

Addressing Wages of the Direct Care Workforce Through Medicaid Policies

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Introduction

Recruiting and retaining direct care workers, including certified nursing assistants (CNAs), home health aides, direct support professionals, personal care aides and other non-licensed personnel, has represented a longstanding challenge in the United States due to low wages and the intense demands of these occupations. The COVID-19 pandemic exacerbated these issues by increasing health risks to direct care workers. As states have grappled with staffing concerns in both facility and home and community-based (HCBS) settings, they are seeking long-term solutions to recruit and retain workers, an objective that also has significant equity implications because most direct care workers are women and people of color.¹ Developing both wage growth and career opportunities can facilitate economic mobility, address inequities and help improve the lives of these workers and those for whom they care.

The National Governors Association Center for Best Practices (NGA Center) has been analyzing direct care workforce challenges and policy trends throughout the pandemic. This paper, the third in a series, examines Medicaid policy vehicles states can use to increase direct care worker wages.² Medicaid is the largest payer for facility-based and HCBS care, paying for 42.1 percent of all long-term services and supports in 2020.³ Although many health care providers have received rate increases through temporary federal COVID-19 relief and state funding, only a limited number of states have policies to ensure funds are passed on to direct care workers.

This paper provides a summary of state approaches to increase direct care worker wages, with a focus on those that have reporting requirements, enforcement vehicles or other mechanisms to help ensure funds go to intended recipients working in facility and HCBS settings.

Benefits, such as health insurance, paid time off, childcare and transportation also represent important tools that can help to recruit and retain workers.⁴ These strategies have a clear monetary value and these non-wage benefits can give employers a competitive advantage over other professions that may offer similar or even slightly higher wages without such benefits. This paper includes some examples of policies states have implemented that address non-wage benefits within or alongside their wage strategies.

Governors have a unique opportunity to influence policies and budgets. Although the Governor must work collaboratively with the legislature to approve budgets and advance legislation, the executive and legislative branches can create policies that improve wages for direct care workers.

Scope and Methodology

This paper focuses on state strategies to address direct care worker wages through Medicaid that are being actively implemented. All examples included in this paper have been validated by state officials. Importantly, some states have policy authority for reporting and/or enforcement, but they have not implemented these policies, and these examples are not included.

Given only active policies are covered here, this paper is not exhaustive in nature but provides information on a diverse array of policy approaches states have taken. The paper also provides a review of notable state approaches, including a summary of each strategy, information on applicable settings and details on reporting and enforcement requirements.

Research for this paper included a literature review; review of state legislation, regulations and guidance; and interviews with state officials and other national experts. On June 1, 2022, the NGA Center hosted a virtual roundtable that brought together state officials and national experts to engage in dialogue about state strategies. **Arizona, Colorado, Connecticut, Iowa, Minnesota, Rhode Island, Tennessee** and **Washington** participated in the roundtable. This paper summarizes state strategies to address direct care worker wages and key takeaways that emerged from the roundtable and associated research.

While important – both in the short- and long-term – the paper does not address the following approaches to address direct care worker wages:



Temporary strategies: Federal COVID-19 relief funds, such as the American Rescue Plan Act signed into law in March 2021, provided new resources to address direct care worker recruitment and retention and test innovative strategies to address wages.⁵

Approaches that rely on short-term funding are outside of the scope of this paper; however, a limited number of states are building upon work funded through COVID-19 relief dollars to implement longer-term wage policies, and some of these examples are included.



Statewide minimum wage strategies: Most states have a minimum wage that applies to all workers. Fifteen states, Puerto Rico and the Commonwealth of the Northern Mariana Islands (CNMI) have a state-wide or territory-wide minimum wage that aligns with the federal minimum wage of \$7.25 an hour. In 30 states, the District of Columbia, Guam and the Virgin Islands, the minimum wage is higher than the federal minimum wage.⁶ Localities also sometimes set their own minimum wages. Statewide minimum wages offer no competitive advantage for direct care worker recruitment and retention because they are equally applicable to those who, for example, work in retail and who provide home care. As a result, workers may be more likely to pursue jobs that have fewer training and certification requirements and are less demanding than direct care work.⁷



Family caregivers: Both paid and unpaid family caregivers are critical providers of support services that help offset demand for the direct care workforce and allow individuals to live within the community rather than in institutional settings. However, this paper focuses on wage strategies for non-familial paid caregivers.

State Policy Approaches to Address Direct Care Worker Wages

This report presents two categories of state strategies that address direct care worker wages:

- (1) A wage/benefit increase through rate increase or supplement to rate (as a payment outside of their provider rate), including two potential implementation approaches:
 - a. Providers required to direct a specific percentage or dollar amount of their base payment rate to direct care worker wages (e.g., **Connecticut and Kansas**).
 - b. Providers receive an enhanced payment based on criteria, such as achieving high scores on quality metrics (e.g., **Rhode Island**), or a formulaic calculation (e.g., **Iowa**), with requirements to pass on some portion of the additional funding to direct care worker wages.
- (2) A minimum wage, also referred to as a wage floor:
 - a. Establishing a minimum wage or wage floor for all direct care workers (e.g., **Florida**) or a specific category of direct care workers (e.g., **Louisiana**).
 - b. A minimum wage for direct care workers that is a specific percentage or dollar amount above the state minimum wage (e.g., **New Jersey**).

Importantly, states may implement multiple strategies to address direct care worker wages, which may intersect in important ways. For example, **Colorado** and **Louisiana** have implemented both of the above strategies, using a provider rate increase to account for their direct care minimum wage requirements.

Mechanisms for Advancing Wage Strategies

Wage strategies are often implemented through state statute, which in many cases happens directly through appropriations legislation. The Governor can play a critical role in championing legislative action and associated appropriations to address direct care wages by prioritizing these objectives in their proposed budget.



Authorities to address wages vary across settings based on federal and state requirements and may influence the type of wage strategy a state pursues.⁸ In the Medicaid program, states pay for direct care services through Medicaid fee-for-service (FFS), Medicaid managed care and under specific Medicaid waiver authorities.⁹ Under FFS, states have flexibility to offer enhanced payments (rate increases) to providers in addition to base service rates for the purpose of direct care worker wage increases (e.g., **Washington**). However, states are not able to direct managed care plans to pay providers according to specific rates or methods unless they obtain federal approval through an 1115 waiver or state directed payment authority (e.g., **Wisconsin**), which can enable payments

to managed care plans that require expenditures be used to fund provider payments focused on direct care wage increases.¹⁰

The state Medicaid Director, usually an appointed member of the executive branch, typically works with the federal Centers for Medicare & Medicaid Services (CMS) to negotiate waivers under the authority of the Governor. In some instances, states may pass legislation to address direct care worker wages that requires waiver authority, or pursuit of a waiver may necessitate legislation to fund wage objectives. Therefore, the Governor, state Medicaid agency and state legislative branch, in addition to stakeholders like providers, all play key roles in policymaking to address direct care worker wages.

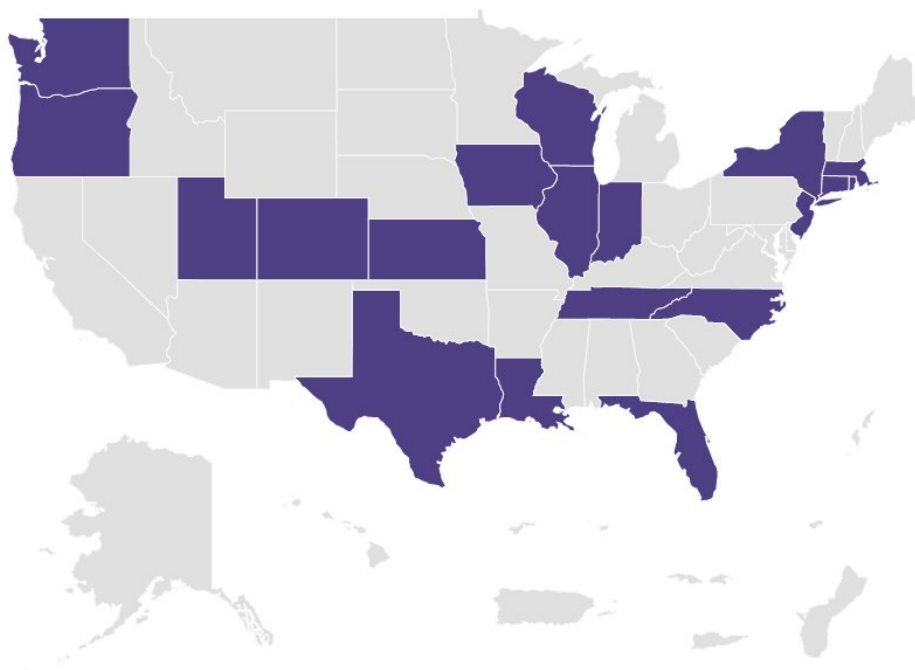
Reporting/Auditing and Enforcement

To ensure that a wage strategy achieves the intended goals, states may institute reporting and enforcement requirements. For purposes of this paper, reporting provisions include auditing, routine provider reporting and provider attestations. Reporting can facilitate program and policy evaluation. Enforcement provisions can help ensure compliance and may be paired with sanctions (such as rate adjustments or fines) or civil action for non-compliant parties. Both strategies encourage transparency and accountability.













Findings





Based on the analysis for this paper, at least 19 states are actively implementing strategies to address direct care worker wages through reporting and/or enforcement mechanisms. The following table includes information about the states, settings, policy, reporting and enforcement requirements.













Examples of States Implementing Strategies to Address Direct Care Worker Wages with Active Reporting and Enforcement





State	Setting <i>HCBS, Facility</i>	Wage Strategy <i>Rate Increase, Supplement to Rate or Minimum Wage</i>	 Reporting/Auditing <i>Auditing, Required Reporting, Attestation</i>  Active Enforcement <i>Sanction, Recoupment of Funds, Civil Action</i>
Colorado	HCBS ¹¹	Rate Increase, Minimum wage: Provider rate increase to support providers in achieving \$15 per hour minimum wage. Providers that already pay workers \$15 per hour can use the rate increase to further enhance the wage or address related issues, such as other recruitment and retention initiatives or risk of wage compression.	 Attestation, Required Reporting: Providers must report wage changes at individual level.  Recoupment of funds: Non-compliant providers must return funds to the state.
	Facility ¹²	Supplement to Rate: State calculates a minimum hourly wage gap by employee and facility to calculate a by-facility supplemental payment (dependent on availability of appropriation).	 Required Reporting: Providers must report employment and wage data upon request and provide quarterly financial statements.  Recoupment of funds: Failure to report may result in recovery of supplemental funds.









State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Connecticut	HCBS ¹³	<p>Rate Increase: All providers receive a minimum 3.5% and 5% recruitment/retention threshold increase. Optional one percent rate increase for HCBS providers who meet certain quality metrics. Metrics include staff participation in racial health equity training and beneficiary progress on individually identified goals assessed through a standardized goals scale. Providers receive a rate increase according to their success in helping a beneficiary achieve their goals. HCBS providers that receive a rate increase must pass funds to direct care workers.</p>	<p> Attestation, Required Reporting Outcome reporting based on defined metrics.</p> <p> Active Enforcement: None</p>
	Facility ¹⁴	<p>Rate Increase¹⁵: Rates increases by a certain percentage that must be used for employer wage enhancements. Providers apply to receive a rate adjustment to provide enhanced health care and pension benefits for employees. If applications exceed funding, distribution is pro-rata based on cost of enhancements.</p>	<p> Auditing: Formalized auditing process to assess compliance.</p> <p> Recoupment of Funds: Non-compliant providers must return funds to the state. The state may impose civil monetary penalties. If a provider does not provide enhanced benefits, they are subject to rate decrease in the same amount as adjustment.</p>





State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Florida	Facility and HCBS ¹⁶	<p>Rate Increase, Minimum Wage: Rate increase to raise wages to at least \$15 per hour, including those who are classified as independent contractors.</p>	<p> Attestation: Providers must agree to pay employees at least \$15 per hour and attest under penalty of perjury that they will do so.</p> <p> Civil Action: An employee of a provider receiving an increased rate that is not receiving a wage of at least \$15 per hour may bring a civil action against the provider. Upon prevailing, the employee shall recover the full amount of any back wages unlawfully withheld plus the same amount as liquidated damages.</p>
Illinois	Facility ¹⁷	<p>Supplement to Rate: To support CNA retention, providers receive supplemental payment associated with CNA tenure beginning at \$1.50 per hour for the first year retained, and then \$1 per hour for every year after up to a max of \$6.50 per hour. In addition, CNAs can receive \$1.50 per hour for promotions associated with additional training/skills (dementia care) and/or responsibilities (supervisory).</p>	<p> Required Reporting: Providers report on costs and revenue during the period of implementation.</p> <p> Active Enforcement: None</p>







State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Indiana	HCBS ¹⁸	<p>Rate Increase: Rate increase of 14 percent from which 95 percent must be passed on to support direct care workers through use for payroll tax liabilities, wage, or benefits.</p>	<p> Auditing, Required Reporting: Providers are required to submit a written and electronic plan as to how the increase will be used. Provider records may be audited.</p> <p> Recoupment of Funds: Funds may be recouped if providers are non-compliant.</p>
Iowa	Facility ¹⁹	<p>Supplement to Rate: Providers submit quarterly quality assurance assessments, calculated based on certain criteria. Fees go into a quality assurance trust fund that supports state match for federal financial participation. Funding is then returned to facilities with a rate increase. Providers must pass on at least 35 percent of increase to support direct care worker compensation and employment costs and at least 60 percent must be used for compensation and costs for all nursing facility staff.</p>	<p> Required Reporting: Providers submit a report outlining use of the supplement toward direct care and nursing facility staff compensation and employment costs, which are publicly accessible.</p> <p> Sanction, Civil Action: Facilities that fail to pay the assessment in a timely manner may pay a penalty of 1.5 percent of the amount owed for each month that the payment is overdue. If the assessment is not provided within a month of the due date, the state withholds the amount from payment due to the facility for reimbursement. Civil actions may be invoked.</p>





State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Kansas	Facility ²⁰	Supplement to Rate: Nursing facilities and intermediate care facilities can apply for an extra \$4 per resident day in provider rate to support the wage or benefits of direct care workers.	<ul style="list-style-type: none">  Required Reporting, Auditing: Quarterly wage audits for participating providers.  Recoupment of funds: Termination from program for failure to meet reporting requirements and recoupment of allocated funds.
Louisiana	HCBS ²¹	Rate Increase, Minimum Wage: Rate increase of \$2.50 per hour and minimum hourly wage floor of \$9.00.	<ul style="list-style-type: none">  Auditing: Audit documentation may include payroll records, wage and salary sheets, and pay stubs.  Sanction: Sanctions/penalties with amount based on magnitude of non-compliance. Any civil fines and interest are maintained in a New Opportunities Waiver Fund, which supports home and community-based activity-focused services to individuals with disabilities who would otherwise be in an institutional setting. Disenrollment from Medicaid.
Massachusetts	Facility ²²	Rate Increase: Nursing Facility providers are held financially accountable for prioritizing investment in direct care staff. Providers are required to spend at least 75 percent of total facility revenue on direct care related expenditures.	<ul style="list-style-type: none">  Required Reporting, Attestation: Nursing facilities are required to submit both an interim and final report on revenue and spend to measure compliance with the “Direct Care Cost-Quotient Threshold.”  Active Enforcement: None

State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
New Jersey	Facility ²³	<p>Minimum Wage: Phased increase to result in a minimum wage that must be \$3 more than the prevailing minimum wage by 2024. At least 90 percent of provider's aggregate revenue must be spent on direct patient care (which may include direct care wages).</p>	<p> Required Reporting, Auditing: Providers must report revenues collected, along with the portion of revenues that are expended on direct care staff wages. State may conduct an audit of reported financial information to ensure compliance.</p> <p> Recoupment of funds: Payments may be recovered if a provider exceeded the allowed ratio for administrative costs and profits.</p>
New York	HCBS ²⁴	<p>Minimum Wage: Minimum wage for home care aides is increased by \$3 over prevailing regional minimum wage. The minimum wage increase is implemented over two years; the home care aide minimum wage increases by \$2 on October 1, 2022, and by an additional \$1 on October 1, 2023.</p>	<p> Reporting/Auditing: None</p> <p> Active Enforcement: The Commissioner of Labor may take direct administrative enforcement action, which could include requiring an employer to pay: (1) Minimum wage underpayments and liquidated damages, plus; (2) Interest and civil penalties up to 200 percent of the unpaid wages.</p> <p>A home care aide, or the Commissioner of Labor acting on behalf of the home care aide, may bring civil action if paid less than required minimum wage.</p>

State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
<p style="text-align: center;">North Carolina²⁵</p>	<p style="text-align: center;">Facility²⁶</p>	<p>Rate Increase: Rate increase with a requirement to pass on 80 percent of increase with intent to support minimum wage of direct care workers in intermediate care facilities up to \$15 per hour.</p>	<p> Attestation, Auditing: Providers must attest that 80 percent of rate increase was passed on to direct care workers. Providers must maintain documentation of direct care worker pay levels and accounting/payroll information for auditing purposes.</p> <p> Active Enforcement: None</p>
	<p style="text-align: center;">HCBS²⁷</p>	<p>Rate Increase: Rate increase for HCBS providers to support wage increase. Medicaid encourages providers to pass on 80 percent of rate increase to direct care workers.</p>	<p> Auditing: Providers advised to maintain records that rate increase was passed on to direct care worker wages, which may be audited for review.</p> <p> Active Enforcement: None</p>
<p style="text-align: center;">Oregon</p>	<p style="text-align: center;">Facility <small>28 29</small></p>	<p>Supplement to Rate, Minimum Wage: Four percent rate increase to support starting wage of \$17 per hour, with increase to \$17.50 per hour for CNAs.</p>	<p> Required Reporting: Providers must submit documentation of \$17 per hour starting wage.</p> <p> Active Enforcement: None</p>
		<p>Supplement to Rate: Supplemental payment to support provision of health care benefits to direct care workers and other employees.</p>	<p> Attestation, Required Reporting: Providers must have a memorandum of understanding with the Oregon Health Authority specifying how the supplemental payment will be used and submit annual reporting on quality and other metrics.</p> <p> Active Enforcement: None</p>

State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Rhode Island	HCBS ³⁰	<p>Supplement to Rate: Value-based supplement to rate must be passed on to direct care workers. Behavioral health care enhancement is only available to providers who have at least 30 percent of their direct care workers certified in behavioral health care training. Direct care workers who have received this 30-hour training will receive 100 percent of the rate enhancement.</p>	<p> Required Reporting, Auditing: Initial report providing personal information on all direct care workers who have completed behavioral health care training. Providers submit an annual compliance statement showing wages, amounts received from increases, and compliance with required pass-through.</p> <p> Active Enforcement: None</p>
Tennessee	HCBS ³¹	<p>Rate Increase: Phased rate increases with expectation for comparable increase in hourly wages for direct support professionals (home health not included).</p>	<p> Attestation, Auditing: Annual attestation for Medicaid Managed Long-Term Services and Supports and auditing (which includes review of provider payroll records, claims and other related documents).</p> <p> Recoupment, Civil Action: Recoupment of funds and provider may be reviewed for potential False Claims Act violations if conditions of payment are not met.</p>

State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Texas	Facility ³²	Supplement to Rate: Providers may choose to participate in a rate enhancement program whereby they must meet minimum staffing requirements and meet spending floor requirements on direct care staff revenue.	<p> Required Reporting, Auditing: Providers must submit annual staffing and compensation reports, which may be reviewed or audited.</p> <p> Recoupment of funds, Sanction: Providers failing to meet spending requirements will have the add-on amount recouped. Vendor payments may be withheld until the provider submits reporting.</p>
	HCBS ³³	Supplement to Rate: Providers may choose to participate in a rate enhancement program whereby they must spend 90 percent of total attendant revenues on compensation (defined to include salaries, payroll taxes, benefits and mileage reimbursement).	<p> Required Reporting: Providers must submit annual reports documenting spending for compliance review.</p> <p> Recoupment of funds: Providers failing to meet spending requirements will have the add-on amount recouped.</p>
Utah	HCBS ³⁴	Rate Increase: Providers receive rate increases with a requirement to pass on 100 percent of the increase to direct support workers.	<p> Required Reporting: Providers are required to report on distribution of the increases to ensure 100% of the amount went to wages. An evaluation was conducted on the impact of the increase on wages.</p> <p> Recoupment of funds: Providers who do not report or are not in compliance will be required to pay back the increased amount.</p>

State	Setting	Wage Strategy	Reporting/Auditing Active Enforcement
Washington ³⁵	HCBS ³⁶	<p>Rate Increase: Rate Setting Board to determine labor rate that is then collectively bargained for paid self-directed caregivers providing direct, hands-on personal care services to persons with disabilities or elderly. Increases are passed to home care agency employees by way of parity statute.</p> <p>Benefits may also be available to home care workers through Taft-Hartley trusts, which are partially funded by the labor rate.</p>	<p> Required Reporting: Monitor reporting of contract requirements.</p> <p> Active Enforcement: None</p>
Wisconsin	HCBS ³⁷	<p>Supplement to Rate: Direct Care Workforce Funding Initiative supports wage/benefit increase for direct care workers of participating providers within managed care networks. Specified amount of funds provided to managed care plan to pass on to providers for things such as wage increases, bonuses, additional paid time off, hazard pay, increased overtime and employer payroll tax increases associated with wage increases.</p>	<p> Attestation: Managed care organizations attest annually via survey that funds were passed on to providers.</p> <p>Providers must attest through completion of an annual survey to indicate how funds are used.</p> <p>Providers are advised to maintain documentation on precise amounts expended on each direct care worker.</p> <p> Active Enforcement: None</p>

Considerations

There is no one-size-fits-all approach to addressing wages for direct care workers. Each state may have unique considerations and priorities that influence their approach, such as a high statewide minimum wage, union involvement or a specific need to recruit and grow a particular class of workers. States have flexibility to design strategies based on their priorities and market context, which could include, for example, targeting an approach to a specific subset of direct care workers or setting, focusing on both wages and benefits, or implementing incentive-based wage increases to support training objectives. The following considerations can help inform Governor and state agency policy and budgetary priorities, both where they have executive authority and in coordination with the legislature and CMS.

- **Wage as Part of Broader Strategy.** Wage is one of several factors that influences recruitment and retention of direct care workers. Strategies addressing direct care worker wages may complement other state efforts, such as pathways for students, workforce development programs, training and career growth opportunities. States may find it easier to encourage entry into the direct care workforce and support pathways that facilitate transition to higher skilled jobs with better wages and career growth. Many of these strategies are addressed in the aforementioned NGA Brief [State Strategies for Sector Growth and Retention of the Direct Care Health Workforce](#).³⁸
- **Alignment Across Settings.** Policymakers may consider parity across settings that employ similar workers to avoid competition. For example, if a state implements a wage increase for direct care workers in facility-based settings, it could result in retention issues for direct care workers in HCBS settings if average wages are significantly lower in those settings.
- **Coordinate with Broader Workforce Investment Strategies.** In many instances, state workforce agencies and boards prioritize investments in careers with higher wage potential because of the immediate economic potential. However, coordination between labor agencies, health care agencies and employers regarding supply, demand and workforce policy can help ensure adequate wages and career trajectories while maintaining a critical workforce. As mentioned in the previous briefs in this series, employment as a direct care worker can serve as a stepping stone for individuals and facilitate economic mobility. Governors can play a central role in establishing the vision and calling for coordination across state agencies. Decisions about how to use *Workforce Innovation and Opportunity Act* funding represent a prime example of where state agencies can coordinate to achieve multiple goals.³⁹

- **Broader Market Forces.** When selecting strategies to increase wages for direct care workers, policymakers can consider individual policy approaches in the context of broader market forces. For example, establishing a minimum wage for direct care workers may be unproductive in supporting recruitment and retention if it is not competitive or does not offer an advantage over other labor markets. **New Jersey** is one state that requires direct care workers receive \$3 above the prevailing minimum wage, potentially providing competitive advantage over other jobs that pay minimum wage. Relatedly, establishing a minimum wage or providing an increase that does not account for future market changes will limit the value of the approach. To address this issue, **Minnesota** uses wage data from the U.S. Bureau of Labor Statistics and other sources to account for a competitive factor within the base rate calculation and adjusts provider reimbursement rates for providers in its disability and aging waiver programs.⁴⁰ On a biennial basis, Minnesota considers wages for jobs in other industries that require similar education and experience and updates disability and aging provider rates as appropriate to enable them to offer competitive wages to their direct care workers. By using biannual adjustments, the state can make updates that are consistent with market rates rather than risk stagnating rates.
- **Sustainability.** In recent years, there have been an array of temporary approaches implemented across states to address acute direct care worker challenges associated with the COVID-19 pandemic. Short-term strategies can serve as stopgap measures to address issues quickly or to serve as compromises when the budgetary or political climate cannot sustain long-term changes. However, temporary wage increases or one-time bonuses do not provide long-term solutions. Strategies that are sustainable over time help to reduce the likelihood of a cliff effect or wage reduction that could adversely impact retention.
- **Evaluation.** Evaluating policies that address direct care worker wages is important to understanding the impact of specific approaches to achieve key goals and objectives, such as improvements in recruitment and retention. For instance, in **New Jersey**, one year after strategies are put in place by the state or a designated entity, a study of costs and payments with recommendations for reimbursement rate adjustment must be prepared.⁴¹ Evaluation of wage strategies in isolation can be challenging given that workforce improvements are often multi-faceted. The analysis for this report did not directly explore potential negative ramifications of reporting or enforcement requirements for direct care workers (e.g., if a provider hired fewer workers or could no longer continue to operate because of sanctions). However, papers and policies reviewed as well as states consulted as part of the analysis did not indicate such challenges. Rigorous evaluation of implementation approaches and outcomes may reveal additional findings. States may benefit from designing evaluation approaches at the outset of wage strategy development and in coordination with their broader efforts related to the direct care workforce.

Conclusion

The direct care workforce represents a critical component of the United States employment market, yet pay remains low. States have taken a variety of actions through provider rate increases and minimum wage policies through the Medicaid program as two strategies to address recruitment and retention. Reporting and enforcement mechanisms can help ensure policies related to direct care worker wages are implemented as intended.

As the nation continues to face high inflation and an extremely competitive employment market, it will be important for states to evaluate the role of both longstanding and newer wage strategies, including temporary and longer-term policies, to help direct care workers achieve a living wage and to sustain the workforce to ensure alignment of supply and demand. At this juncture, while it is believed that reporting and enforcement can improve accountability, there is little to no public information about the effectiveness of different reporting and enforcement approaches in the direct care workforce to help inform future state actions.

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