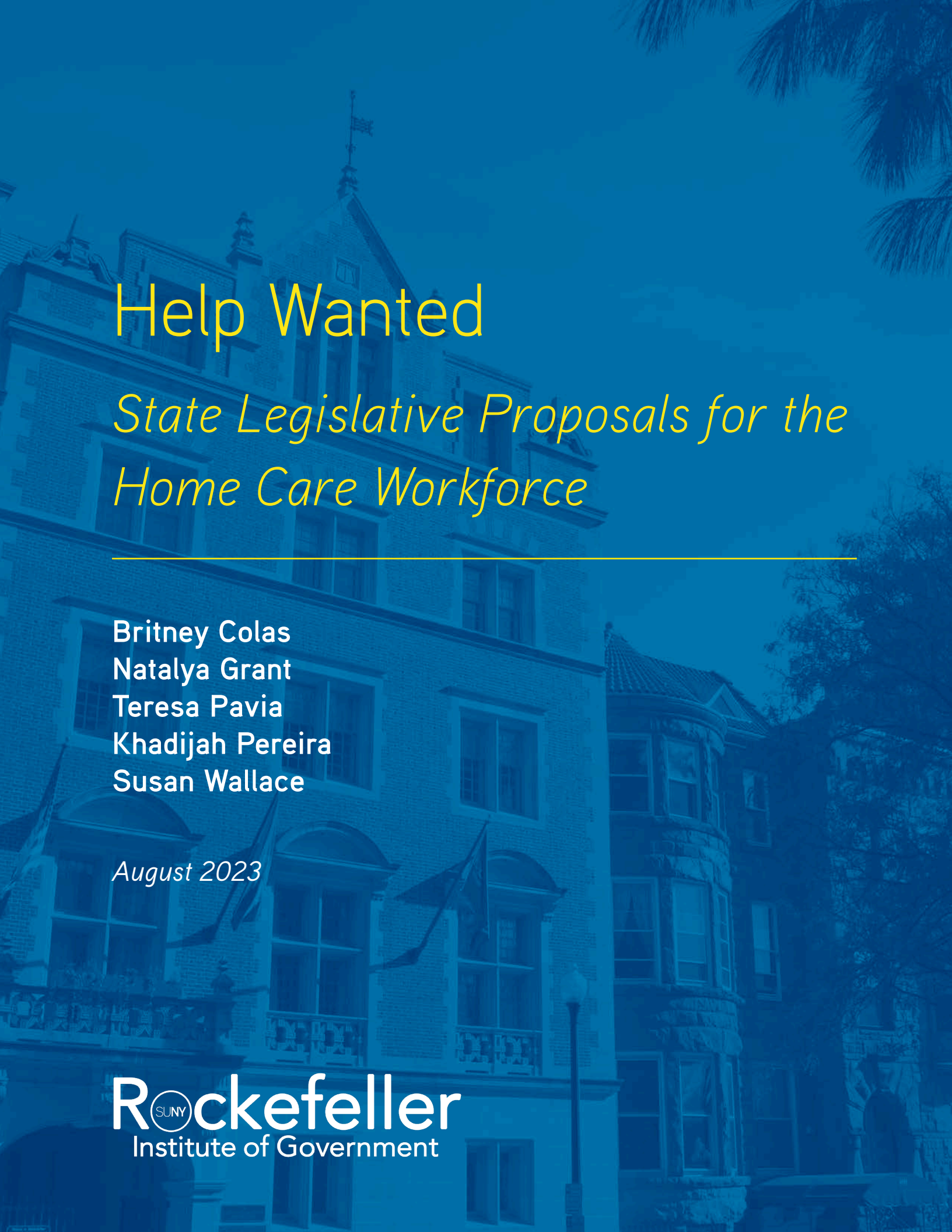

Help Wanted

State Legislative Proposals for the Home Care Workforce

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Introduction

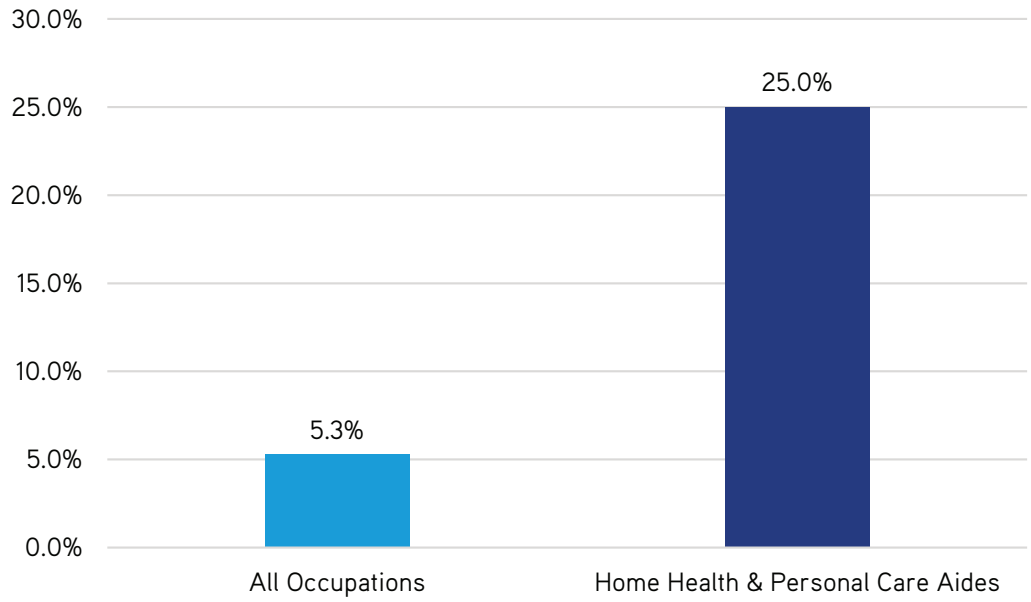
Between 2021 and 2031, the need for home health and personal care aide positions is expected to increase by approximately 25 percent, or 924,000 jobs.[1] This increase—the largest projected across all professions—is driven in part by an aging population. While in 2016, roughly 15 percent of people in the United States were over 65 years old, by 2060, the US Census estimates that over 23 percent of the population will be over 65 years old.[2] That change reflects a shift from roughly 49 million people to about 95 million people.[3]

Despite this growing and projected need for home health and personal care aides, there is a demonstrated lack of workers to fill this need in the workforce. Home health and personal care aides, collectively referred to here as "home care aides" or the "home care workforce," monitor and provide assistance to people with daily activities. Those receiving assistance include older individuals, people with chronic illnesses, and people with disabilities. The activities may include dressing and bathing, housekeeping tasks, groceries, or appointments outside the home. Such activities not only assist people with day-to-day needs, but more broadly help enable people to stay in their homes and communities rather than move to an assisted care facility. The increasing demand for home care aides is primarily driven by the larger and aging baby boomer generation[4] and people "living longer with complex health needs."[5] This is furthered by increased preferences and movements toward at home care, which in

turn alleviates strain on care facilities.[6] This growing need has also been exacerbated by the COVID-19 pandemic. The pandemic affected all people of all characteristics and needs, but particularly impacted vulnerable populations, including older individuals and those with disabilities, who were at greater risk due to underlying conditions and increased potential exposures in care facilities, which likewise impacted staff.[7,8]

FIGURE 1. **Need for Home Health and Personal Care Aides Expected to Vastly Outpace Growth Across All Occupations**

Percentage change in employment, projected 2021–31



SOURCE: US Bureau of Labor Statistics.

TABLE 1. **State Populations Over 65 Compared to Home Health & Personal Care Aide Workforce**

State	Percent Population 65 and Over(a)	Population Over 65 (Census data 2020 from Population Reference Bureau)(b)	Workers in HH and PC Workforce (PHI 2021)(c)	Ratio of Population Over 65 to HH and PC Workforce
California	15.2%	5,976,000	717,220	8:1
Florida	21.1%	4,638,000	66,920	69:1
New York	17.5%	3,370,000	478,620	7:1
Pennsylvania	19.0%	2,335,104	193,460	13:1
Texas	13.1%	3,874,000	378,110	10:1
National	16.8%	55,992,309	2,418,290	23:1

a Lillian Kilduff, "Which U.S. States Have the Oldest Populations?," Population Reference Bureau (PRB), December 22, 2021, https://www.prb.org/resources/which-us-states-are-the-oldest/.

b Ibid.

c "Workforce Data Center," PHI, accessed July 27, 2023, https://www.phinational.org/policy-research/workforce-data-center/#tab=State+Data&natvar=Employment+Projections&var=Employment+Trends.

SOURCES: US Census Bureau Data reported by Population Reference Bureau and PHI.

This report considers existing research on challenges to attracting and retaining the home care workforce and how the five largest states—California, Florida, Texas, New York, and Pennsylvania—have legislatively addressed the growing home health and personal care aide workforce shortage in recent years, from 2019 to 2022. It also considers the demographic characteristics of the home care workforce in each state. Taken together, these states account for 52.4 percent of the home health and personal care aide workforce and 36.4 percent of the population over the age of 65.[9] The report concludes by analyzing how and to what degree states' legislative proposals and enacted laws align with what research has identified as the key issues related to attracting and retaining a home care workforce.

Background

Home health and personal care (HH & PC) aides fall under the broader umbrella of what are sometimes referred to as home care services that may be hired privately or through licensed agencies. Despite the fact that they are sometimes classified as distinct occupations, they often perform similar tasks, such as dressing and bathing, housekeeping tasks, groceries, or appointments outside the home. However, home health aides may be under the supervision of medical professionals and—depending on the state—may provide assistance with "basic health-related services" like checking vitals, changing bandages, and in some cases, medical equipment or medication.[10] Personal care aides, on the other hand, are typically only allowed to perform nonmedical tasks, such as washing laundry, cleaning the house, preparing meals, and running errands. However, many of the tasks they do assist with—like getting into and out of bed, going to the bathroom, cleaning, etc.—may require that assistance because of underlying medical or health reasons. Additionally, personal care aides typically make less money than home health aides employed in this field.

Home Care Workforce by the Numbers

According the US Department of Labor, home health and personal care aides have the largest projected job growth of any profession—over 25 percent between 2021 and 2031.[11] Projections for the total number of jobs in the profession by 2031 range from 4,560,900 to 4,685,500.[12] At present, the national home care workforce is disproportionately made up of women, immigrants, and Black, Hispanic, Asian American, or Pacific Islander workers (see Table 2). This is also true across the five states considered in this study, if unevenly. These workers, as will be further discussed below, tend to make low wages, with an annual mean wage in 2021 of $29,260—approximately 50 percent of the national average wage.

TABLE 2. **Home Health and Personal Care Aide Workforce Demographics**

	HH & PC Workforce	US Population
Women	83%	51%
Black, Hispanic, AAPI, and Other	64%	42%
Foreign Born	31%	14%

SOURCE: American Community Survey and "Workforce Data Center: Race and Ethnicity," Paraprofessional Healthcare Institute (PHI), accessed July 27, 2023, https://www.phinational.org/policy-research/workforce-data-center/#tab=National+Data&natvar=Race+and+Ethnicity.

Attracting and Retaining Home Care Workers

Previous research on the home care workforce has used employment and wage data as well as interviews with workers to better understand trends and to identify challenges to the attraction and retention of workers. This body of work has found that there are a series of overlapping factors that contribute to workforce shortages in these fields. Working conditions, compensation structures, and lack of professional growth opportunities all negatively impact workers interest in home care employment. Research has also identified broader underlying policy challenges, such as the reimbursement structures of Medicaid and Medicare, that create barriers to building a workforce.

Compensation and Career Growth

Compensation and opportunities for professional and financial growth are perhaps the most frequently discussed impediment to attraction and retention of the workforce. Brannon et al. surveyed direct care workers, including home care aides, in Iowa, North Carolina, Oregon, Pennsylvania, and Vermont, finding that overwork and lack of career mobility were the largest drivers related to intent to leave their roles. When asked for reasons to stay in their jobs, income was the least cited while helping others was the most frequently cited reason.

Similarly, Covington-Ward's study of African immigrants in the Pittsburgh area direct care workforce found that many workers were initially interested in the role because of a passion for care work, more easily obtained employment, and a potential pathway to other health occupations. However, almost all participants viewed their roles as temporary jobs with no long-term future. Butler et al. include the example of an older home care worker who discussed how she would not stay in her job if she were younger due to a lack of benefits, lack of recognition by her employer, and the lack of a wage increase in the past five to six years.

These qualitative accounts are supported by analyses of wage and compensation data. For example, a 2017 study of home care workers in California found that "nearly three quarters of home care workers are low wage, compared to a third of all workers." In both California and nationally, median home care annual earnings were less

than half of the median for all workers.[13] The provision of health insurance benefits was also relatively low, with roughly 41 percent having employer provided plans as compared to around 70 percent of all workers. Jabola-Carolus et al.'s projections of the economic costs and benefits of raising wages for home care workers in New York State, in particular, found that public investments in raising wages would result in a net economic gain of $3.7 billion, as "costs would be more than offset by the resulting savings, tax revenues, and economic spillover effects."[14] Some of this savings is due to the frequency with which workers in these professions rely on public benefits given their relatively low wages.

Working Conditions

Common challenges related to the working conditions of home care aides include: emotional and physical strain, violence and verbal abuse, overwork and responsibilities outside of their scope of practice and training, and lack of recognition. Quinn et al. discusses how taxing on the body the roles of home care aides are. While back injuries are the most frequent type of physical injury aides experience, there are additional risks including infectious disease exposure and sometimes violence or verbal abuse. Aides sometimes aren't trained to address or manage all of these potential risks.[15] Mittal et al.'s work surveying direct care workers in Pennsylvania outlines common reasons for leaving the profession, including: a lack of respect, inadequate management, work/family conflicts, and difficulty of work.[16] Likewise, Stacey discusses how aides in Central City, California, frequently cited demands related to "overwork and added responsibilities, increased risk, and the physical and emotional strain."[17] They further note how aides felt stressed by these high demands and underappreciated with regard to the corresponding lack of recognition they received.

Funding the Home Care Market

Medicare and Medicaid are important drivers for the home care labor market. These programs, particularly Medicaid, play an outsized role in determining both access to home care and the pay of workers because they serve such a large portion of the aging and low-income population. While Medicare provides health insurance for individuals 65 and older, Medicaid provides coverage for low-income individuals, people with disabilities who cannot work or have limited employment, and people in long-term care who exhaust their insurance. They often do this through waivers, which provide patients with the ability to access care that would not otherwise be provided for under typical Medicaid or Medicare provisions. Most, though not all, home care services under these programs are funded through Medicaid long-term services and supports (LTSS),[18] which includes home- and community-based services (HCBS) Section 1915 waivers[19] or Section 1115 demonstration waivers.[20] Some states allow Medicaid recipients to choose their own aides through a consumer-directed care model,[21] which may include the ability to hire family members.[22]

Barriers to access care and relative reimbursement rates related to Medicaid and Medicare for home care aides remain consistent challenges with respect to the workforce, as well as the individuals they work with. Because Medicaid and Medicare rules vary from state to state, there are often differing guidelines as to what kind of care can be offered. Jaffe (2019) describes these incongruences with respect to scope-of-practice. As she notes, states "require different degrees of physician oversight and approval" in order for individuals to access home care.[23] This means, for example, that in some states advanced practice registered nurses (APRNs), who often act as a primary caregiver in many rural communities, are not allowed to order home care services for a patient without a certification form signed by a physician. Because of these requirements and the relative absence of primary care physicians, patients in need of home care often go without services due to delays in certification.

A significant portion of the population needing home health services are insured by Medicaid and Medicare programs. As a result, the reimbursement rates paid through these programs play an outsized role in driving or maintaining wages through setting reimbursement rates. There is a great deal of variation across states in the rates offered. Reimbursement schedules are often negotiated in advance through state budgets. As a result, the rates cannot be revised to adjust for market conditions or unexpected changes, such as those related to COVID-19. Depending on state waiver programs, home care services provided by family members who function as a personal care aide may be eligible for compensation.[24]

Chapman et al. observed that the largest gaps between need and provision of home care services exist for adults with self-care disabilities that impact their ability to conduct activities of daily living without assistance in rural areas of Southern states. The authors suggest that policies to address this shortage should seek to increase wages through the setting of higher reimbursement rates (particularly for Medicaid).[25] Similarly, Covington-Ward found that wages were an important driver for attracting workers that was constrained by Medicaid.[26] And likewise, Brannon et al., who found that wages were a salient aspect related to attrition among direct care workers in Iowa, North Carolina, Oregon, Pennsylvania, and Vermont, recommend that state governments experiment with Medicaid reimbursements.[27]

Methodology

The home care workforce shortage has been well-documented and studied. Policymakers understand that the shortage could have negative consequences on the health outcomes and well-being of their constituents. This research addresses the question of how lawmakers in the five states with the largest populations over 65 are legislatively addressing their home health and personal care aide workforce needs. For these five states—California, Florida, Texas, New York, and Pennsylvania—we identified the size of the of home health and personal care aide workforce, the existing and projected workforce needs, the median wages, and the demographics for the home care workforce as compared to the state's general workforce.

TABLE 3. **State Legislation Addressing Home Care, 2019–22**

Year	California	Florida	New York	Pennsylvania	Texas	Total
2019	0	3	7	1	0	11
2020	1	4	6	0	0	11
2021	2	2	10	2	1	17
2022	3	4	43	4	0	54
Total	6	13	66	7	1	93
Enacted	5	1	12	2	0	20
Vetoed	1	0	0	0	0	1
Total Bills Introduced All Four Years	9,168	13,862	39,349	10,783	22,743	95,905

Using the Legiscan legislative database of state level policy proposals and enacted laws, we identified legislation introduced or enacted between 2019 and 2022, representing the two most recent and completed legislative sessions in these states.[28] We did this using a full text search for legislation in each state for each of the included session years using search terms. These terms included: "direct care," "home care," "home health," and "personal care." The returned results were further analyzed for relevance and inclusion. In total (see Table 3), this identified 93 bills introduced across the five states—20 of which were enacted and one of which was vetoed. The total bills introduced in each state are included to provide information on the relative scale of legislative activity over the time period.

TABLE 4. **List of Codes**

Career Development
Children
COVID-19
Economic Development
Education and Training
Government Authority
Home Care Agencies
Insurance
Medicaid
Patients' Rights and Protections
Service Availability, Quality, and Access
State Priorities and Strategies
Task Force, Study, or Report
Types of Care
Wages
Workers' Rights and Protections
Recruitment and Retention
Licensure

The resultant bills were then coded thematically according to the focus of the underlying legislation. Individual bills could be assigned multiple codes, but no bill was coded with more than three codes, though up to four codes were allowed. The codes, 18 in all (see Table 4), were derived through an iterative and grounded approach with respect to the legislation and the literature discussed above. Each piece of legislation was coded by two different researchers independently and any differences were then subject to resolution by the entire research group. This coding was then analyzed comparatively across states for further trends, overlapping or divergent approaches among states, and relevance to the issues and solutions proposed in the literature discussed above.

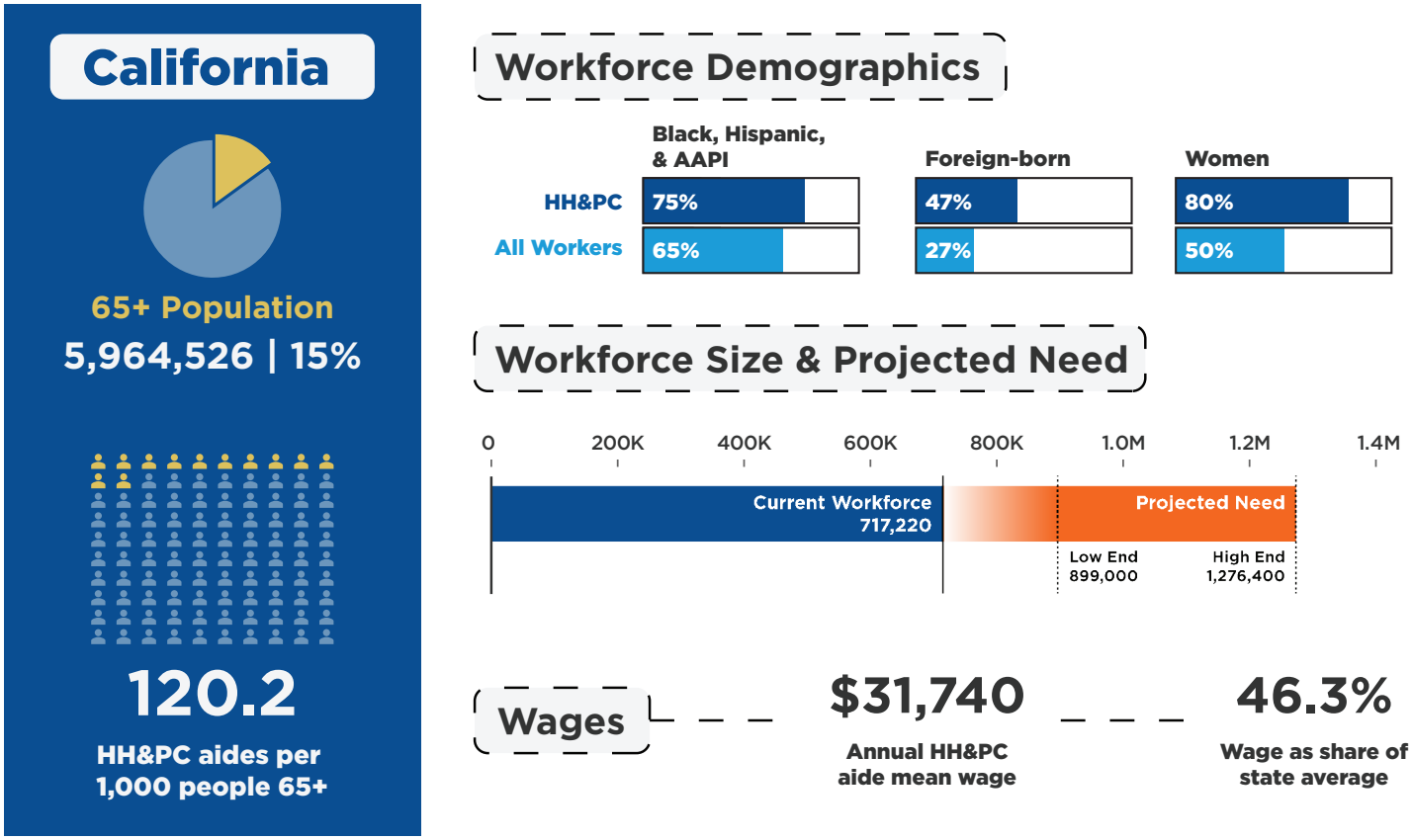
Findings by State

California

California is the nation's most populous state and has the largest state population over 65—nearly 6 million people, or 15.2 percent, of California's population.[29, 30] Given the large population of older residents there is a similarly high demand for home health and personal care aides.[31] The projected need for healthcare aides from 2021 to 2031 in California is 899,000 on the low end and 1.2 million on the high end.[32, 33, 34] The state's annual mean wage for a home care aide is $31,740—approximately 46.3 percent of the state's average wage across all professions. And, as with the national home care workforce in California, the workforce is disproportionately made up of women (80 percent compared to 50 percentof all workers), workers who are foreign-born (47 percent compared to 27 percent), and workers who are Black, Hispanic, and Asian American or Pacific Islander (75 percent compared to 65 percent).

California's legislature introduced 9,168 bills between 2019 and 2022. During this period, there were six bills related to home care aides. Five of these bills were enacted and one was vetoed. The most frequent codes for these bills included: COVID-19, Medicaid, and workers' rights and protections.

Two of the six bills were coded as workers' rights and protections—both of which were enacted. These bills directly addressed some of the challenges and solutions identified in the literature above with respect to occupational risks and stressors. Senate Bill 321, established an advisory committee[35] to develop recommendations related to ensuring healthy and safe working conditions for domestic workers in home settings, including caregivers.[36] That committee has since issued a report on their policy recommendations—the primary focus of which is to "remove the household domestic services exclusion from the California Labor Code" and therein bring them under the regulation of California's Division of Occupational Safety and Health.[37] While Assembly Bill 1751 primarily expanded workers compensation for injuries that workers received due to COVID-19, the bill also expanded the time period for eligibility and included new classes of workers, such as employees of home health agencies and providers of in-home support services.[38]



Three bills that were enacted were coded as both Medicaid and service availability and access. Senate Bill 214 expanded eligibility for services funded by Medicaid for individuals transitioning out of an inpatient facility[39] under a model "designed to achieve various objectives with respect to institutional and home- and community-based long-term care services."[40] Senate Bill 184, among various provisions related to health coverage and services, included a provision to expand approved benefits under California's Medicaid program for home and community-based services.[41] These bills were primarily focused on expanding access to home care services, but did not address expanding the workforce needed to provide those services.

The state legislature also enacted two bills coded as recruitment and retention. Assembly Bill 172 of 2021, directed the Department of Social Services to administer a pilot program: the Career Pathways Program. The program was designed to improve the quality of care and increase recruitment and retention in the home care and healthcare industry by providing voluntary paid training and career advancement opportunities.[42] In addition, the California legislature passed Assembly Bill 2069 of 2022, the Home Health Aide Training Scholarship Act.[43] However, the governor vetoed this bill, which would have provided $1,500 scholarships to up to 1,000 students enrolled in training programs for home health aides, on the basis that it would duplicate existing programs and was not included in the state budget plans.[44]

Beyond the timeframe of our legislative search, in 2023, California legislators have introduced a proposal to increase the minimum wage for home care workers to $25 an hour. This followed local ballot initiatives to do the same in Southern California, with mixed results, and negotiations at the state level in 2022 to raise the home care

minimum wage that failed to reach an agreement.[45] The current legislation recently passed the State Senate in late May of 2023.[46]

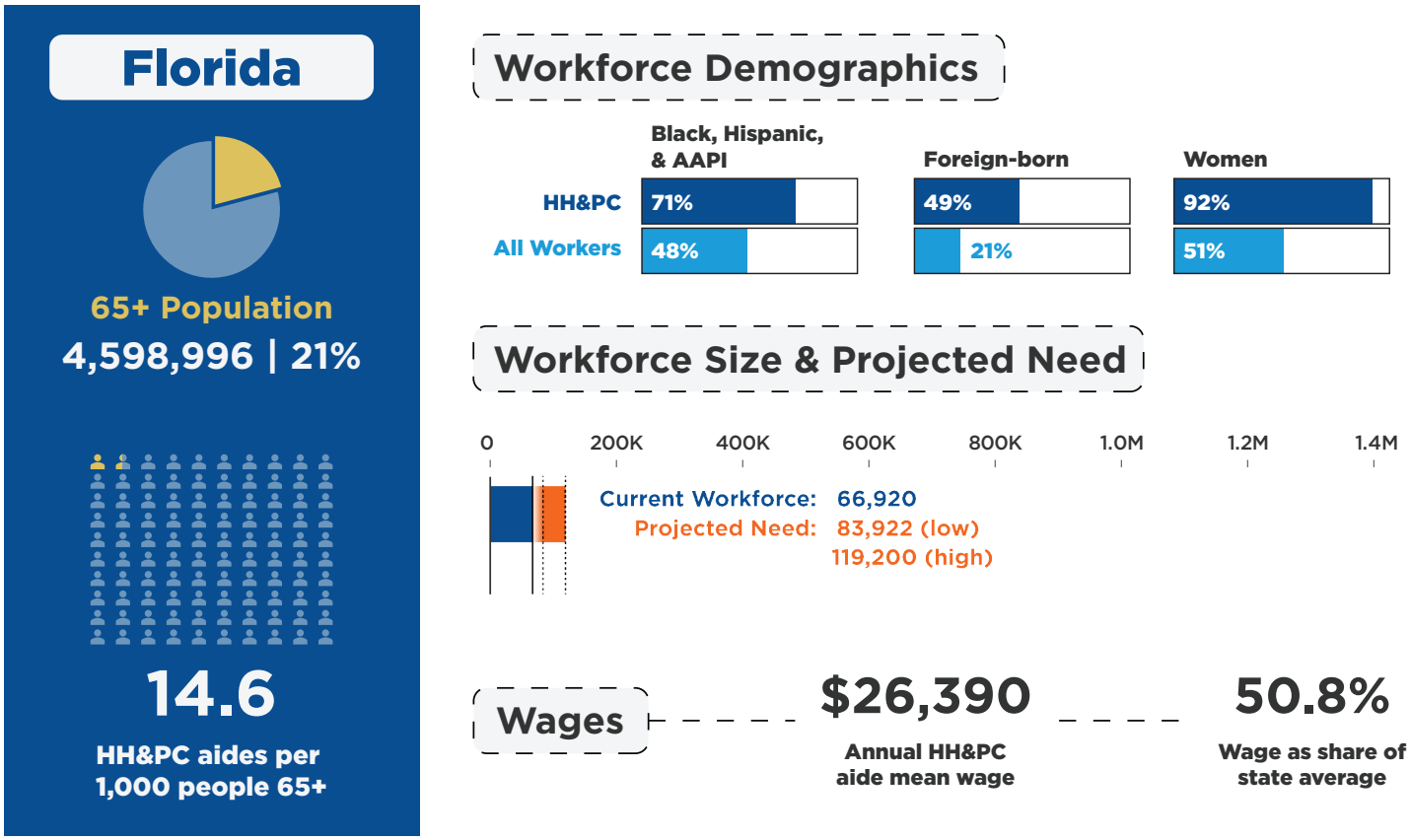
Florida

As of 2020, 21.1 percent of Florida's total population was over the age of 65 years old, or 4,598,996 of 21,538,187 residents. In 2021, the number of home health and personal care aides in the state totaled just 66,920.[47] The number of home care aides per resident over 65 in Florida is far lower—one for every 68 residents over 65 years old—than the other states considered here, which range from one for every seven to 17 state residents over 65 years old. We cannot determine within the scope of this report exactly what factors explain the difference in the relative home care workforce of Florida as compared to the other states studied. This difference could be impacted by varying classifications of professions across states. While Florida's home care workforce is far smaller than the other states considered here, it is not an outlier nationally, and Florida's total healthcare support occupations workforce does not substantially differ from other states. By 2031, Florida is projected to need 83,922 aides on the low end and 119,200 aides on the high end.[48, 49]

The annual mean wage for home care aides in the state is $26,390 or 50.8 percent of Florida's state average wage. Similar to the other states, Florida's home care workforce demographics reflect an overrepresentation of women (92 percent compared to 51 percent of the general workforce), foreign-born workers (49 percent compared to 21 percent), and Black, Hispanic, Asian American, and Pacific Islander workers (71 percent compared to 48 percent).

Florida's State Legislature meets every year for 60 consecutive days with special sessions added as needed. In total, Florida legislators introduced 13,862 bills between 2019 and 2022. Of those, we identified seven bills that directly addressed the home care workforce, none of which were enacted.

The most frequent codes for these bills pertained to home care agencies, education and training, and most commonly, service availability, quality, and access. There were three bills introduced related to service availability, access, and quality. In general, these bills were written to address present availability or administration of home care services, but not the need to increase the workforce. Senate Bill 1544 of 2020, for example, proposed to address the significant need for long-term home and community care by requiring the Department of Elderly Affairs to create and prioritize a waitlist. The bill would have also required aging resource centers to annually rescreen individuals with high priority cases or significant changes of circumstance for the purpose of prioritizing the state's waitlist. Likewise, House Bill (HB) 3069 of 2020 would have designated appropriations for community-based long-term care services related to Alzheimer's disease and other dementia conditions. Finally, among other provisions, HB 5201 of 2019 would have made amendments to the states' existing comprehensive redesign of home- and community-based services for individuals with developmental disabilities, which is primarily focused on aligning expenditures for such services with existing appropriations, extending the timeline given for that redesign, and related Medicaid waivers.



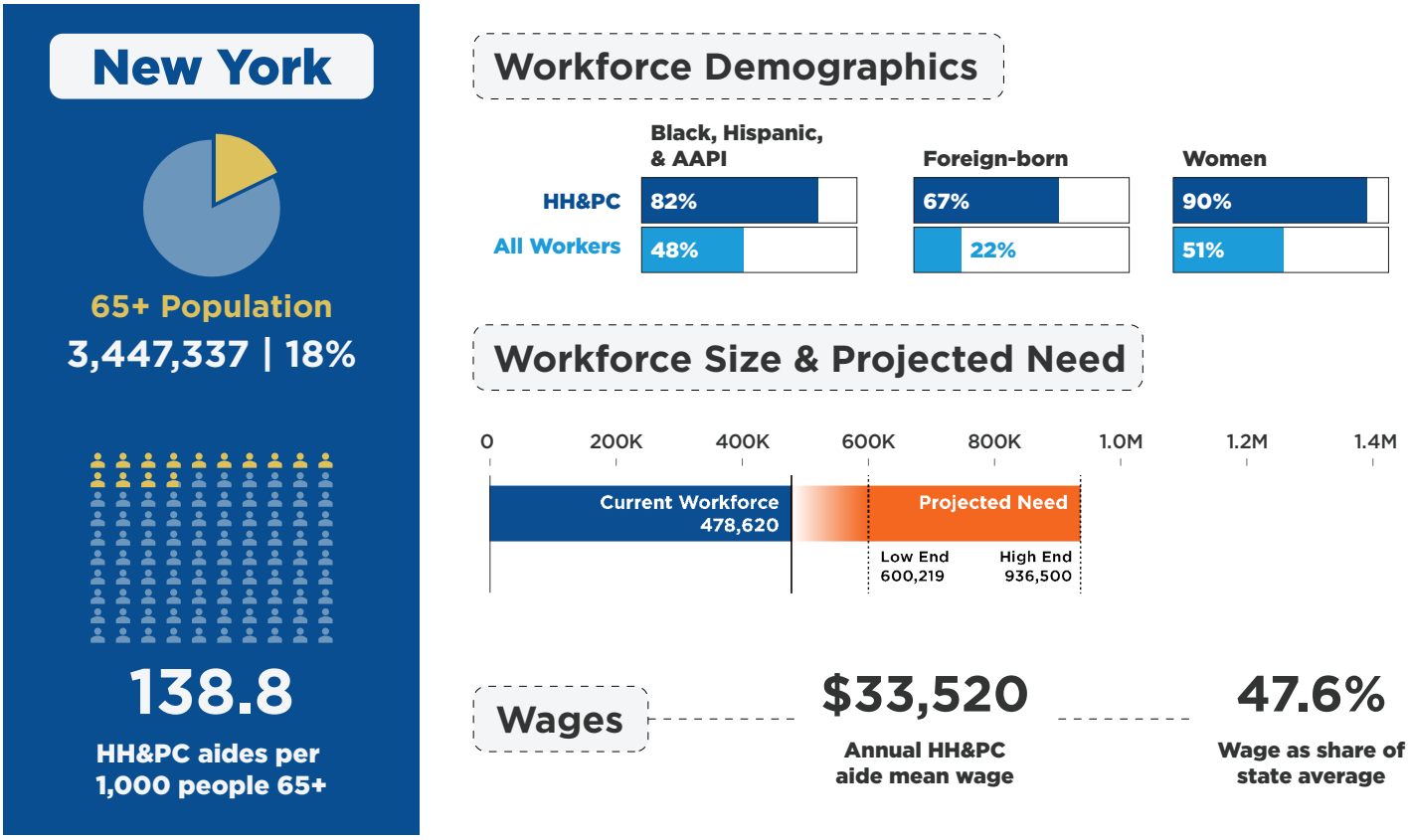
Of the two bills coded as education and training, HB 209 of 2022 more directly addressed workforce challenges. That bill would have established a Family Caregiver Nursing Assistant program to train family caregivers to effectively care for individuals and be certified as nursing assistants. HB 1507 of 2022, also coded in this category, would have required training on Alzheimer's disease and related forms of dementia for a number of care providers, including companion and homemaker providers and home health agencies.

Two further bills were categorized as relating to home care agencies. One of these bills, Senate Bill 1676 of 2020, was jointly classified as related to recruitment and retention. That bill would have established an Excellence in Home Health Program, required licensed agencies to provide information about their employees—including information related to job satisfactions, safety, and retention—and provided related appropriations. It would further expand the scope of practice for home health aides and CNAs (certified nursing assistants) to perform certain tasks, such as administering prescription medication. The other bill, Senate Bill 184 of 2019, proposed to transfer the regulation of hospices, assisted living facilities, adult daycare centers, and adult family-care homes, and home health agencies from the Department of Elderly Affairs to the Agency for Health Care Administration.

As noted above, none of these bills were enacted. Just two of these bills more directly addressed workforce needs for home care aides, Senate Bill 1676 and HB 209, though others sought to address access to existing services, and none of these bills addressed wages or compensation.

New York

New York State is home to a population of 19 million people, roughly 18 percent of which are over the age of 65. The home health and personal care aide workforce increased by 228,720 from 2011 to 2021, to a current workforce total of 478,620 in 2021. The projected workforce needs for home health and personal care aides from 2021 to 2031 is 600,219 on the low end and 936,500 on the high end. As of 2020, 90 percent of the workforce are female and 67 percent are foreign-born. The home care aide workforce in New York has an annual mean wage of $33,520—the highest of the states considered here, but representing just 47.6 percent of the state's average wage.



From 2019 to 2022, state legislators introduced 39,349 bills in total and 58 of those bills were identified as directly related to home health and personal care aides, 11 of which were enacted. The state's number of relevant bills introduced and enacted, both individually and collectively, were greater than the combined number of bills introduced and enacted in the other four states.

The bills enacted were most frequently coded as education and training or service availability, quality, and access—14 and 18 bills, respectively. However, while four education and training bills were enacted, just one bill related to service availability, quality, and access was. The education and training bills generally pertained to requirements for competency exams for home care aides and expanding training requirements for aides. This included training on relating to people with diverse gender identities and sexual orientations, sepsis prevention, and CPR; grants for home care workforce mentor support; and providing information about or requiring

competency exams for home care workers. Six of these bills, particularly those focused on competency exams, were also coded as recruitment and retention as they were geared towards getting additional individuals to take those exams. Just one of these bills proposed grants or resources for education (Senate Bill 1352 of 2019), however that bill was not specifically targeted towards home care aides, and did not pass. Of the bills coded as service availability, quality, and access, seven were also coded as insurance (2) or Medicaid (5) and were generally focused on expanding eligibility or coverage of services. Several other bills, five in total, were cross coded as state priorities or task force, study or report, and addressed the integration of home care in broader policy and strategy or the need to inform that policy and strategy. The one bill that was enacted, Assembly Bill 9542 of 2022, established a state program of all-inclusive care for those 55 and older who qualify for "nursing home levels of care" and Medicaid.

New York State was responsible for 11 out of the 13 bills coded as wages and compensation. These bills addressed compensation for home care aides in a number of ways, including: increased wages with respect to reimbursement rates for certain providers, broader increased pay relative to the state minimum wage by either an absolute dollar value or 150 percent, and, most commonly, tax credits or deductions.

The sole bill coded as wages that was enacted phased in an increase to the minimum wage for home care aides of $3 over the state minimum wage, with regional variations. This included an hourly wage increase of $2 beginning October 2022, and an additional increase of $1 in October 2023. In October 2023, the minimum wage for home care workers should have reached $18 in New York City, Long Island, and Westchester, and $17.20 for the rest of New York State (for 2023).[50] Workers downstate also receive a supplemental wage rate in addition to that minimum, though this may be provided through benefits (education, pension, insurance, etc.).[51] Though outside our period of analysis, this law was amended in 2023 through the state budget process altering that schedule and the compensation received. This resulted in a delay of the minimum wage increase scheduled for October 2023 to January 2024, but increased the amount. The minimum wage for home care workers will be $18.55 downstate and $17.55 in the remainder of the state effective January 2024. The amendment also changed how the supplemental wage rate is paid such that for some workers they will not receive an increase in their monetary compensation.[52, 53]

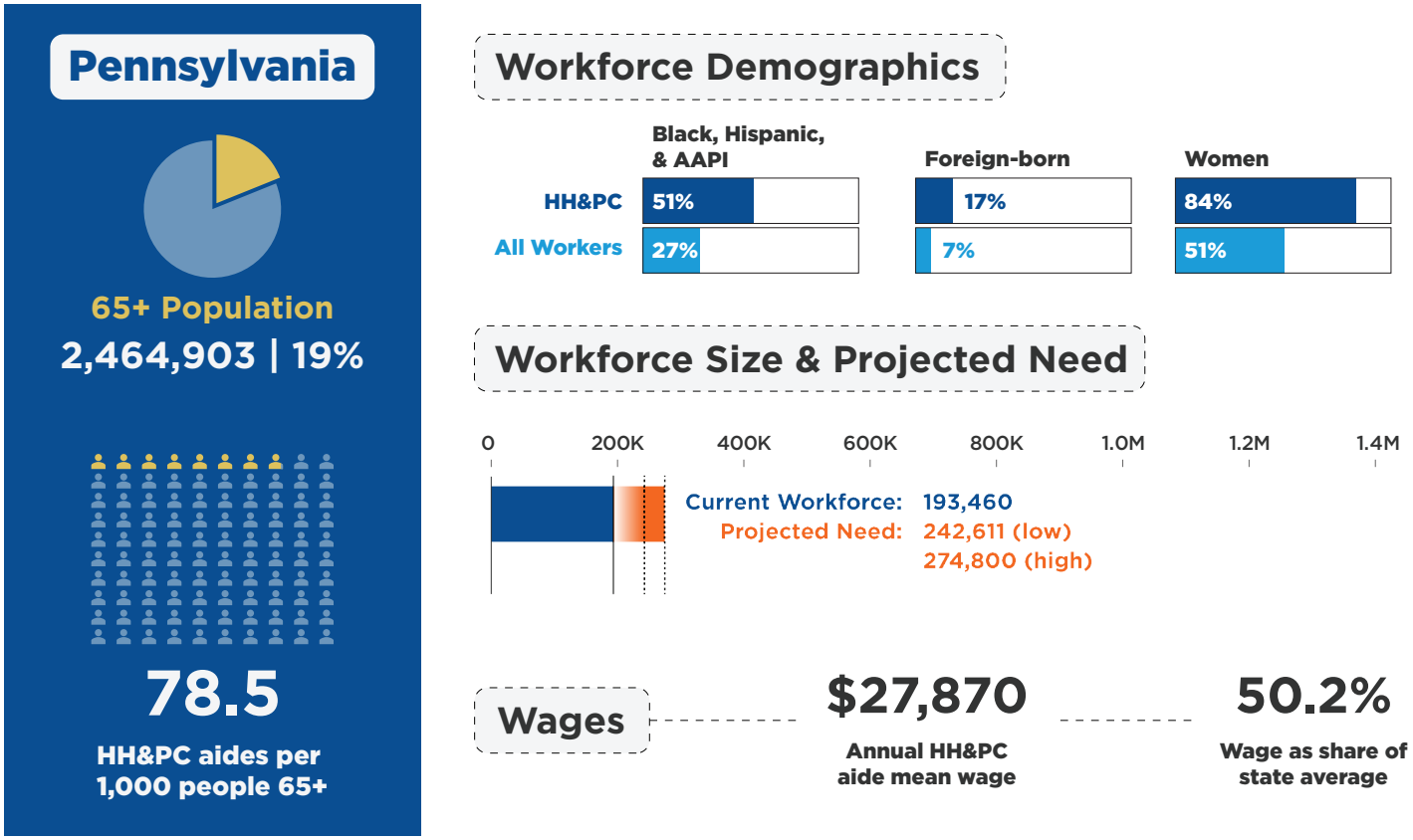
An additional 12 bills were introduced that were coded as Medicaid. Of these, eight pertained to adjusting or increasing reimbursement rates, a few of which directly cited wages as part of their intent or bill language. Many of these related more broadly to broadening service availability and accessibility. For example, the one bill coded as Medicaid that was enacted, Assembly Bill 9542 of 2022, provides regulatory oversight for and authorized the seeking of Medicaid and Medicare waivers respective to Programs of All-Inclusive Care, which provide medical and social services for individuals 55 years old or older who remain in their communities.

In addition to many of the bills related to wage and Medicaid, the 12 bills coded as recruitment and retention that were introduced generally aligned with the challenges and solutions presented in existing research. However, several of these bills addressed the need for expanded outreach for competency exams. Others were focused on

studying, creating a strategy to address, or a pilot program to address recruitment and retention. Of the three recruitment and retention bills that were enacted, two addressed exams and one called for a study. That bill, the "Investing in Care Act" or Senate Bill 4652B of 2021, directed the commissioners of Economic Development, Health, and Labor to study and develop a long-term strategy to support the growth of the caregiving industry. Similarly, and overlapping with this legislation, there were nine bills coded as task force, four of which were enacted (including once again the Investing in Care Act). These bills directed the further study or development of state strategies related to long-term care, home care, and related services.

Pennsylvania

Pennsylvania has a population of almost 13 million people, 19 percent of which are over the age of 65.[54] In 2021, Pennsylvania employed a total of 193,460 personal care and home health aides, adding 97,090 employees at a growth rate of 101 percent from 2011 to 2021. The mean wage for home health and personal care aides in the state is $27,870. Similar to the other states considered here, that wage amounts to 50.2 percent of the state's average wage. Although the percent of home care aides that are foreign-born or identified as Black, Hispanic, Asian American, and Pacific Islander is lower than in other states, they were still disproportionately represented compared to the state's workforce. Women were likewise disproportionately represented but at percentages similar to the other states considered.



The Pennsylvania General Assembly meets in two-year sessions. Between 2019 and 2022, state legislators introduced 10,783 bills.[55] During that time, we identified six bills directly related to home health and personal care aides that were introduced and two of those bills were enacted. Both of those bills were enacted in 2022.

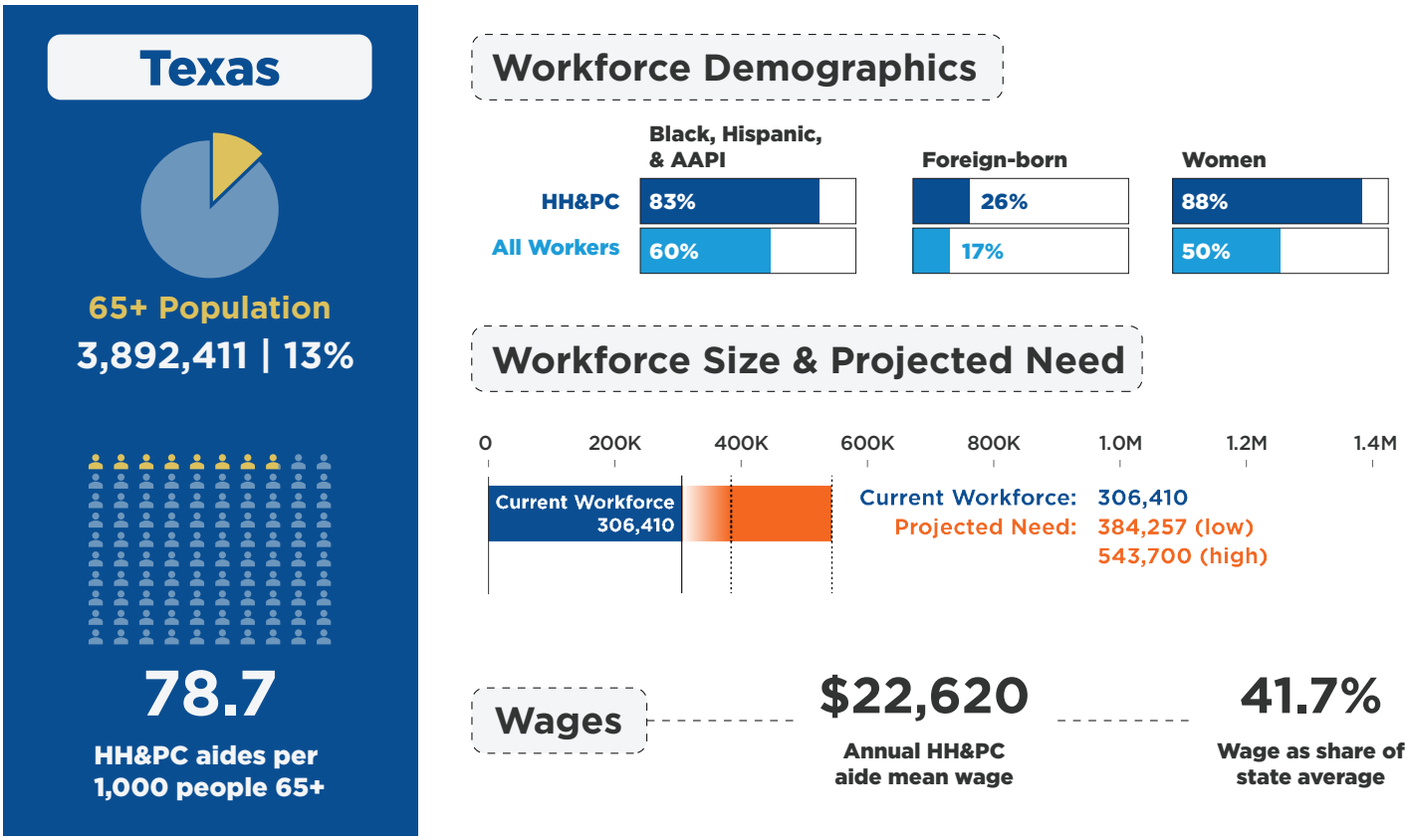
HB 2401 was introduced and enacted in 2022 and was coded as Medicaid, licensure, home care agencies, and service availability, quality, and access. Among other provisions, the enacted legislation made permanent temporary waivers implemented during the COVID-19 pandemic. This included provisions that allowed nurse practitioners and physician assistants to order home healthcare services and gave up to 30 days to obtain signatures for such orders. This was more broadly provided for under the federal CARES Act in March of 2020, but Pennsylvania law required a physician to order or oversee home care services and allowed up to just seven days for obtaining signatures for those orders. Similarly, the new law put state law in line with federal regulations that allow certain supervisory assessments in home care services to occur via telecommunications. These changes were intended to mitigate and prevent delays to access to care and allow for broader utilization of services under Medicaid and Medicare. The second bill enacted in Pennsylvania, HB 1630, repeals the existing regulatory requirement for a physician to order such services.

Texas

Texas is the second most populous state, with 30,029,572 residents. Approximately 13.1 percent of those residents or 3,874,000 people in the state are age 65 and older.[56] The number of home care workers in Texas is 378,110, ranking right in the middle of the states considered when it comes to the number of aides per 1,000 residents over 65 years old—with 78.7—though it is roughly the same as Pennsylvania which has 78.5 aides per 1,000 residents over 65 years old. Texas is projected to need 384,257 home care aides on the low end and 543,700 aides on the high end by the year 2031.

The demographics of the home care workforce in Texas, as in all the states considered, is disproportionately made up of Black, Hispanic, Asian American, and Pacific Islander workers (83 percent compared to 60 percent of the general workforce), foreign-born (26 percent versus 17 percent of the general workforce) and women (88 percent versus 60 percent of the general workforce). The mean wage for this workforce is, however, lower in both absolute terms, at $22,620, and relative terms, at 41.7 percent of the state average wage, than all the other states considered. The only other state this is the case for in this study is Pennsylvania.

The Texas legislature meets every odd numbered year, for a maximum of 140 days starting the second week of January.[57] Across the two sessions that occurred from 2019–22 the legislature introduced 22,374 bills. Of those total bills, only one was introduced and enacted related to home care aides. In 2019, through the General Appropriations Act,[58] the legislature and governor enacted an increase in the pay for home care aides—often referred to in the state as community or personal care attendants—from $8 to $8.11 per hour. The enacted legislation also appropriated funds and established an interagency forum to inform the development of strategies to recruit, retain, and ensure access to home care services.



In 2021, Texas legislators introduced a related bill, HB 3307, to increase the minimum wage for direct care workers in supported living centers, but not home care settings. That bill, which was not enacted, would have set the minimum wage for those workers at $15.00 or the federal minimum wage, whichever is greater.[59] While outside the scope of our study, in 2023, the state legislature then introduced legislation to establish a family health aide program to enable family members of "a recipient receiving private duty nursing services in a home setting to assist in providing those services as a licensed health aide,"[60] and to increase the wages of personal attendants to $17 an hour or the federal minimum wage, whichever is greater.[61] Both bills have the potential to increase the home care workforce in the state, however as of this report neither of those bills has been enacted.

Analysis

In addition to the many people who already need and utilize home health and personal care aides, the rapidly growing population of people over 65 is projected to result in an even more significant need for home care workers. The home care workforce is the largest growing occupation in the country, and there is still a projected need of close to one million additional home care aides within the next decade. Whether or not states are able to meet that need, however, is yet to be determined and will depend in part on the success of the legislative efforts of states to address them. Our research aimed to understand how state legislatures in California, Florida, New York, Pennsylvania, and Texas have attempted to remedy this healthcare workforce issue

over the last few years and to consider the degree to which those attempts mirror what existing research says is needed.

TABLE 5. **Introduced and Enacted Legislation by Issue Type**

	Introduced Legislation					
	California	Florida	New York	Pennsylvania	Texas	Total
State Priorities and Strategies	1	0	3	0	0	4
Patients Rights and Protections	0	1	5	0	0	6
Licensure or Scope of Practice	0	1	4	1	0	6
Insurance	0	1	4	2	0	7
COVID-19	1	0	8	0	0	9
Workers Rights and Protections	2	0	5	1	0	8
Task Force, Study, or Report	1	1	8	1	0	11
Wages or Compensation	0	0	11	0	2	13
Home Care Agencies	0	2	12	2	0	16
Recruitment and Retention	2	1	12	1	0	16
Education and Training	2	2	14	1	0	19
Medicaid	3	1	12	3	0	19
Service Availability, Quality, and Access	3	3	18	1	0	25
	Enacted Legislation					
	California	Florida	New York	Pennsylvania	Texas	Total
State Priorities and Strategies	1	0	1	0	0	2
Patients Rights and Protections	0	0	1	0	0	1
Licensure or Scope of Practice	0	0	0	1	0	1
Insurance	0	0	0	0	0	0
COVID-19	1	0	3	0	0	4
Workers Rights and Protections	2	0	0	0	0	2
Task Force, Study, or Report	1	0	3	0	0	4
Wages or Compensation	0	0	1	0	1	2
Home Care Agencies	0	0	1	1	0	2
Recruitment and Retention	1	0	3	0	0	4
Education and Training	1	0	4	0	0	5
Medicaid	3	0	1	2	0	6
Service Availability, Quality, and Access	3	0	1	1	0	5

As noted, the most frequently discussed challenges cited in the existing literature include wages, working conditions, and Medicaid/Medicare. The home care workforce broadly performs physically and emotionally demanding labor and has grappled with expanding responsibilities and overwork. In many states, hourly pay rates are close to or at the minimum wage, annual mean wages are roughly half of the state's average wage, and there is generally a lack of mobility or a career ladder to help attract and

retain workers. Medicaid and Medicare reimbursement structures play major roles in this, particularly with respect to reimbursement schedules and program waivers, which may differ from state to state, and their impact or limit on wages for aides. States have direct control on the wages in the state through the reimbursement rates offered.

Both the content and the volume of legislation introduced and enacted from 2019 to 2022 with respect to the home care workforce varied greatly across states. The discussion above provides greater insight into what is occurring within each state. Looking at the coding of legislation across states helps provide broader insight into how state legislative efforts to address home care workforce shortages and needs align or fail to align with the challenges identified in existing research.

The most common codes assigned to legislation were patient or agency facing in the concerns they addressed. This included: service availability, quality, and access (25), education and training (19), Medicaid (19), and home care agencies (16). Those coded as service availability, quality, and access all generally worked to improve service delivery and did not address workforce needs, as did many of the education and training bills. While expanding access is important to those who need home healthcare services, this goal will be unachievable without an adequate labor force to meet these demands.

Some education and training coded bills did serve to expand recruitment and retention efforts. Out of the 19 education and training coded bills introduced in four of the states, six were passed, with five enacted, and one vetoed. All of those passed were in either New York or California. A majority, three out of five bills enacted aligned with the challenges and needs identified in the literature with respect to growing the workforce—two addressed broadening outreach for competency exams and one established a pilot Career Pathways Program for home care aides, while the other bills set out additional training requirements. While increased training and educational requirements may address important and necessary quality of care issues, they can also add further barriers or administrative burdens to entering this workforce.

Out of the 19 bills coded as Medicaid, six of them were enacted. Half of those bills (3) enacted were in California, while the others were in New York (1) and Pennsylvania (2). While some of the Medicaid coded bills introduced addressed rate adjustments that have the potential to impact wages and a few referenced wages or compensation specifically, Medicaid coded bills generally worked to expand coverage for potential patients or consumers.

Other common codes related to legislation more directly addressed the challenges and needs outlined in existing research with respect to growing the workforce for home care. This included recruitment and retention (16), wages or compensation (13), and task force, study, or report (12). A total of four bills coded as recruitment and retention were enacted, though three of these were in New York, with the remaining bill enacted in California. Of those bills enacted, two were those noted above related to competency exam outreach, while the other two pertained to broader programs and strategies aimed at increasing recruitment and retention in the home care workforce.

Just two of the 13 bills coded as wages were enacted, in New York and in Texas. As noted in the individual state analysis above, despite the 11 cent per hour increase implemented in Texas, the state still had the lowest mean annual wages across the five states and the lowest relative annual wages to the state's own average wage. New York on the other hand had the highest mean annual wage of the states considered, but as a share of the state's average wage it was similar to the others states and remains relatively low. New York's legislatively enacted increase to wages was more substantial than Texas, stepping up to $3 above the state minimum wage. As noted, however, more recent legislative changes in 2023 further adjusted that increase such that the monetary compensation for some workers will not be further increased.

Most of the task force, study, or recommendation coded bills were introduced (8 out of 11) and enacted (3 out of 4) in New York, with the additional enacted bill being in California. Several of the task force, study, and recommendation bills introduced acknowledged or were intended to address the shortage and need for home care workers, while others addressed on the job safety and job related stressors. Half those bills enacted related to establishing the Reimagining Long-Term Care Task Force in New York. The others established an advisory council to assist frontline workers, including home care workers impacted by COVID-19, with accessing mental healthcare service and established an advisory committee with respect to the health and safety of domestic workers, including caregivers.

Conclusions

Research has highlighted the importance of addressing low wages and compensation with respect to increasing the home care workforce, as well as the relative amount, breadth, and strenuousness of the work being carried out, and the respective lack of professional support or growth opportunities provided. While just one avenue for policy change, state legislation is a salient means of reflecting attention to an issue, how policymakers attempt to address it, and how or in what ways they are successfully able to do so. The broader body of bills introduced by the five states related to the home care workforce included legislation aimed at growing the workforce and doing so in the ways that existing research has highlighted as key. However, this legislation was generally far outweighed by bills that sought to address access to and quality of home care services and was either agency or patient and consumer facing. This was likewise true of those bills that were enacted, if less so. Improving access and quality of care are key to ensuring that people get the services they need, and they are not in opposition to workforce needs, but without the people who provide those services we will fall short of addressing the existing and projected shortages in home care services. Relatively few pieces of state legislation considered here reflect substantive efforts to do just that—even as a good portion of the small number of bills enacted unevenly across states did so—leaving the question of how states will meet our near future home care workforce needs uncertain.

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