match for certain LTSS paired with requirements to ensure competitive wages for direct care workers. Nevertheless, BPC is not currently proposing such measures due to challenges in achieving bipartisan support in Congress.

Alternatively, BPC's recommendations emphasize Medicaid rate transparency and adequacy; direct care worker compensation transparency; evaluation of state investments; improved training access; the establishment of career paths; financial support for family caregivers; and other changes to strengthen supports for workers. These actions serve as a first, necessary but insufficient step toward better supporting direct care workers.

A. CMS and Congress should strengthen transparency and oversight of states' Medicaid provider payment rates for certain LTSS and direct care workers' compensation as an initial step toward ensuring adequate Medicaid provider payment rates and competitive compensation for direct care workers.

i. Building on its recently proposed rules, CMS should require states to annually publish select LTSS Medicaid provider payment rates and the percentage spent on direct care workers' compensation in a standard format across both home and community and institutional settings.

As detailed in the Background section, compensation for direct care workers remains low and uncompetitive with comparable occupations. Employers, which is often a home health agency or nursing home, establishes compensation, but the Medicaid provider payment rate limits what they can offer. The Medicaid provider payment rate can be inadequate to support competitive compensation for direct care workers and other necessary costs. Increasing transparency in Medicaid provider payment rates and worker compensation is an important first step to ensuring that provider payment rates allow for appropriate compensation, including wages and benefits, for direct care workers.

As the primary payer for LTSS, Medicaid provider payments affect how employers compensate direct care workers. These payments cover various provider expenses, such as employee compensation, equipment, and administrative costs. In home and community-based settings, a larger portion of provider payment rates likely go toward direct care workers' compensation, compared with institutional settings with higher indirect and facility costs (e.g. buildings, utilities, and maintenance). Nevertheless, provider payment rates in home and community-based settings still cover expenses outside of direct care workers' compensation, such as transportation and personal protective equipment.

MEDICAID PROVIDER PAYMENTS

States must establish Medicaid provider payments that meet federal requirements, including:

- consistent with "efficiency, economy, and quality of care standards";
- sufficient to "enlist enough providers"; and
- based on an actuarially sound basis.

Sufficient provider payments for LTSS are a necessary first step to ensure competitive compensation for direct care workers. States set Medicaid provider payment rates within federal rules.[151] Because some states use provider payment reductions to control Medicaid costs, policy experts have grown increasingly worried that these states are setting Medicaid provider payments at unreasonably low levels. Experts raise concerns about the adequacy of Medicaid provider payment rates for LTSS and what, if any, influence these rates have on the compensation that employers can offer to direct care workers.

However, policymakers lack enough data to monitor whether states' Medicaid provider payments for LTSS comply with federal regulations and to understand how much of these payments actually reach direct care workers' compensation. Several states publish some of this data, but federal law does not require states to do so.

As a step toward ensuring adequate compensation, CMS should establish rate transparency requirements for select LTSS delivered across both home and community-based and institutional settings. For home and community-based settings, CMS should require states to publicly post the average Medicaid rates for homemaker, home health aide, and personal care services on the state's Medicaid website annually. States should report their fee-for-service payments as a standardized hourly rate. Managed care plans should report this information to states on an annual basis, with the states then responsible for publishing the information. For institutional settings, CMS should require states to publicly post annually on the state's Medicaid website the average statewide fee-for-service per diem Medicaid rates for nursing and intermediate care facilities for individuals with intellectual disabilities.

CMS should also increase transparency of the percentage of Medicaid payments spent on compensation for direct care workers in both the home and community as well as institutional settings. For home and community-based settings, CMS should require states to publish, in the aggregate for each service, the percentage of Medicaid payments for homemaker, home health aide, and personal care services that employers spend on compensation for direct care workers. Regarding nursing facilities and intermediate care for individuals with intellectual disabilities, CMS should require states to publish the percentage of Medicaid payments that employers spend to compensate direct care workers. On their Medicaid website annually, states should publish updated data on the average rates and percentage of payments passed through to direct care workers' compensation. These compensation transparency requirements should apply to both fee-for-service and managed care delivery systems.

To assist states and to ensure uniform data reporting, CMS should develop a standardized reporting template and require states to publish the data using this template. CMS should allow states to develop their own template, akin to the federal template, subject to the agency's approval.

These recommendations are similar to requirements proposed in CMS' proposed rules published in September and May 2023. There is one significant difference between BPC's recommendations and the proposed rules: CMS' May 2023 proposed rule would require states to demonstrate that they pass through at least 80% of select LTSS delivered in home and community-based settings to direct care workers' compensation, but BPC cannot recommend a specific percentage due to insufficient data at this time. BPC recommends that CMS implement the proposed Medicaid transparency requirements as detailed in this report in its final rules.[n]

BPC's recommendations aim to enhance transparency, which would enable policymakers to gain a clearer understanding of the portion of payment rates allocated to compensate direct care workers. With this understanding, policymakers can make evidence-based decisions regarding whether to mandate a specific percentage of select LTSS funds to be allocated directly to direct care workers. Additionally, policymakers can use this data to assess the required level of additional investment, if any, to ensure that current payment rates are competitive enough to maintain access to Medicaid LTSS.

n As authorized by Sections 2402(a)(1) and 2402(a)(3)(B)(iii) of the Affordable Care Act (ACA), the secretary of HHS ensures that states' HCBS develop systems that, among other requirements, respond to the needs and choices of beneficiaries receiving HCBS. As authorized by Sections 1819(d)(4)(B) and 1919(d)(4)(B) of the ACA, the HHS secretary can establish any additional requirements relating to the health, safety, and well-being of residents in skilled nursing facilities and nursing facilities.

ii. CMS should require states to establish a direct care workforce compensation advisory group to advise the state on proposed provider payment rate changes and appropriate wages for direct care workers.

Although some states have created advisory groups that elevate the voices of direct care workers, and consumers, policymakers need to strengthen stakeholders' engagement in states' rate-setting processes.

CMS should require states to establish a direct care workforce compensation advisory group that would include direct care workers, Medicaid beneficiaries, advocacy organizations, policy experts, and other stakeholders determined by the state. This group should advise states on proposed payment rates changes and appropriate wages for direct care workers. To ensure balance, CMS should explore strategies that prevent any single group from unduly influencing the state's process. The advisory group should consult with the state on the sufficiency of provider payment rates for select LTSS. CMS should also require Medicaid agencies to provide the advisory group with current and proposed payment rates and consider the advisory groups' feedback when setting new payment rates.

Forming advisory groups will amplify the influence of workers and beneficiaries. However, it is essential to understand that ensuring fair compensation will still depend on employers allocating a sufficient portion of the payment toward direct care workers' compensation.

This recommendation resembles the interested parties advisory group that CMS outlined in its May 2023 proposed rule. Similar to this proposed rule, CMS should require states to provide staffing, financial, and administrative support for the group, and states would be able to claim federal funding at the standard administrative match rate. One notable difference between CMS' proposed rule and BPC's recommendation is that BPC recommends naming the group the direct care compensation advisory group, because this name better emphasizes the role of the advisory group. BPC recommends that CMS implement the proposed advisory group detailed in this report in their final rule.

iii. Congress should appropriate a maximum total of $1 million to each state for conducting at least a total of two market rates analyses: one within three fiscal years and another within six fiscal years after the enacting legislation becomes law. The analyses should compare the state's median Medicaid hourly wages for direct care workers delivering select LTSS to median hourly wages for private market direct care workers. States' analyses should also examine how direct care workers' compensation compares to that of occupations with similar entry requirements in the state.

Some states have demonstrated the value of analyzing how Medicaid provider payment rates for LTSS and direct care worker compensation compare to market rates. These market analyses can help inform states' Medicaid provider payment rate setting. Additionally, BPC learned from interviews with state stakeholders that these analyses can help state Medicaid departments advocate for appropriate funding from their state legislature; however, many states do not conduct these market analyses. Congress has an opportunity to incentivize states to continuously monitor and ensure provider payment rates and direct care workers' compensation keep pace with the economy.

Congress should require states to conduct at least two market rate studies, comparing the state's median Medicaid hourly wages for direct care workers delivering homemaker, home health aide, and personal care services to private market wages for direct care workers.[o] The analysis should also detail the state's median hourly wages for direct care workers providing Medicaid-covered services in nursing and intermediate care facilities for individuals with intellectual disabilities. States should examine how direct care workers' compensation compares to that of occupations with similar entry requirements in the state (i.e., similar education or training requirements). For example, the analysis could compare wages and benefits between personal care aides and retail workers.

This requirement should be ongoing, with states submitting these analyses to CMS at least once every three fiscal years for a minimum of six fiscal years after passage of the act. Congress should allocate a maximum total of $1 million at the beginning of these six fiscal years to the Medicaid departments in each state to carry out these activities (see Appendix C for a timeline of these activities).[p]

This policy builds upon CMS' September and May 2023 proposed rules and helps ensure that states are considering their state's economy when establishing payment rates for LTSS. However, BPC acknowledges that enhanced transparency might result in some direct care workers leaving the workforce. To mitigate this risk, BPC does not suggest publicly posting these analyses. Differences in rural and urban areas pose a challenge for states in capturing nuances of the market in large states. The state, or the contractor employed by the state, should account for and, whenever possible, take steps to mitigate these challenges when completing the analysis.

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o This comparison is likely to be incomplete due to the challenges of collecting wage data from the private pay "gray market."

p BPC estimated this cost by referencing Montana's expenses for conducting a provider rate study with a similar structure, which totaled $900,000. We recognize that states will likely have varying costs for completing these analyses due to differences in their Medicaid programs and health care landscapes. For more information, see: https://medicaidprovider.mt.gov/docs/current/MontanaHCBSSpendingNarrativeandPlan09282021.pdf.

iv. **Congress should require states to create, submit to CMS, and publicly publish strategies outlining the state's provider payment rate-setting methodology for select LTSS. The strategies should also detail the state's plans for monitoring provider payment rates and direct care worker compensation. States should publish their strategies within four fiscal years after the enacting legislation becomes law. Congress should require that states not meeting certain standards following the sixth fiscal year conduct one additional rate study analysis and update their strategies.**

To help states leverage the findings from the analyses, Congress should require states to create strategies for ensuring appropriate provider rate-setting methodology for LTSS. The strategy should be based on the state's first market rate study analysis and include the state's plans for monitoring provider rates for the studied services and compensation for direct care workers. For example, the strategy could describe findings from the rate study analysis; develop a provider rate-setting methodology based on these findings; establish a system for tracking changes in the market conditions; and create performance goals that aim to ensure that compensation for direct care workers remains comparable with changing market conditions. Congress should require states to publish the strategies on their Medicaid websites and submit the strategies to CMS within four fiscal years of Congress enacting the act.

Congress should also provide additional funding to CMS to collect and review states' analyses and strategies. The agency should complete these reviews within seven fiscal years of Congress enacting the act. These reviews should include a determination of whether the states have implemented evidence-based provider rate-setting practices and established procedures to monitor and, when necessary, adjust rates and direct care workers' wages based on economic conditions. Before CMS' evaluation, CMS should establish and disseminate evaluation criteria.

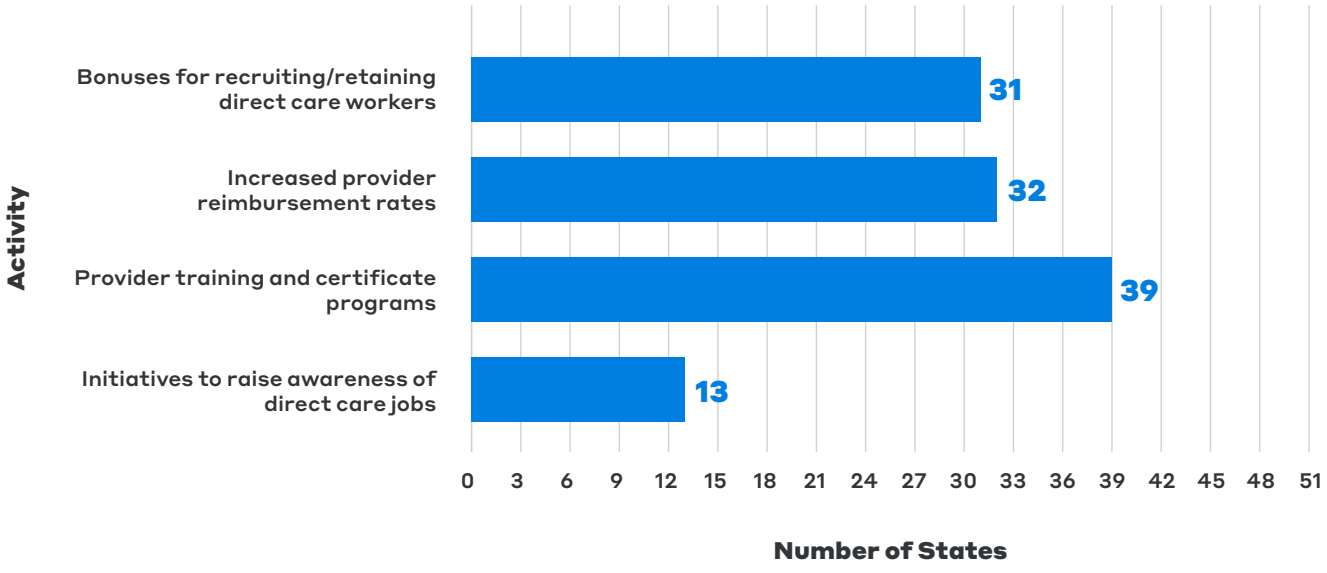
For states that fail to meet this standard, Congress should require them to conduct an additional market rate study within three fiscal years of CMS' determination and to update their strategy within four fiscal years of CMS' determination (see Appendix C for a timeline of these activities). States must submit these materials to CMS and make them accessible on their Medicaid website. This policy builds upon the transparency requirements that CMS proposed in its September and May 2023 proposed rules, incentivizing states to address their direct care worker challenges strategically.

B. Congress should direct HHS to conduct a national study and provide a report to Congress on the relationship between the increased Federal Medical Assistance Percentage provided by the American Rescue Plan Act (ARPA) and its effects on the direct care workforce, associated costs, and quality of care. Within the study, HHS should:

- **collect and analyze qualitative data and, when available, quantitative data;**
- **identify the state-level workforce investments that improved direct care worker recruitment or retention, reductions in federal and state costs, and enhancements in quality of care; and**
- **describe how states modified training requirements for and compensation to direct care workers, including payments to family caregivers under the consumer-directed services model.**

As mentioned in the Background section, many states used the enhanced funding from the ARPA to strengthen their direct care workforces.[152] However, states used significantly different approaches to strengthen their workforces (see Figure 5). This presents an opportunity for the federal government to evaluate the outcomes of states' interventions and identify effective policies for strengthening the direct care workforce.

Figure 5: State Strategies for Using the ARPA Funding to Strengthen the Direct Care Workforce



Source: Advancing States
Notes: Data include the District of Columbia. Data reflect states' plans and may vary in practice.

The federal government has not undertaken or commissioned a comprehensive evaluation of the ARPA's enhanced funding. Although some organizations and states have carried out evaluations, this research is often limited to a subset of states or relies on partial data. A comprehensive evaluation directed by the federal government would build upon this existing research and more effectively capture promising approaches for state and federal policymakers striving to address the direct care worker shortage.

Congress should direct HHS to conduct a national study and provide a report to Congress on the relationship between how states used the ARPA's temporary enhanced Federal Medical Assistance Percentage for HCBS and measures that capture effects on the direct care workforce, federal and state costs, and quality of care. Through interviews with state Medicaid departments and other stakeholders, BPC learned that some states lack sufficient data to assist the federal government with a comprehensive evaluation. To address this concern, the evaluation should include both qualitative and quantitative data collection. For example, qualitative measures could involve capturing the perspectives and attitudes of employers and direct care workers through interviews or surveys, while quantitative measures for workforce analysis might encompass such factors as workforce size or wages.

The national study would assist policymakers by identifying evidence-based policy solutions to address the direct care worker shortage. The research would offer a snapshot of states' direct care workforce landscapes, including information on training requirements and compensation to direct care workers. This information is crucial to federal policymakers to understand the diverse landscape of states' direct care workforces and LTSS systems. The study would identify cost-effective policy solutions that improve direct care worker recruitment and retention and enhance the quality of care for Medicaid beneficiaries receiving LTSS. This research can serve as the foundation for future federal policies aimed at strengthening the nation's direct care workforce and LTSS system.

The evaluation should also consider its findings within the context of broader shifts in the labor market and heightened health risks faced by direct care workers due to the COVID-19 pandemic. Many employers in sectors beyond direct care encountered shortages in their workforces during the pandemic and competed for the same pool of workers. However, for employers in the direct care field, recruiting personnel likely posed greater challenges due to the pandemic's increased health hazards for direct care workers. Additionally, states established their provider reimbursement rates before the pandemic, which limited employers' ability to increase employee incentives in the direct care field. Comparatively, employers in competing fields might have had greater

flexibility to offer enhanced incentives to attract new workers.

As the direct care workforce is made up of and cares for a diverse population, the report should disaggregate data whenever feasible. Researchers could disaggregate data by race, ethnicity, gender, immigration status, and disability type. The research should also include an intersectional policy evaluation that identifies policies to reduce disparities in employment and LTSS access and quality. For example, this research could assess the effects of providing training to direct care workers in various languages. It could also explore the advantages for racial and ethnic minorities who receive LTSS from direct care workers sharing a similar racial or ethnic background.

C. The Administration for Community Living (ACL), through its National Technical Assistance and Resource Center, should assist states in developing and implementing recruitment and retention initiatives that address direct care worker shortages, including (1) developing career lattices for direct care workers and (2) establishing or improving direct care worker training programs, which should allow workers to self-direct their career trajectory through continuing education opportunities and should be available in multiple languages.

Through interviews with state stakeholders, BPC learned that some states and communities need help assessing their direct care workforces and developing interventions to enhance their recruitment and retention strategies. BPC also learned that states and communities would benefit from resources that help them develop training and education programs and career lattices for direct care workers.

With assistance, states can develop training programs for direct care workers that provide statewide, ongoing education opportunities to allow the workers to self-direct their professional pathways. These training programs are essential to improving recruitment and retention of direct care workers. Such programs can also ensure the quality of care provided by equipping direct care workers with training materials and evidence-based practices. Although many states used funding from the ARPA's enhanced federal funding to create these training programs, states will need guidance and support to sustain and improve their programs.

In October 2022, ACL awarded a five-year, $6.5 million grant to establish a national center that offers technical assistance to states and service providers to strengthen the direct care workforce.[153] The center will serve as a hub for tools, resources, and training that states and communities can leverage in their recruitment and retention efforts. The center will also promote state systems change, work directly with states and communities to assess their direct care workforces, and provide customized technical assistance. ACL has commissioned ongoing evaluations of the technical

assistance center, which is set to debut at the end of 2024. The center offers an opportunity for systemic improvements to better support direct care workers.

The National Technical Assistance and Resource Center should assist states with creating online training programs for caregivers that will be available in accessible formats and multiple languages. These programs should also be tied to career lattices. For example, the program could start with a foundational training level that all home health aides enroll in as a state requirement. The state's training center could offer continuing education courses for home health aides seeking to expand their knowledge at post-foundational levels. These courses could create lateral pathways for direct care workers to specialize in specific populations or care needs, such as gaining certificates in dementia care, while also offering opportunities for career advancement through leadership and supervisory training by enabling individuals to obtain certificates and promotions to managerial positions.

In addition to job-related skills and knowledge, the technical assistance center should aid states and employers in offering training and support to help workers navigate aspects of their personal lives beyond their immediate job responsibilities. Training courses could teach workers how to access health care, housing, transportation, financial literacy, community resources, and other determinants of well-being. Because a disproportionate share of the workforce is immigrant, the technical assistance center should help states reduce barriers for foreign-born workers entering and remaining in the direct care workforce.[154] For example, states could develop training courses that explain the immigration system or provide English proficiency classes. Expanding the technical assistance center's focus beyond job-related training can help meet the overall needs of direct care workers. This approach aims to attract and retain direct care workers and improve their job satisfaction.

While the technical assistance center offers a promising avenue for enhancing states' recruitment and retention initiatives, the time-limited nature of the center's work introduces certain challenges. Meeting the growing demand for direct care workers requires a sustained investment in supporting states' recruitment and retention of workers. Slated to operate for just five years, the center might not fully address the need for lasting change. It is essential for Congress and ACL to closely monitor the center's effectiveness, gauging its impact, to make informed decisions about the possibility of extending the center beyond five years.

D. The Center for Medicare and Medicaid Innovation (CMMI) should conduct a demonstration program, considering lessons learned from Kansas' PEAK 2.0 Program and Minnesota's Value-Based Reimbursement Program, across

several states; this program should test a new value-based demonstration for Medicaid payments, where Medicaid provides incentive payments to nursing facility providers that meet certain quality standards and benchmarks for workforce development and staff satisfaction.

State Medicaid programs are shifting from fee-for-service to value-based payment (VBP) models to encourage high quality and cost-effective care. With VBP, the state Medicaid agency creates incentive payments to financially reward high-performing providers. When VBP models include staffing metrics, they encourage providers to expand and support their workforces.

Although state Medicaid departments have historically paid fee-for-service for LTSS provided in nursing homes, states have begun operating VBP models for nursing facilities. At least 20 states and the District of Columbia included value-based initiatives in their payment systems for these facilities in 2021, with seven states including staffing measures.[155] Only two states, Kansas and Minnesota, have conducted formal evaluations of their VBP programs: PEAK 2.0 Program and the Value-based Reimbursement Program, respectively.[156,157] Both evaluations suggested that VBP is a viable option for incentivizing culture-change practices in nursing homes, such as staff education and training, and for increasing wages.

The federal government has increasingly used VBP. For example, Medicare payments for hospital and skilled nursing facility care are linked to performance through mandatory VBP programs.[158] However, the federal government has not implemented a nationwide VBP initiative for Medicaid-covered nursing facility care.[159]

CMMI should design and pilot a demonstration model across several states to evaluate how federal payments can incentivize nursing facilities to recruit and retain their direct care workforces. Similar to the state-implemented models, CMMI's model should provide incentive payments to providers who meet certain quality standards and benchmarks for workforce development and staff satisfaction. The CMMI model could include measures on direct care workers' wages or retention rates and provide incentives for nursing homes that meet staffing levels that are above the new minimum staffing requirements in CMS' September 2023 proposed rule. By aligning financial incentives with workforce development, adequate staffing, and staff satisfaction, Medicaid incentivizes nursing facilities to invest in recruitment, training, and retention. This, in turn, can help alleviate the direct care workforce shortage.

When designing the model, CMMI should consider the lessons learned from Kansas and Minnesota's VBP models, such as including a limited number of performance measures to reduce providers' administrative

burden of operating in the model and ensuring sufficient incentives for providers to meet performance goals. CMMI should also consider how modifying the reimbursement rates for LTSS in nursing homes can impact LTSS providers in other settings, such as home and community settings.

E. Congress should appropriate $4 million for the National Health Care Workforce Commission in FY2025 to perform a comprehensive evaluation of the health care workforce, including the direct care workforce landscape. The commissions should deliver a report to Congress within three years of receiving the appropriation, describing findings of the evaluation and providing policy recommendations to strengthen the impact of federal education and training programs on mitigating the workforce shortage. It should also offer strategic partnership to HHS, the departments of Labor, Veterans Affairs, and Homeland Security, as well as other federal agencies administering federal workforce programs, to ensure the programs address health care labor shortages.

BPC learned in interviews with researchers and state stakeholders that the fragmented federal education and training programs do not sufficiently address recruitment and retention challenges fueling the direct care workforce shortage. The federal government does not have a unified approach to understand and strategically mitigate the health care labor shortages. Conducting a comprehensive assessment of the health care labor market, enhancing federal education and training initiatives, and bolstering federal coordination of workforce programs would collectively ensure that Americans receive high value health care services.

The Affordable Care Act established the National Health Care Workforce Commission to address health care workforce issues.[160] Its purpose was to serve as a national resource, coordinate with relevant federal agencies, evaluate federal education and training programs, identify and address barriers to improved coordination of these programs, and encourage innovation to address health care labor shortages. However, Congress never appropriated funding for the commission, preventing the commission from beginning its work.

As a crucial step toward addressing the health care labor shortages, including for direct care workers. Congress should appropriate $4 million to the commission in FY2025. BPC based this estimate on the Senate Labor-HHS Appropriations Subcommittee's proposed $3 million for the commission in FY2015, adjusted for inflation. The commission should perform a comprehensive evaluation of the health care workforce landscape, including the direct care sector. Congress should continue to fund the commission following FY2025.

The commission should describe its findings in a report to Congress. The report should evaluate how the existing federal education and training programs address recruitment and retention challenges in the direct care sector; it should also discuss opportunities to strengthen the programs' impact on mitigating the shortage. For example, BPC learned that a lack of testing sites and proctors is significantly delaying nurse aide certification in many states. The report could explore how states could use existing federal programs to increase access to certified nurse aide education and certification sites. The report should also include estimated supply and demand of health care workers, including direct care workers. Congress should direct the commission to submit the report within three years of Congress appropriating the funding.

The commission should also partner with federal agencies that administer the education and training programs and advise the agencies on implementation. This would help ensure that federal entities create a coordinated and proactive response to the ongoing health care labor shortages.

F. As part of a larger update to tax policy required in 2025 due to many expiring provisions, Congress should establish a refundable tax credit for caregivers to help with out-of-pocket costs for paid LTSS-related care, allowing those with qualifying incomes to claim up to a maximum $3,000 credit for each qualifying family member. Congress should scale this credit as needed, consistent with a full tax plan that strengthens the overall fiscal outlook.

Unpaid caregivers play an important role in supporting the paid direct care workforce by helping them meet the increasing demand for care. Unpaid and paid caregivers share an interconnected relationship; each provides relief to the other, reducing burnout among both types of caregivers and increasing retention among paid direct care workers and continued caregiving by unpaid caregivers. Given that many individuals prefer to receive care from family members or friends, reforms to support unpaid caregivers can help increase the availability of paid direct care workers.

Despite the economic value of their contributions reaching $600 billion, unpaid caregivers often bear a financial burden for providing their help.[161] For example, the average out-of-pocket expense for unpaid family caregivers in 2021 was $7,242.[162] Younger caregivers and Black and Hispanic/Latino caregivers incur higher financial strains, with Hispanic/Latino and Black caregivers experiencing the greatest financial strain of unpaid caregiving.[163] The financial costs are further complicated by the fact that caregiving can affect caregivers' income. For example, caregivers may need to take time off work to provide care for a family member. The total financial burden on unpaid caregivers affects if and to what extent they can step into these roles.

CMS created flexibilities allowing state Medicaid departments to pay family caregivers during the PHE. Thirty-nine states used these authorities for some of their HCBS populations.[164] Of the 39 states that paid family caregivers, 20 states reported that they would continue the policy after the PHE ended.[165] However, some family caregivers, depending on the state and waiver type, will again be unpaid caregivers.

Congress should provide a refundable tax credit equal to 30% of a caregiver's qualified out-of-pocket LTSS-related expenses, up to a maximum $3,000 credit for each qualifying family member (i.e., requiring $10,000 worth of expenses to claim the full $3,000 refundable credit).[q] The tax credit should be refundable to help subsidize the expenses of those who have no tax liability. The tax credit would begin phasing out for couples with annual household income above $120,000 (or $80,000 for single filers), and fully phase out at $200,000 for couples (or $133,000 for single filers). There would be no income limit for the care recipient. For caregivers to qualify for the tax credit, the taxpayer must be at least age 25 and the care recipient would need to either be (1) a qualifying relative (regardless of cohabitation with the taxpayer), or (2) an individual, of any age, who has the same principal place of abode as the taxpayer and is a member of the taxpayer's household.[r] The family member would also have to meet the Health Insurance Portability and Accountability Act's standard for functional or cognitive impairment. For out-of-pocket costs to count toward the tax credit, expenditures must assist the care recipient in accomplishing ADLs or instrumental activities of daily living (IADLs); expenditures must also be provided solely for the use of the qualified recipient. See Appendix D for a comparison of BPC's proposed tax credit with current law tax benefit options for family caregivers.

BPC's 2017 report, *Financing Long-Term Services and Supports*, explored this refundable caregiver tax credit and contracted with the Urban Institute to evaluate the cost to the federal government. At that time, the Urban Institute estimated that the 10 year federal budgetary cost of the tax credit, in the form of reduced federal revenues and increased tax expenditures, would be $130 billion over the 2018-2027 window.[166] Although policymakers should consider the financial implications of this recommendation, BPC backs this option because it is one of the quickest and most direct ways to ensure caregiving for a growing elderly population. Congress should incorporate this tax credit within the broader framework of the nation's tax system and budget when revisiting

q BPC described this policy option in a previous report, *Bipartisan Solutions to Improve the Availability of Long-term Care (2021)*.

r Qualifying relatives include (i) siblings and stepsiblings; (ii) parents or ancestors of either, including father/mother-in-law of a widow(er) who is no longer in a tax unit with the child; (iii) stepparents; and (iv) siblings of father or mother of taxpayer (i.e. aunts/uncles). Cohabitation with the taxpayer is not required for these qualifying relatives.

a comprehensive tax bill in 2025.[s,167] It is important to note that some of these costs could offset other LTSS spending, especially within Medicaid. The unpaid care and financial aid that family caregivers provide can help to keep frail and functionally or cognitively limited individuals in their homes and, in turn, delay the need for expensive LTSS, such as nursing facilities.

This recommendation resembles the Credit for Caring Act of 2021, introduced by Sen. Joni Ernst (R-IA) with two initial Democratic and one Republican co-sponsor in the 117th Congress. Rep. Linda Sánchez (D-CA) introduced a bipartisan companion bill, with 63 Democratic and 11 Republican co-sponsors.

II. Grow the Number of New Workers via Domestic and Targeted Immigration Reforms

Policymakers should strengthen worker recruitment to meet the escalating demand for direct care workers. Given the urgent and significant labor shortage, BPC recommends legislative reforms to increase the number of new workers, some of whom are currently residing outside of the United States or are in the country without authority to work. These reforms should strength domestic development initiatives such as Registered Apprenticeship programs and establish a grant program to lower barriers for individuals entering direct care occupations.

Domestic reforms to increase the number of direct care workers

A. The Labor Department and Congress should strengthen registered apprenticeship programs.

i. Congress should provide statutory authority for the Labor Department's Office of Apprenticeship, the National Advisory Committee on Apprenticeship, and state-level administrative units.

Apprenticeship programs, led by employers and encompassing hands-on learning and classroom instruction, are highly effective in preparing individuals to enter the direct care workforce. In the United States, businesses, labor groups, community organizations, or colleges usually oversee these programs. The Labor Department collaborates with these entities to develop Registered Apprenticeship programs.

While the National Apprenticeship Act laid the foundation for apprenticeships in the United States, Congress has not officially established the administrative systems that currently govern the nation's

s The Tax Cuts and Jobs Act amended numerous provisions of U.S. tax law. These changes took effect on January 1, 2018, and many provisions are scheduled to expire after December 31, 2025.

apprenticeship infrastructure.[t,168] For example, Congress has not provided statutory authority to the Labor Department's Office of Apprenticeship, which oversees the national Registered Apprenticeship programs and provides technical assistance to state apprenticeship agencies and employers.[169]

Congress should provide statutory authority for the Office of Apprenticeship, the National Advisory Committee on Apprenticeships, and state-level administrative units; in doing so, it should ensure an ongoing commitment to develop apprenticeship programs nationally and to address urgent labor shortages, including direct care worker shortages. This recommendation is similar to the bipartisan National Apprenticeship Act of 2021, which Rep. Bobby Scott (D-VA) introduced along with eight Democratic and eight Republican original co-sponsors in the 117th Congress.

ii. The Labor Department should approve personal care aides as a registered occupation within its Registered Apprenticeship programs.

REGISTERED OCCUPATIONS

Registered Occupations are eligible for a variety of benefits, such as:

- technical assistance and support from a national network;
- national credentials;
- tax credits in many states; and
- federal resources.

The Labor Department approves occupations as Registered Occupations, granting employers in these occupations access to more resources and a streamlined process for developing apprenticeship programs. Typically, employers engage the Office of Apprenticeship if they wish to set up a Registered Occupation designation. Although employers can create registered apprenticeship programs for occupations not yet approved by the Labor Department, the process is more burdensome and time consuming than the process for employers to create programs for Registered Occupations.

Currently, the Labor Department has designated home health aides, psychiatric aides, direct support professionals, and certified nursing assistants as Registered Occupations; personal care aides lack this designation.[u] To help address the direct care workforce shortage, the Labor Department should approve personal care aides as a Registered Occupation. This would increase the availability of apprenticeship programs for personal care aides because it would reduce the

t In 2008 and 2016, the Labr Department issued two final rules, 29 C.F.R. Part 29 and 29 C.F.R. Part 30, that established regulations governing the National Apprenticeship System and made changes to enhance equal opportunity to Registered Apprenticeship Programs.

u The Labor Department considers occupations listed under Alternative Occupation Titles as Registered Occupations as long as the occupations' ONET Code is a Registered Occupation.

administrative barriers for employers seeking to create apprenticeship programs.

B. Congress should reauthorize federal workforce development programs under the Workforce Innovation and Opportunity Act (WIOA) and career and technical education programs under the Carl D. Perkins Career and Technical Education Act through FY2030.

Reauthorization of the WIOA

The workforce programs under the WIOA provide education and training services to prepare individuals for joining the workforce, including job search assistance, supportive services, and occupational skill training.[170] States and localities can use WIOA-funded workforce programs to increase the recruitment of direct care workers. Each state has a statewide workforce investment board and multiple local boards that oversee WIOA service delivery and decide on funding. For example, a board could award a competitive grant to a community organization to provide certified nurse aide training. The WIOA requires that the majority of a board's membership consist of business leaders representing industries with employment opportunities, which can include long-term care providers.

Congress originally funded the WIOA from FY2015-2020 and has since extended authorization through the annual appropriations process.[171] Currently, appropriations for WIOA programs and activities are set to expire on July 1, 2024.[172]

To tackle labor shortages, including in the direct care workforce, Congress should reauthorize federal workforce development programs under the WIOA until FY2030. This reauthorization, spanning six years, would mirror the initial authorization period of the WIOA. Achieving a sufficient direct care workforce involves making long-term investments in WIOA programs. Extending the reauthorization of these programs presents an opportunity for states and programs to enhance their planning and implementation of workforce development initiatives. An extension until FY2030 would enable states to more strategically allocate federal funds, resulting in a more efficient utilization of federal resources.

Reauthorization of the Carl D. Perkins Career and Technical Education Act

The Carl D. Perkins Career and Technical Education Act of 2006 (Perkins IV) is the primary federal law aimed at developing and sustaining vocational and education courses, which recruit and train direct care workers.

States use Perkins-funded career and technical education programs to recruit and train certified nurse aides, but it is less common for a state to create these programs for other direct care occupations, such as

personal care aides. States often prioritize programs that train workers for high wages and high skills jobs that align with the needs of the local job market. Although the need for direct care workers in most local job markets is significant, the low wages and minimal training standards for some direct care occupations can pose barriers to creating Perkins-funded programs. States also often prioritize programs that offer a credential of value, which is a barrier for direct care occupations that have no federal training requirements, such as personal care aides.

Despite these challenges, enhancing access to Perkins-funded career and technical education programs could help address the shortage in direct care workers.[173] Besides providing training, these programs have the potential to raise awareness about direct care occupations among individuals and contribute to the professionalization of these roles. These measures can lead to improved societal perception of direct care jobs. As policymakers strive to bolster wages and career lattices for direct care roles, career and technical education programs will likely assume a more prominent role in increasing the number of these workers.

The Perkins funding is set to expire at the end of FY2024.[174] Congress should reauthorize career and technical education programs under Perkins IV through FY2030. This reauthorization would bolster the recruitment of direct care workers by increasing individuals' awareness of available employment opportunities in the direct care sector and by providing training for individuals to enter direct care occupations.

C. Congress should establish a grant program and appropriate $225 million to support up to 75 grantees with awards of up to $3 million over three fiscal years to develop and carry out projects that reduce barriers to recruiting direct care workers and match prospective workers with direct care employers. The Health Resources & Services Administration (HRSA) should administer the grant program and set aside at least 10 of these grants for applicants helping immigrants enter direct care occupations.

HRSA oversees programs aimed at training health professionals and sending them to areas with provider shortages. Managed by HRSA's Bureau of Health Workforce, these programs encompass over 40 grants dedicated to health professional training.[175] Congress has a significant opportunity to establish an HRSA program that would focus on recruiting and retaining direct care workers. Although HRSA's Geriatrics Workforce Enhancement Program currently offers grants for organizations focused on training certified nursing assistants, HRSA does not offer broader grants to increase the number of workers in other direct care occupations.[176]

Congress should establish a three-year grant program, similar to HRSA's Community Health Worker and Health Support Worker Training Program (CHWTP), to support projects aimed at increasing the pool of direct care workers. These projects should equip workers with the necessary skill sets to deliver high value care to patients, while also addressing barriers to direct care worker recruitment. For example, a project could offer industry-specific English language training to mitigate language barriers to direct care occupations. Projects could also provide childcare and transportation assistance to overcome common barriers to employment. To ensure the sustainability of projects, HRSA should require applicants to submit plans outlining their strategies for ensuring continued operations after the grant concludes.

Congress should allocate $225 million to support up to 75 grantees. Eligible applicants should include states, territories or local governments, tribes and tribal organizations, and any other appropriate public or private nonprofit entities. This proposed funding amount is based on HRSA's CHWPT.[177] Grantees should be eligible to receive a maximum of $3 million over the three-year grant duration. Recognizing the additional barriers immigrants face in the direct care labor market, Congress should mandate HRSA to reserve at least 10 of these grants for applicants assisting immigrants in entering direct care occupations. To enhance health equity, HRSA should prioritize awarding participation to applicants operating in regions experiencing higher-than-average unmet demand.

Targeted immigration reforms to supplement the number of direct care workers

In addition to domestic reforms, BPC recommends a series of immigration reforms to expand the direct care workforce. For the past two decades, Congress has not passed comprehensive immigration reform despite consensus across party lines that the current immigration system is broken.[178] *In light of this, BPC recommends that Congress undertake comprehensive immigration reform.*[v] *However, recognizing the urgent need to address the direct care worker shortage, Congress should also implement the following incremental immigration reforms to bolster the accessibility of visas for direct care workers.*

These recommendations include reforms to increase the number of permanent employment-based visas (i.e., green cards) available for direct care workers and expedite the visa process for these workers. We also recommend changes to nonimmigrant visas (i.e., temporary work visas), including modifications to the J-1 Visa Exchange Visitor Program and creating a nonimmigrant employment-based visa for low-skill workers (see Appendix E for information on the different visa classifications). The final recommendation establishes a program for eligible direct care workers to earn legal status through continued direct care work employment.

v See BPC's report, *Reforming Employment-Based Immigration* (July 2022). Available at: https://bipartisanpolicy.org/report/reforming-employment-based-immigration/.

D. Congress should amend the Immigration and Nationality Act (INA) to recapture permanent employment-based visas (i.e., green cards) previously unused for FY1992 through FY2021 to increase the number of employment-based visas, up to 65,000 visas, available for FY2024 or any subsequent fiscal year to fill health care workforce shortages. Congress should reserve 25,000 of these visas for direct care workers. Congress should not count visas for certain family members to accompany the principal beneficiary of these permanent employment-based visas against the 65,000 cap.

Permanent employment-based visas (i.e., green cards) aim to fill labor shortages across various skill and education levels. Green card recipients are permitted to live and work in the United States indefinitely, for any employer (although they must work for some period of time for their sponsoring employer to avoid concerns about fraud in the application). Green card holders can apply for citizenship through naturalization after they have been a permanent resident for at least five years, if they so choose; naturalization is neither automatic nor required of permanent residents.

The INA establishes an annual limit on permanent employment-based immigrant visas, including numerical restrictions and per-country caps, leading to backlogs and long applicant wait times. Although this cap can fluctuate if visas go unused in prior years, it has generally remained at or close to 140,000 since 1990. The total includes primary visa applicants in all five employment-based categories and their accompanying family members.[179] In addition to the overall annual cap, per-country caps allocate 7% of total visas to any single country.[w] Because of these numerical limits and per-country caps, applicants with approved visa petitions might still have to wait to apply to receive their green cards. When the number of approved applicants exceeds the annual or per-country caps, a backlog forms. This results in substantial wait times for applicants to receive a green card.

Still, due to bureaucratic and administrative delays, the government sometimes grants fewer employment-based visas than the numerical cap available in that year. For example, in FY2021, largely due to processing issues and travel restrictions arising from COVID-19, the government did not issue approximately 25% of the total available employment-based visas.[180] Although the agencies issued all available employment-based visas in FY2022, unused employment-based visas from prior years cannot be recaptured for future use under current immigration law.[x,181]

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w See Appendix F for information on preference categories and numerical limits.

x Congress, however, approved an exception that allowed unused EB-3 visas from that year to carry over to the next fiscal year.

Prospective employers can sponsor direct care workers for green cards in the employment-based third preference (EB-3) visa category. The EB-3 category is designated for "skilled, professional, and unskilled workers."[y] Each year, approximately 40,040 EB-3 visas are newly available, along with any additional visas that remain unused from the employment first- and second-preference categories.[182]

To expedite the visa backlog and lessen the shortage of direct care workers, Congress should amend the INA to recapture permanent employment-based visas that remained unused from FY1992 through FY2021. This recommendation aims to increase the pool of available permanent employment-based visas, up to 65,000 visas, for FY2024 or any subsequent fiscal year, specifically to address health care workforce shortages. Within this allocation, Congress should reserve 25,000 visas for direct care workers. Congress should not count visas for certain family members to accompany the principal beneficiary of these permanent employment-based visas against the 65,000 cap. To reduce delays some applicants experience in securing visas, Congress should also exempt country caps when processing the EB-3 visas.[183]

This recommendation would increase green cards for foreign workers in the direct care field, which can help alleviate direct care worker shortages. Greater availability of foreign workers could be especially important for rural areas because residents in these areas tend to be older than those living in metropolitan areas.[184] Additionally, foreign-born workers often bring diverse cultural experiences and multiple language proficiencies that can help address health disparities and improve the value of direct care services.

The recommendation resembles provisions in the bipartisan Healthcare Workforce Resilience Act, which Sens. Dick Durbin (D-IL), John Cornyn (R-TX), Patrick Leahy (D-VT), Todd Young (R-IN), Christopher Coons (D-DE), and Susan Collins (R-ME) introduced in the 117th Congress and will reportedly reintroduce in the current session with some changes. However, BPC's recommendation increases the number of permanent employment-based visas available from that bill by 25,000 and allocates these visas to direct care workers. Also, BPC's recommendation does not tie the timeframe in which employers can petition for the visas to the end of the COVID-19 PHE, which the Biden administration ended in May 2023.

In previous work, BPC has recommended overall increases in employment-based immigration to meet various economic and labor needs in the country. However, Congress has not passed such reforms despite urgent

y The U.S. Citizenship and Immigration Services defines subcategories of EB-3 visas as skilled, professional, and unskilled. Within these categories, direct care occupations are classified as unskilled. Although BPC has adopted this classification for consistency with statutes and regulations, these positions do require significant skills and play an essential role in the functioning of the economy.

workforce shortages.[z] Recent bipartisan legislation has focused on "recapturing" unused visas from past years and allocating them to needed industries or occupations. Considering Congress's lack of progress in passing broader immigration reforms, BPC supports recapturing unused visas from past years as an interim step to alleviate direct care and other workforce shortages. This recommendation should not be seen, however, as abrogating the need for Congress to comprehensively reform the country's employment-based immigration system. And it should be noted that reserving 25,000 visas for direct care workers would be lower than the anticipated need for direct care workers; Congress should therefore still enact overall increases in employment-based immigration.

E. Congress should direct the Labor Department to classify direct care professions as Schedule A shortage occupations for at least five fiscal years, allowing streamlined and simplified visa processing.

The Labor Department determines which occupations, referred to as Schedule A occupations, face a shortage of U.S. workers who are "able, willing, qualified, and available" to fill the demand.[185] To designate an occupation as Schedule A, the department must also determine that the employment of noncitizens in this field will not "adversely affect" the wages and working conditions of U.S. workers in comparable positions.[186]

Currently, the Labor Department has designated three occupations as Schedule A: physical therapists, professional nurses, and immigrants with exceptional ability in the sciences or arts.[187] While Schedule A was intended to maintain a current, evidence-based list of occupations experiencing labor shortages, the department has not updated the list since 1991.

Applicants and employers seeking to fill occupations listed under Schedule A benefit from an expedited and simplified employment-based visa process. Under the standard employment-based visa process, a U.S. employer must undergo supervised domestic recruitment by the Labor Department to prove that it attempted to hire a U.S. worker and that no U.S. workers who are able, willing, qualified, and available accepted the job opportunity.[188] Between January and February 2023, the average processing time for permanent labor certifications was about five and a half months.[189]

For Schedule A occupations, employers bypass this process. Although employers still need to obtain a prevailing wage determination from the Labor Department and submit forms to the U.S. Citizenship and

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z BPC believes employment-based immigration should be flexible to address labor needs. For more information, see BPC's 2022 report, *Reforming Employment-Based Immigration*. Available at: https://bipartisanpolicy.org/report/reforming-employment-based-immigration/.

Immigration Services (USCIS), this process takes between 26 days and three months depending on the data the employer uses to complete these steps.[190] The faster review process results in quicker decisions for applicants seeking employment-based visas in these occupations.

Designating direct care occupations under Schedule A would streamline and simplify the employment-based visa process for these workers. The designation could also help attract native-born workers and enhance resources to these professions, because a Schedule A designation can raise public awareness of a job's importance and underscore the necessity for additional resources to bolster the workforce.[191]

BPC has recommended policymakers to update and continuously maintain a Schedule A occupation list that is based on labor data and trends. BPC explored the possibility of setting up an Independent Permanent Commission on the Labor Market. This commission would serve as a neutral arbiter of data, be staffed by career experts rather than political appointees, and ensure that the visa system accurately reflects labor market needs.[192] These recommendations would address the direct care workforce shortage. In interviews with BPC, labor experts said that the absence of Schedule A designation for direct care occupations is a consequence of the Labor Department's infrequent updates to the list. These experts agreed that the shortages warrant Schedule A designation.

Given the lack of progress in updating and maintaining a Schedule A shortage occupation list and the urgent need to augment the direct care worker shortage, BPC recommends that Congress direct the Labor Department to establish a temporary Schedule A designation for direct care occupations. Although the department does not need congressional authorization to make such a designation, BPC recommends Congress issue a directive because the department has competing priorities and because of the urgent need for direct care workers. This temporary Schedule A designation should sunset after five fiscal years. Congress should direct the Labor Department to update the Schedule A occupation list, including completing an evaluation of direct care occupations to continue as Schedule A, during this time. Congress should also direct the department to establish a process for continuously evaluating and updating the list no less than once every five years. BPC's intention is to establish an interim option to immediately address the direct care worker shortage while also ensuring the Labor Department continuously updates Schedule A so that the visa system more accurately reflects current workforce needs.

F. The State Department should modify the J-1 Visa Exchange Visitor Program's au pair category to increase cultural exchange and to permit qualifying migrants to work legally in caregiving professions for older adults. The

State Department should also establish separate training requirements for J-1 au pair recipients working with older adults and improve oversight of the J-1 Visa Exchange Visitor Program.

The J-1 Visa Exchange Visitor Program is a nonimmigrant, cultural exchange program run by the U.S. Department of State that grants visas to foreign individuals involved in work- and study-based programs and allows them to temporarily reside in the United States. The program consists of 14 categories, including au pairs, physicians, and teachers.[193] The au pair category matches about 21,000 international au pairs each year with American families to provide child care in exchange for wages and an experience of American culture.[194] The J-1 visa allows au pairs to legally reside in the United States for one year while caring for children in an approved host family. Au pairs in good standing can apply for an extension of six, nine, or 12 months to continue in the program. The primary objective of the J-1 Visa Exchange Visitor Program is to "increase mutual understanding between the people of the U.S. and the people of other countries by means of education and cultural exchange."[195]

The J-1 Visa Exchange Visitor Program, established by the Fulbright-Hayes Act of 1961, enrolled almost 300,000 participants across all categories in 2022.[196,197] Each participant is connected to a program sponsor, who serves as a legal entity designated by the Secretary of State to oversee exchange visitor programs. Program sponsors must adhere to certain requirements, such as offering exchange visitors a variety of cross-cultural activities and "encouraging exchange visitor to participate in activities that are for the purpose of sharing the language, culture, or history of their home country with America."[198]

The J-1 Visa Exchange Visitor program results in several positive outcomes, including promoting cultural exchange, increasing workforce diversity, improving diplomatic relations, and filling gaps in the workforce. Surveys of J-1 visa au pairs found that 63% had a more positive view of the United States, 79% improved in their English comprehension, and 84% thought the program supported their career and educational goals.[199] Research also found that families hosting au pairs benefited from the program, such as improving the host families' abilities to interact with individuals from other countries. Two-thirds of host families said they would not have been able to find suitable care for their children if it were not for the program.[200]

However, controversies have surrounded the J-1 Visa Exchange Visitor Program. Some participants have encountered exploitative working conditions, insufficient legal safeguards, or limited oversight.[201] A group of J-1 visa recipients participating in the au pair category filed a lawsuit against their sponsors, citing collusion and wage theft.[202] The existing oversight framework, where program management and monitoring are

largely delegated to program sponsors, contributes to many of these problems. The State Department conducts compliance reviews and imposes sanctions; however, issues remain due to the current oversight structure.[203]

With more robust oversight and enhanced worker protections, however, the J-1 au pair category offers a valuable avenue to foster cultural exchange between care recipients and caregivers, while also addressing the direct care worker shortage.[204] To alleviate the worker shortage, the State Department should modify the J-1 Visa Exchange Visitor Program's au pair category to increase cultural exchange and permit qualifying migrants to legally work in caregiving roles for older adults. This program would provide a cultural exchange opportunity where participants can learn about American health care practices and culture while engaging with diverse communities; individuals receiving care, meanwhile, can learn about participants' home countries. In providing this cultural exchange, the program would also increase the direct care workforce.

Additionally, the State Department should establish separate training requirements for J-1 au pair recipients working with older adults and, in conjunction with the Labor Department, enhance oversight of the J-1 Visa Exchange Visitor Program to guard against exploitation of program participants and older adults receiving care. This multipronged approach utilizes the potential of the J-1 Visa Exchange Visitor Program.

G. Congress should amend the INA to establish a four-year nonimmigrant employment-based visa classification (i.e., temporary work visa) for low-skill health care workers. The new category would be capped at no more than 15,000 visas each fiscal year starting FY2025 through FY2027. Starting in FY2028 and ending in FY2030, Congress should modify this cap based on the National Health Care Workforce Commission's comprehensive evaluation of the direct care workforce. Congress should also require the petitioning facility to complete a labor certification process, including an attempt to recruit U.S. citizens for these positions.

The U.S. immigration system has historically addressed labor shortages in high skilled health professions, including nurses and physicians, but it has neglected to respond to shortages in low-skill health care professions. The current system lacks a temporary nonimmigrant visa for low-skilled health care workers despite the persisting labor shortage of direct care workers. Introducing such a visa category would permit foreign-born workers to fill roles when native-born workers are unable to meet the demand.

In the past, Congress took steps to address nursing shortages through the creation of nonimmigrant visas. The Nursing Relief for Disadvantaged Areas Act of 1999 introduced four-year nonimmigrant (H-1C) visas tailored

for registered nurses operating in health professional shortage areas.[205] This program, however, capped visas at 1,000 annually and ended in 2009. The program also did not include low-skill health care workers. In 1997, Congress discontinued the prior H-1A nonimmigrant visa for nurses created by the Immigrant Nursing Relief Act of 1989.

Congress should amend the INA to establish a four-year nonimmigrant employment-based visa classification (i.e., temporary work visa) for low-skill health care workers. The structure of these visas should mirror that of existing nonimmigrant employment-based visas, such as H-1B visas, which allow for green card sponsorship.[aa] However, similar to other work visa programs, such as H-2A or H-2B, Congress should require the petitioning facility to complete a labor certification process, including an attempt to recruit U.S. citizens for low-skill health care positions before granting eligibility to sponsor a foreign worker.

The new category should be initially capped at no more than 15,000 per year for FY2025 through FY2027. BPC based this cap at 25% of the existing temporary H-1B visa cap, which limits the number of H-1B visas to approximately 65,000 per fiscal year.[ab] Ideally, USCIS should make the number of visas flexible based on labor needs. However, BPC is not including this recommendation to address the direct care workforce shortage due to political feasibility and the urgent need to address the shortage. As a compromise, BPC recommends that Congress adjust the annual cap beginning in FY2028 and through FY2030 based on the findings of the National Health Care Workforce Commission's comprehensive evaluation of the direct care workforce (see recommendation I.E.).

This recommendation is an interim step that is politically more feasible than comprehensive immigration reform, which BPC has advocated for, and would immediately address the direct care worker shortage. In addition, Congress should pursue comprehensive immigration reform that would achieve a more equal balance of temporary and permanent visas. Congress should also adopt changes that would adjust the number of visas based on labor needs.[206]

BPC's intention behind this recommendation is to target regions experiencing higher-than-average unmet demand. Pinpointing these areas poses a challenge, however. BPC could not find data identifying regions experiencing higher-than-average unmet need for direct care workers. BPC considered restricting these visas to direct care workers employed in

aa The H-1B program is a temporary work visa program that allows employers to hire foreign nationals in specialty occupations, typically requiring a bachelor's degree or higher, for a specified period. For more information, see: https://www.dol.gov/agencies/whd/immigration/h1b.

ab H-1B visa caps include an additional 20,000 visas designated for individuals with master's degrees or higher.

designated health professional shortage areas. But, BPC determined that there was insufficient evidence to link professional shortage areas with heightened shortages of direct care workers, as HRSA does not consider shortages of direct care workers when determining health professional shortage areas.[207]

H. To address the urgent direct care workforce shortage and ensure quality of care for individuals with LTSS needs, Congress should establish a legalization program for qualifying foreign-born workers who will help relieve the country's direct care workforce shortage. This program should be available to eligible foreign-born workers who currently reside in the United States and should provide them with the proper authorization to legally remain in the country, work, and pay taxes. Key program details include:

- ***Eligibility*: Individuals who apply within an 18-month application period, are present in the United States as of the legislation's date of enactment, have performed at least 180 days of direct caregiving labor over the past two years, and are otherwise admissible.**
- ***Certified Direct Care Worker (CDCW) status:* Eligible individuals should receive CDCW status, valid for five years and renewable indefinitely, provided that the CDCW holder continued to work in direct care for at least 100 days per year. Congress should allow long-term CDCW holders to adjust to lawful permanent resident (LPR) status by engaging in additional direct care work and paying a $1,000 fine.**
- ***Protections*: Congress should establish safeguards for individuals (and their spouses and minor children) applying and participating in this program.**
- ***Reporting*: Congress should direct the secretary of Labor and the secretary of HHS to submit a report evaluating the impact of the program within three years after enactment of the legislation and every three years thereafter.**

A large population of unauthorized immigrants currently resides within the United States, with a substantial portion having established their lives and employment in the country over multiple years, often having entered legally. Between 2017 and 2020, estimates of the number of individuals who resided in the United States without proper authorization ranged from 10.5 million to 11.5 million, depending on the source.[208] An increasing share of undocumented residents arrived through legal channels and have overstayed their visas.[209] An estimated 65% of the undocumented resident population was employed in 2019, fulfilling essential roles in the nation's labor market.[210] Although data on the number of undocumented residents currently working in direct care roles is limited and difficult to capture, one estimate found that 140,000

undocumented residents worked as home health aides, nursing assistants, and personal care aides in 2020.[211]

There are a variety of arguments for offering legalization for long-term undocumented residents. Humanitarian considerations are vital, recognizing the need to provide refuge and stability for those who have fled adversity and often unsafe circumstances in their home countries. Family unity is another important consideration. Undocumented residents often have family members who are residing legally in the country, and offering legalization for undocumented residents would help ensure families can remain together.

Legalization for undocumented residents also aligns with economic demands, such as addressing workforce shortages. Some employers can address labor shortages by raising wages and offering other incentives. However, external factors can affect some employers' ability to increase wages or provide other incentives. Given the existing landscape where a substantial number of undocumented residents are already active contributors to the direct care workforce, offering legalization would play an important role in collecting taxes and mitigating the risk of worker exploitation.

To uphold both the quality of care and the quality of life for those with LTSS needs while addressing the existing labor shortage, Congress should establish a limited program for qualifying undocumented residents, their spouses, and minor children to earn status through continued direct care work. This program would resemble the legalization program for certified agriculture workers proposed in the bipartisan Farm Workforce Modernization Act.[ac] Acting on this recommendation should not supplant Congress's obligation to pass broader reforms to legalize long-term undocumented residents.

Congress should make this program available to foreign-born workers currently residing in the United States but lacking the necessary authorization to stay, work, and pay taxes. Eligible individuals should include those who are foreign-born, present in the country at the time Congress enacts the act, apply within an 18-month application window, have completed at least 180 days of direct caregiving labor over the previous two years, and meet other immigration admissibility requirements, such as passing criminal and security background checks. Eligible individuals would receive CDCW status, which would be valid for five years and could be renewed indefinitely, provided that the individual continues to work in direct care for at least 100 days per year. Spouses and

ac Rep. Zoe Lofgren (D-CA) reintroduced the Farm Workforce Modernization Act (H.R. 4319) in the 118th Congress with five Democratic and four Republican co-sponsors. The legislation passed the House with strong bipartisan support in the 116th and 117th Congresses.

minor children of CDCW holders could legally remain in the United States and work so long as the primary CDCW holder continues to renew and participate in the program.

Individuals with CDCW status should have the opportunity to earn legal permanent resident (LPR) status. Individuals applying for LPR status would have to pay a $1,000 fine and meet one of two additional direct care work criteria. Direct care workers with a minimum of 10 years of experience prior to the act's enactment would be eligible for LPR status if they work for an additional four years while holding CDCW status. Those who had less than 10 years of experience in direct care before enactment would be eligible for LPR status after working in direct care with CDCW status for at least eight years. Those with LPR status may apply to sponsor their spouses and minor children.

To remove barriers to participation and ensure the well-being of those participating in the program, Congress should establish protections for applicants and participants. These protections should include the confidential handling of application records, free mediation services, freedom to switch direct care worker employers, and exemptions from the 100-day-per-year work requirement in unexpected circumstances that severely affect their ability to work (e.g., illness, disability). Applicants should also be protected against retribution. The program should also ensure family unity and safeguard the rights of family members sponsored by a CDCW holder.

To evaluate the program, Congress should direct the secretary of Labor and the secretary of HHS to submit a report describing participation in the program and analyzing its impact. Congress should require the secretaries to submit the report to Congress within three years after enactment of the act and every three years thereafter.

I. Congress should appropriate additional resources to the Labor Department, USCIS, and other agencies involved in immigration processing needed to implement the policy reforms in this report.

The implementation of the immigration reforms outlined in this report will increase the administrative demand and costs for USCIS, the Labor Department, and other agencies involved in immigration processing. The recommendations will require the hiring of additional staff to process increased temporary and permanent visa applications and might require modifications to systems and procedures. However, it is worth noting that employers and workers applying for the visas will pay fees, which will offset some of these administrative increases. BPC could not find sufficient information or data to estimate the additional resources that Congress should authorize to support these new requirements. Congress, however, should appropriate the necessary resources needed to effectively implement the relevant immigration policies outlined in this report.

III. Improve Data on Workforce Characteristics to Measure Progress Expanding the Workforce

One of the biggest challenges to addressing the direct care workforce shortage is the lack of detailed, comparable federal and state data on workforce volume, stability, compensation, and other characteristics. To better measure the effects of policy reforms on expansion of the workforce, federal policymakers should advance reforms to improve data collection and reporting on the direct care workforce. The recommendations below focus on establishing standardized workforce metrics across states and care settings, as well as making that data publicly available.

A. CMS should create and implement a standardized set of data measures for the direct care workforce based on the Recommended State Minimum Dataset on Workforce for Long-Term Care Systems Change previously developed by the agency's Direct Service Workforce Resource Center. The dataset should capture the volume, stability, compensation, and profile of the direct care workforce.

State efforts to collect data on the direct care workforce vary significantly, and standardized collection and reporting of direct care workforce data at the federal level are limited. The primary source for current direct care workforce employment and wage data are estimates from the Bureau of Labor Statistics' Occupational Employment and Wage Statistics Survey (OEWS), the Bureau of Labor Statistics' National Compensation Survey (NCS), and the Census Bureau's American Community Survey (ACS). Researchers typically cross-reference these surveys to build a picture of the national direct care workforce, but each source has significant limitations.

Data from all three surveys are based on estimates from relatively small sample sizes of different groups of respondents (see Table 1). This means that current publicly available federal data on workforce characteristics, such as workforce size and wages, are limited to averages across industries and sectors; it does not reflect all individual workers' actual working conditions and compensation. Direct care job titles are also not standardized across the federal datasets, and they do not capture the full scope of individuals employed in LTSS.

Table 1: Sample Size and Response Figures from Federal Work and Wage Surveys

Agency	Survey	Data Source	Most Recent Data	Sample Size	Respondents	Response Rate
Bureau of Labor Statistics	OEWS[212]	Employers, by Standard Occupational Classification	November 2019 – May 2022	1,027,465	671,552	65%
Bureau of Labor Statistics	NCS[213]	Employers, by North American Industry Classification	March 2022	14,720	8,870	60%
Census Bureau	ACS[214]	Households	2022	3,538,392	1,980,550	56%

Because Bureau of Labor Statistics data is collected from employer-based surveys, data on workforce size, wages, and benefits encompass settings such as home health agencies and skilled nursing facilities, but they exclude hundreds of thousands of direct care personnel working under private arrangements, such as independent providers hired directly by consumers.[215] This data might include some independent providers, but that would depend on their relationship with government funding, which varies from state to state. For example, self-directed services provided under certain Social Security Act authorities allow consumers to independently hire and fire direct care providers through an "agency" that performs payroll and tax duties for the state Medicaid program.[216] The Bureau of Labor Statistics is able to provide data on job openings and labor turnover for broad industries, such as all health care and social assistance establishments, but it does not have enough data from employers to calculate attrition for specific occupations, such as home health aides.[217]

The ACS collects data from individual households rather than businesses, thereby including responses from across the spectrum of direct care settings. However, the survey does not distinguish between direct care workers who work for a larger employer and those who are independent providers. In addition, the ACS only asks respondents about full-time employment, missing many individuals who might provide direct care part time or work multiple jobs.

Federal policymakers have been aware of these critical data gaps for over a decade and have repeatedly recommended that HRSA take appropriate steps to establish comprehensive data collection on the direct care workforce.[218,219] Although HRSA can now project future demand for direct care workers, the lack of nationwide employment data still prevents the agency from projecting worker supply.[220]

Multiple states conducted employer-based surveys of their direct care workforce pre-COVID-19—particularly as part of the 2012 CMS National Balancing Indicators Project—but these efforts have all been one-time evaluations.[221] Some states plan to use the ARPA funds to improve data collection on direct care workers, but those efforts could take years to design and implement.[222] Policymakers at all levels of government still need more data to fully assess and address the workforce shortage.

The proposed rule that CMS published in May 2023 includes efforts to increase transparency and accountability, as well as to standardize data monitoring, across state HCBS programs.[223] Although the rule would require states to report on the new Home and Community-Based Services Quality Measure Set every other year, the survey does not capture workforce demographics.[224] The rule would also require states to publicly post annual Medicaid payment rates for certain HCBS benefits, but it is limited to personal care, home health aide, and homemaker services, and it does not require states to share actual wage data.[225]

To improve understanding of the volume, stability, compensation, and profile of the direct care workforce, CMS should establish a minimum dataset on the workforce to be collected nationwide by states and provider-employers (e.g., skilled nursing facilities, nursing homes, and home health agencies) participating in Medicaid and Medicare (see recommendation III.B.). CMS developed a recommended minimum dataset in 2009 as part of the National Direct Service Workforce Resource Center, and it should build on these measures.[226] The updated dataset should be collected along the full continuum of direct care settings and should include mandatory and optional measures, adapted for both provider-employers participating in Medicaid/Medicare and individual providers (see Table 2).

Table 2: Potential Metrics for a Minimum Direct Care Worker Dataset

Provider-Employer Organizations	Independent Providers
• **Care provided** – Populations served – Types of services provided – Setting of services provided – Number of consumers by setting • **Workforce volume** – Number of full-time workers – Number of part-time workers • **Workforce stability** – Turnover rate – Vacancy rate • **Workforce compensation** – Average hourly wage – Benefits provided • **Workforce profile** – Racial/ethnic composition – Gender composition – Disability status – Immigration status *Data on specific metrics collected from employers should be further stratified by setting and job title.	• **Care provided** – Populations served – Types of services provided – Number of consumers serving – Relationship with consumer • **Workforce volume** – Number of hours worked per week • **Workforce stability** – Tenure with current employer • **Workforce compensation** – Hourly wage – Benefits provided • **Workforce profile** – Race/ethnicity – Gender identity – Disability status – Immigration status

Standardized collection of workforce data would create datasets of information that policymakers, workers, consumers, employers, and other stakeholders could access to better understand the growing direct care workforce shortage, measure the impact of workforce reforms, and make other informed policy and program decisions. A minimum set of required core measures would also allow for comparisons of workforce information across populations, settings, and state programs, as well as enable uniform public reporting. States and federal agencies could build upon the minimum set of measures and request additional metrics as desired to meet the needs of specific communities, such as starting wages for workers, training required and provided, and reasons for entering/leaving the field.

B. CMS should require collection and reporting of standardized direct care workforce data (outlined in III.A.) across settings and programs and allow voluntary submission of other measures.

Direct care workers care for millions of individuals across all 50 states, in multiple settings, for diverse populations, and for numerous public health programs. CMS should therefore use existing authority to collect workforce data from the various Medicare and Medicaid programs that provide enrollees with LTSS in institutions and the community. Targeting the data collection approach to each authority would allow the federal government to best understand the state of the direct care workforce, considering the fragmented offering of LTSS across states.[ad]

i. CMS should require skilled nursing facilities and nursing homes to report standardized direct care workforce data (outlined in III.A.) as a condition of program participation in Medicare and Medicaid.

To participate in Medicare and Medicaid, skilled nursing facilities and nursing homes are already required to submit staffing information on direct care workers. Long-term care facilities must submit such information as the role, turnover rate, tenure, hours of care provided per resident per day, and hours worked of direct care staff electronically to CMS at least once per quarter.[227] The HHS secretary also has broad authority under the Social Security Act to impose additional requirements related to the health and safety of residents.[228]

CMS should build on these requirements and amend 42 C.F.R. §483.70(q) to require the submission of additional direct care workforce data from skilled nursing facilities and nursing homes participating in Medicare and Medicaid. Specifically, CMS should require that skilled nursing facilities and nursing homes report standardized direct care workforce data (outlined in recommendation III.A.) as a condition of program participation in Medicare and Medicaid. Because long-term care facilities often hire workers through staffing agencies, CMS should ensure that the use of short-term workers does not affect employer calculations of turnover rates. Given that these facilities already regularly collect and report direct care staff data, requiring the reporting of additional workforce metrics will build on an existing practice.

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ad These recommendations would only collect data about the direct care workforce participating in Medicare or Medicaid effectively capturing data on private pay and "gray market" workers—those who are hired directly by consumers outside of government programs—would pose significant challenges. Some stakeholders suggested that the federal government could collect data on workers at private pay nursing homes and home health agencies through state licensing and recertification processes, but that would likely require new congressional authority.

ii. Through the Home Health Quality Reporting Program, CMS should require Medicare-certified home health agencies to report standardized direct care workforce data as a condition of program participation.

One of the listed priorities of CMS' Home Health Quality Reporting Program is "putting the power of health care information to work."[229] Home health agencies are required to report data from the Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HH CAHPS) and Outcome and Assessment Information Set (OASIS) to CMS as a condition of participation in Medicare.[230] These tools focus on beneficiaries' health outcomes and satisfaction, but they do not capture data on the direct care workforce delivering home health services.[231]

CMS should take a similar approach to the above proposed requirement for skilled nursing facilities and nursing homes (see recommendation III.B.i) and require Medicare-certified home health agencies to collect and report data on direct care staff as a condition of program participation. The HHS secretary has authority under Sections 1861(o)(6) and 1861(o)(8) of the Social Security Act to establish additional conditions that home health agencies must meet to participate in Medicare.[232] Specifically, CMS should amend 42 C.F.R. §484.105, which details administrative conditions of participation for home health agencies. It should be amended to include direct care workforce data requirements similar to current administrative conditions of participation for long-term care facilities at 42 C.F.R. §483.70(q), *Mandatory submission of staffing information based on payroll data in a uniform format*, albeit with the full dataset outlined in III.A. Because providers already submit OASIS data quarterly, CMS should require home health agencies to also submit direct care workforce data at least once per quarter.

Medicare-certified home health agencies totaled 11,474 in 2021, and approximately 3 million Medicare fee-for-service beneficiaries used home health care—a number that is likely to grow with the nation's population aging rapidly.[233] Requiring staff data from home health agencies will help policymakers and providers better understand the current workforce shortage in a critical care setting, and, with data already collected from HH CAHPS and OASIS, provide insight into how workforce factors, such as wage and turnover, can impact care delivery and health outcomes.

iii. CMS should require states to collect, and report standardized direct care workforce data (outlined in III.A.) for home and community-based services provided through Sections 1915(c), 1915(i), 1915(j), and 1915(k) authorities, and Section 1115 demonstrations.

Section 1902(a)(6) of the Social Security Act gives the HHS secretary broad authority to request reports from state Medicaid programs. CMS relies on this authority in the May 2023 proposed rule to require standardizing HCBS quality measure data collection across states by amending reporting requirements under Sections 1915 and 1115 of the Social Security Act. The rule would also require states to report annually on the percentage of payments that providers spend on compensation for direct care workers providing three Medicaid HCBS benefits: homemaker services, home health aide, and personal care services. CMS is also considering requiring states to report annually on median hourly wages, benefits, and payroll taxes for direct care workers.[234]

CMS should mirror this approach and require states to annually collect, aggregate, and report standardized direct care workforce data for all services across Sections 1915 and 1115 waivers and state plan programs. Most individuals receiving direct care through Medicaid do so through these authorities. In 2020, 3.6 million enrollees received HCBS through Sections 1915(c) and 1115 waivers and 1915(i) and 1915(k) state plan authorities, across all 50 states and Washington, DC (see Appendix B).[235] Requiring states to collect and report this data would provide policymakers and other stakeholders with a more exact value of the direct care workforce's size, compensation, and other factors on a nationwide scale, for both agency and self-directed care.

Data collected at the provider level would not be as effective a strategy for HCBS as for direct care provided in institutional settings (see recommendations III.B.i and III.B.ii). For example, self-directed care is included in 1915(j) and 1915(k) state plan authorities, but is optional under the 1915(i) state plan authority, 1915(c) waiver, and 1115 waiver—and many states operate multiple authorities.[236] With this approach, CMS could fold direct care workforce data collection into current reporting requirements for states using these authorities. Under existing regulations, states operating Section 1115 demonstrations, 1915(c) waivers, 1915(j) state plan authorities, or 1915(k) state plan authorities must submit annual reports to CMS on the delivery and impact of the specific services provided under each authority.[237]

iv. CMS should publish standardized direct care workforce data collected from Medicare and Medicaid programs in an easily accessible and understandable format. Congress should appropriate the additional resources CMS needs to regularly publish standardized direct care workforce data.

The lack of available data on workers and working conditions has been one of the primary challenges policymakers have faced in addressing the direct care workforce shortage.[238] Federal and state efforts to

improve recruitment and retention of direct care workers will only be as effective as the data that is available to policymakers, workers, employers, consumers, and other stakeholders. As CMS receives data on direct care workers from skilled nursing facilities, nursing homes, home health agencies, and states (see recommendations III.B.i – III.B.iii), it should publish and continually update a database with de-identified workforce information that is publicly available and easily found.

CMS should publish the data on a webpage easily accessible from both the Medicare and Medicaid websites. Users should be able to stratify workforce information by state, Medicare and Medicaid authority, and, as data quality allows, more specific factors of the required dataset (see Table 2) such as job title, care delivery setting, and gender composition.

C. The U.S. Census Bureau should include questions on paid and unpaid caregiving in the American Community Survey (ACS).

While the above recommendations aim to capture data on formal, paid caregiving through Medicare and Medicaid programs, an increasingly large share of direct care comes from either unpaid family caregivers or the "gray market"—the network of direct care workers hired directly by individuals outside of government-funded or regulated programs. Comprehensive estimates of the size of the gray market do not exist, and the primary source for family caregiving data comes from annual estimates provided by AARP.[239]

Sent to approximately 3.5 million households in the 50 states, the District of Columbia, and Puerto Rico annually, the ACS is the primary demographic and largest household survey administered by the Census Bureau. Information is gathered on such topics as ancestry, citizenship, educational attainment, income, language proficiency, migration, disability, employment, and housing characteristics. The ACS also includes questions on functional limitations to independent living, caring for grandchildren, and Medicaid enrollment.[240] The Census Bureau should build on this information and include a set of questions on caregiving services in the ACS—such as whether respondents have ever provided care to a family member, paid for caregiving services, or have unmet need for caregiving.

The inclusion of caregiving questions in the ACS would not reveal the true size of the gray market or unpaid caregiving, but it would help to better capture the full scope of the need for, and provision of, both formal and informal direct care. Stakeholders expressed the need for better data on the full range of caregiving relationships, as well as the demand for direct care services. Additionally, including new questions in the ACS would not require significant government spending or further authority.

D. The Office of Management and Budget should update the 2018 Standard Occupational Classification Manual to create an independent Standard Occupational Classification (SOC) code for direct support professionals that can be utilized by states and federal agencies.

Historically, direct support professionals have been part of the home health and personal care aide occupational data collected by the Bureau of Labor Statistics, even though many stakeholders have noted that direct support professionals provide a broader range of services to consumers. Direct support professionals provide HCBS to individuals with intellectual and developmental disabilities that are beyond the scope of home health and personal care aide roles. Moreover, they support care recipients' participation in the community through, for example, career development, transportation, and communication support services.[241] Although the Bureau of Labor Statistics Occupational Outlook Handbook specifies that some personal care aides work with people with intellectual or developmental disabilities, it does not list direct support professionals as a distinct occupation.[242]

The Bureau of Labor Statistics and other federal agencies use SOC codes, developed by the Office of Management and Budget, to collect nationwide employment and wage data across 867 occupations.[243] Establishing a new SOC code for direct support professionals would allow the Bureau of Labor Statistics to capture data specific to the profession, such as wages and geographic distribution.

While some stakeholders have expressed concern that separating direct support professionals might make it harder to collect data on home health and personal care aides, wide variability already exists in how states categorize, monitor, pay, and train direct care professionals. For example, California credentials home health aides and certified nursing assistants through the Department of Public Health, home care aides through the Department of Social Services, and direct support professionals through the Department of Developmental Services.[244]

There has been bipartisan support for this change; during the development process of the 2018 SOC Manual, 30 members of Congress signed a letter urging the Bureau of Labor Statistics to create a SOC code specific to direct support professionals.[245] As discussed in the Looking Ahead section, Sens. Maggie Hassan (D-NH) and Susan Collins (R-ME) recently introduced the Recognizing the Role of Direct Support Professionals Act (S. 1332), which would direct the Office of Management and Budget to establish a SOC code (31-1123) for direct support professionals. Reps. Brian Fitzpatrick (R-PA) and Joseph Morelle (D-NY) introduced a House version of the bill (H.R. 2941).[246]

E. The Labor Department should instruct the Bureau of Labor Statistics to publish standardized data on home health aides (31-1121) and personal care aides (31-1122) separately.

Home health aides and personal care aides each have their own SOC code but have been grouped together for data reporting purposes by the Bureau of Labor Statistics since the introduction of the 2018 SOC Manual. OEWS data for the three other occupations in the 2018 SOC 31-1000 minor group—nursing assistants, psychiatric aides, and orderlies—are all reported separately.[247]

Similar to the challenge described in the previous recommendation, reporting only OEWS data on home health and personal care aides together makes it difficult for researchers and policymakers to understand how wages, duties, geographic location, and other factors differ across direct care professions and affect employment outcomes. Reporting information on these occupations separately will provide stakeholders and the government with a more detailed picture of the workforce.

Conclusion

As demand continues to outpace the supply of direct care workers, federal legislative and administrative policy reforms are necessary to grow the direct care workforce. These efforts will have important implications for care access and quality; gender and racial equity; and community integration for individuals with disabilities. As such, members of Congress should work across the aisle to advance a bipartisan set of federal policy solutions that will (1) increase supportive work environments to promote worker retention; (2) improve domestic workforce programs and immigration pathways to increase the number of new workers; and (3) ensure standardized data collection and publicly available data on the workforce to better measure the impact of policy reforms. As part of this effort, federal policymakers should advance reforms to support unpaid caregivers who deliver a significant portion of all LTSS care.

Glossary of Terms

ACL	Administration for Community Living
ACS	American Community Survey
ADLs	Activities of Daily Living
ARPA	American Rescue Plan Act
CDCW	Certified Direct Care Worker
CHWTP	Community Health Worker Training Program
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare & Medicaid Innovation
FMAP	Federal Medical Assistance Percentage
HRSA	Health Resources and Services Administration
HCBS	Home and Community-Based Services
IADLs	Instrumental Activities of Daily Living
INA	Immigration and Nationality Act
LTSS	Long-Term Services and Supports
LPR	Lawful Permanent Resident
NCS	National Compensation Survey
OASIS	Outcome and Assessment Information Set
OEWS	Occupational Employment and Wage Statistics Survey
PHE	Public Health Emergency
SOC	Standard Occupational Classification
USCIS	U.S. Citizenship and Immigration Services
VBP	Value-Based Payment
WIOA	Workforce Innovation and Opportunity Act

Appendices

APPENDIX A: DEFINITIONS OF DIRECT CARE WORKER OCCUPATIONS

Personal care aides, as defined by SOC code 31-1122, provide personalized assistance to individuals with disabilities or illness who require help with personal care and activities of daily living (ADLs) support (e.g., feeding, bathing, dressing, grooming, toileting, and ambulation). Many also help with such tasks as preparing meals, doing light housekeeping, and handling laundry. They work in various settings depending on the needs of the care recipient and can include their home, place of work, in the community, or at a daytime nonresidential facility.

Home health aides, as defined by SOC code 31-1121, monitor the health of an individual with disabilities or illness, and they address clients' health-related needs, such as changing bandages, dressing wounds, or administering medication. They work under the direction of offsite or intermittent onsite licensed nursing staff. The aides also assist with routine health care tasks or ADLs, such as feeding, bathing, toileting, or ambulation. They can also help with preparing meals, performing light housekeeping, and doing laundry depending on the patient's abilities.

Nursing assistants, as defined by SOC code 31-1131, provide or assist with basic care or support under the direction of onsite licensed nursing staff. These assistants, who can include nursing care attendants, nursing aides, and nursing attendants, monitor patients' health status and feed, bathe, dress, groom, toilet, or help with mobility in a health or nursing facility. Tasks can include administering medication.

Psychiatric aides, as defined by SOC code 31-1133, assist individuals with mental impairment or emotional disturbance, and they work under the direction of nursing and medical staff. The aides, who include psychiatric orderlies, assist with daily living activities, lead patients in educational and recreational activities, and accompany patients to and from examinations and treatments. Responsibilities include restraining violent patients.

Direct support professionals do not have a SOC code. They work directly with people who have intellectual and developmental disabilities. These professionals support engagement with the community by providing support and coaching. They also provide caregiving and assist with daily living activities, and they advocate for patients' rights and services.

	Personal Care Aides	Home Health Aides	Direct Support Professionals	Psychiatric Aides	Nursing Assistants
SOC Code	✓ Yes	✓ Yes	No	✓ Yes	✓ Yes
Care Authorized to Provide/Assist	✓ ADLs ✓ IADLs ✓ Custodial care	✓ ADLs ✓ IADLs ✓ Custodial care ✓ Limited skilled care	✓ ADLs ✓ IADLs ✓ Custodial care ✓ Limited skill care	✓ ADLs ✓ IADLs ✓ Custodial care ✓ Limited skill care	✓ ADLs ✓ IADLs ✓ Custodial care ✓ Limited skill care
Work Settings	✓ Home ✓ Community ✓ Residential Care Facilities	✓ Home ✓ Community ✓ Residential care facilities	✓ Home ✓ Community	✓ Home ✓ Community ✓ Residential care facilities ✓ Hospitals	✓ Home ✓ Community ✓ Residential care facilities ✓ Hospitals ✓ Skilled nursing facilities

Source: Executive Office of the President, Office of Management and Budget, 2018 Standard Occupational Classification Manual.

APPENDIX B: PEOPLE RECEIVING LTSS BY STATE AND MEDICARE/MEDICAID AUTHORITY, FY2020

State	Authority							
	Medicare	Medicare and Medicaid	Medicaid					
			State Plan Services				Waivers	
	Home Health Benefit	SNF / NH Services	Home Health	Personal Care	Community First Choice [Section 1915(k)]	Section 1915(i)	Section 1915(c)	Section 1115
Alabama	60,766	22,848	5,400				15,700	
Alaska	3,172	675	400	2,400	1,000		4,900	
Arizona	44,960	11,898	included in 1115				57,400	
Arkansas	35,345	17,167	5,000	10,800		NR	14,300	
California	323,834	102,781	37,500	278,900	261,200	55,800	149,500	474,300
Colorado	31,235	16,581	113,800				49,400	
Connecticut	40,371	21,872	28,000		3,200	600	29,700	
Delaware	14,063	4,153	included in 1115	included in 1115		500	1,800	7,800
District of Columbia	4,441	2,309	8,600	6,000		200	6,900	
Florida	273,701	72,876	2,800	600			115,400	
Georgia	78,921	33,203	6,200				47,100	
Hawaii	4,223	3,618	included in 1115				2,900	8,500
Idaho	14,920	4,135	34,800	12,400		64,800	20,100	
Illinois	135,324	65,594	15,200				154,600	
Indiana	55,230	38,721	17,800	600		4,900	58,100	
Iowa	22,877	22,944	11,800	<50		8,900	30,300	
Kansas	28,819	16,858	3,300	included in 1115			29,500	
Kentucky	49,114	22,760	16,500				27,000	
Louisiana	55,760	25,936	6,400	15,200			24,600	
Maine	15,724	5,805	2,000	3,600			8,100	
Maryland	66,710	23,753	2,000	1,000	18,800		27,100	
Massachusetts	102,607	37,242	54,000	66,500			32,600	
Michigan	94,175	37,768	2,500	61,800		2,600	25,400	
Minnesota	31,976	23,660	28,900	43,700			81,500	
Mississippi	56,008	15,679	1,200			900	25,800	
Missouri	52,891	37,848	3,500	64,700			35,100	
Montana	6,214	3,890	600	200	3,400		5,400	
Nebraska	15,740	10,931	3,300	1,700			12,000	
Nevada	28,985	5,778	300	11,000		1,700	6,700	
New Hampshire	20,053	6,441	1,400	100			9,700	
New Jersey	77,387	43,139	56,900	55300				30800
New Mexico	16,151	5,652	4,000	included in 1115			5,100	28,000

State	Authority							
	Medicare	Medicare and Medicaid	Medicaid					
			State Plan Services				Waivers	
	Home Health Benefit	SNF / NH Services	Home Health	Personal Care	Community First Choice [Section 1915(k)]	Section 1915(i)	Section 1915(c)	Section 1115
New York	149,788	104,082	101,400	116,200	NR		104,400	427,800
North Carolina	95,386	36,383	3,600	42,600			28,500	
North Dakota	4,191	5,300	500	900			6,300	
Ohio	97,865	71,543	70,100			24,800	123,700	
Oklahoma	63,380	18,072	3,200	3,300			26,600	
Oregon	24,109	7,284	300	3,500	57,900		602,200	
Pennsylvania	126,050	75,458	24,300	4,800			143,600	
Rhode Island	10,842	7,684	included in 1115	included in 1115				11,500
South Carolina	62,786	16,938	500				36,200	
South Dakota	5,700	5,583	11,200	1,600			6,600	
Tennessee	67,694	26,952	11,500				7,300	18,200
Texas	242,919	92,595	11,600	369,700	30,000	200	47,500	63,600
Utah	22,264	5,657	3,700	300			9,800	
Vermont	10,581	2,407	3,300	1,500				8,000
Virginia	94,328	27,845	1,300				58,100	
Washington	45,202	15,373	5,100	1,200	83,300		71,200	3,800
West Virginia	22,878	9,457	3,400	6,800			12,500	
Wisconsin	35,889	21,522	5,000	14,700			98,100	
Wyoming	4,566	2,302	200				5,800	
Total (51 States)	**3,048,115 (51 States)**	**1,316,952 (51 States)**	**734,500 (51 States)**	**1,203,500 (37 States)**	**458,700 (9 states)**	**165,800 (13 states)**	**1,902,500 (47 states)**	**1,139,700 (12 states)**

Source: KFF analysis of Nursing Home Compare, CMS Chronic Conditions Data Warehouse, KFF Medicaid HCBS Program surveys.
Notes: Total enrollment figures may not sum due to rounding. Figures do not represent total individuals receiving any HCBS, as individuals might receive services under multiple authorities.
NR = State did not report data.
Included in 1115 = Services are delivered as part of the 1115 waiver, so the state is unable to report enrollment figures separately by service.
Blank cell indicates state does not elect option.

APPENDIX C: TIMELINE OF ACTIVITIES TO STRENGTHEN TRANSPARENCY AND OVERSIGHT OF STATES' MEDICAID PROVIDER PAYMENT RATES AND DIRECT CARE WORKERS' COMPENSATION

Timeframe	Actor	Action
Year 0: Enacting legislation becomes law and Congress appropriates a maximum total of $1 million to each state.		
Within three fiscal years of legislation becoming law	All states	Submit and publish first market rate analysis
Within one fiscal year of the first market rate analysis	All states	Submit and publish first strategy
Within six fiscal years of legislation becoming law	All states	Submit and publish second market rate analysis
End of Year 6: Federal funding for market rate analyses and strategies ends.		
Within seven fiscal years of legislation becoming law	CMS	Reviews states' strategies and provides evaluation determination
Within three fiscal years of CMS' determination	States that failed to meet evaluation criteria	Submit and publish a third market rate analysis
Within four fiscal years of CMS' determination	States that failed to meet evaluation criteria	Submit and publish an updated strategy

Note: BPC's recommendation for publicly posting Medicaid provider payment rates and the portion allocated to direct care workers' compensation should be carried out annually and continuously (see recommendation I.A.i).

APPENDIX D: CURRENT LAW AND BPC-ANALYZED TAX BENEFIT OPTIONS FOR FAMILY CAREGIVERS

Comparison of Tax Benefit Options for Family Caregivers				
	BPC	**Current Law Deductions**		**Current Law Credits**
	Proposed Caregiver Tax Credit Examined	**Personal Exemption for Dependents** *Suspended from 2018-2025*	**Non-Reimbursed Medical Expenses**	**Child and Dependent Care Tax Credit**
Type of Tax Benefit	Credit	Exemption	Deduction	Credit
Refundable	Yes	N/A	N/A	No
Maximum Deduction/ Credit	$3,000	$4,050 in 2017 (for each dependent) $0 in 2018-2025	Applicable Expenses in Excess of 7.5% of Caregiver's Income	Varies by Taxpayer Income and Dependent Care Expenses Income Under $15,000: $2,100 max credit (35% of $6,000 in dependent care expenses for two or more dependents) Income Over $43,000: $1,200 max credit (20% of $6,000 in dependent care expenses for two or more dependents)
Amount of Caregiver Spending Required to Obtain Max Credit	$10,000	N/A	N/A	Up to $3,000 (for one dependent) Up to $6,000 (max for multiple dependents)
Minimum Amount of Expenses to Claim Benefit	N/A	Must Pay for More Than 50% of Dependent's Expenses (all expenses, not just LTSS)	Non-reimbursed Medical Expenses Must Exceed 7.5% of Income Must Pay for More Than 50% of Dependent's Expenses (all expenses, not just LTSS)	Must Pay for More Than 50% of Dependent's Expenses (all expenses, not just LTSS)

Comparison of Tax Benefit Options for Family Caregivers				
	BPC	**Current Law Deductions**		**Current Law Credits**
	Proposed Caregiver Tax Credit Examined	**Personal Exemption for Dependents** *Suspended from 2018-2025*	**Non-Reimbursed Medical Expenses**	**Child and Dependent Care Tax Credit**
Income Phase-Out Range	$80,000 to $133,000 (Individuals) $120,000 to $200,000 (couples)	Exemption Reduced for Income Above $261,500 in 2017 (filing single) Phased Out for Income Over $384,000 in 2017 (filing single)	N/A	N/A
Impairment Standard for Care Recipient	HIPAA Standard	N/A	HIPAA Standard	Person who is not physically or mentally able to care for themself. Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.
Qualifying Expenses that Can Be Claimed Under the Credit	Expenditures for goods, services, and supports that: (1) Assist a qualified care recipient with accomplishing ADLs and IADLs; and (2) Are provided solely for the use of the qualified care recipient	N/A	Qualified long-term care services are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are: (1) Required by a chronically ill individual, and (2) Provided pursuant to a plan of care prescribed by a licensed health care practitioner.	Expenses are for the care of a qualifying person only if their main purpose is the person's well-being and protection. Taxpayer can count care provided outside of the home by a dependent care center only if the center complies with all state and local regulations that apply to these centers.

Comparison of Tax Benefit Options for Family Caregivers				
	BPC	**Current Law Deductions**		**Current Law Credits**
	Proposed Caregiver Tax Credit Examined	**Personal Exemption for Dependents** *Suspended from 2018-2025*	**Non-Reimbursed Medical Expenses**	**Child and Dependent Care Tax Credit**
Income Limits on Care Recipient	None	Care Recipient Income Must Be Less Than $4,050 in 2017	Care Recipient Income Must Be Less Than $4,300 in 2020	None
Work-Related Expense Requirement	None	None	None	To be claimed under tax credit, the care expenses (paid for by the taxpayer) for the care recipient must be "work-related" expenses, in that the care provided via the expenses allow for the taxpayer (and spouse) to continue to work or look for work.
Taxpayer-Care Recipient Cohabitation Required?	No	No	No	Yes

APPENDIX E: DIFFERENCES BETWEEN IMMIGRANT AND NONIMMIGRANT VISA CATEGORIES

Category	Purpose	Duration	Intent	Example Visa Type[1]
Nonimmigrant visa	Allows visa holders to stay temporarily in the U.S. and return to their home country when their authorization expires	Specific, temporary duration depends on visa type	Most require applicants to demonstrate that they do not have the intent to immigrate permanently	J-1 (au pair exchange program)
Immigrant visa	Allows visa holders to live and work permanently in the U.S.	Indefinite duration through lawful permanent residency (LPR) and an opportunity for citizenship after residing in the U.S. for at least five years[2]	Visa holders have intent to immigrate to the U.S. and become permanent residents and/or citizens	EB-3 (employment-based immigration for professionals and other workers)

[1] A directory of visa types by category is available at: https://travel.state.gov/content/travel/en/us-visas/visa-information-resources/all-visa-categories.html.

[2] Lawful Permanent Residency (LPR) status and U.S. Citizenship are distinct immigration statuses. LPR status grants the right to live and work in the United States indefinitely but does not include the full rights and privileges of U.S. citizenship (e.g., right to vote, eligibility for certain government positions and programs).

APPENDIX F: EMPLOYMENT-BASED IMMIGRATION PREFERENCE SYSTEM

Category	INA Eligibility Criteria	Annual Numerical Limit[1]
1st preference (EB-1): "Priority workers"	Persons of extraordinary ability in the sciences, arts, education, business, or athletics; outstanding professors and researchers; and certain multinational executives and managers	28.6% of worldwide limit (**40,040**) plus unused 4th and 5th preference
2nd preference (EB-2): "Members of the professions holding advanced degrees or aliens of exceptional ability"	Members of the professions holding advanced degrees or persons of exceptional abilities in the sciences, arts, or business	28.6% of worldwide limit (**40,040**) plus unused 1st preference
3rd preference (EB-3): "Skilled workers, professionals, and other workers"	Skilled shortage occupations workers with at least two years' training or experience; professionals with baccalaureate degrees; and "unskilled" shortage workers	28.6% of worldwide limit (**40,040**) plus unused 1st and 2nd preference; "other workers" limited to 10,000
4th preference (EB-4): "Certain special immigrants"	Special immigrants, including ministers of religion, religious workers, certain employees of the U.S. government abroad, special immigrant juveniles, and others	7.1% of worldwide limit (**9,940**); religious workers limited to 5,000 and broadcasters limited to 100
5th preference (EB-5): "Employment creation"	Immigrant investors who invest at least $1.8 million ($900,000 in rural areas or areas of high unemployment) in a new commercial enterprise that creates at least 10 jobs	7.1% of worldwide limit (**9,940**); 3,000 minimum reserved for investors in rural or high unemployment areas

[1] Total worldwide level: 140,000 employment-based visas.
Source: Congressional Research Service, *U.S. Employment-Based Immigration Policy*.

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