

Request for Information: Delivering An Affordable Home Care Guarantee for American Families

October 16, 2026



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More than 40 years ago, then Department of Health and Human Services (HHS) Secretary Otis Bowen called up this Gray Panther-turned-United States Congressman. The Secretary asked me to join President Ronald Reagan's joint taskforce to reform the nation's broken long-term care system. The taskforce found that millions of Americans could not afford the catastrophic costs of a nursing home stay, and millions more had no reliable access to home care.¹ Starting out as an activist in Oregon, I dedicated my life's work to bettering seniors' lives. I have spent the last forty-plus years begging Republicans to partner with me to enact meaningful reforms, and it pains me to admit that the state of long-term care for seniors and people with disabilities in this country has only worsened since I sat on that task force all those years ago.

This already bleak scenario will turn even more dire. Under Donald Trump's watch, Republicans dealt a death blow to the country's fragmented patchwork of long-term care by slashing nearly \$1 trillion from Medicaid, American families' only meaningful pathway to access and afford long-term care.² Today, long-term care options are prohibitively expensive, overwhelming and confusing to navigate, and fail to cover the services older Americans and people with disabilities truly need to live in their own homes and communities. The weight of America's dysfunctional long-term care patchwork is bearing down on families all across the country. This problem will only get worse: the number of older adults and people with disabilities in need of long-term care will continue to grow, and the shortage of workers and of high-quality direct care jobs will continue to persist without urgent action from Congress.

As I crossed the state of Oregon this summer, I heard from a caregiver who cannot afford the \$33,000 per month cost of home care services, and instead had to put her aging parents in multiple facilities that kept discharging her mother and father as they faced cognitive decline. I heard from a direct care worker, who is already one crisis away from becoming homeless and who is consumed with worry about losing her job because of Trump's and Republicans' devastating Medicaid cuts. Thousands more Oregonian families rely on home care services they receive through Medicaid, as I heard from a young constituent with Down syndrome whose support services allow her to live the fulfilling life she deserves.

Eighteen of my Democratic colleagues in the Senate have joined my Dear Colleague letter³ announcing our commitment to directly confront this crisis. Americans want to have the choice

¹ Spencer Rich, "Tax Breaks Urged as Spur to Nursing Home Insurance," *Washington Post*, September 21, 1987, <https://www.washingtonpost.com/archive/politics/1987/09/22/tax-breaks-urged-as-spur-to-nursing-home-insurance/df3a04d7-9157-4a12-a2ed-f784eae90301/>.

² An act to provide for reconciliation pursuant to Title II of H. Con. Res. 14 (Public Law 119-21).

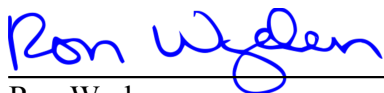
³ "Delivering an Affordable Home Care Guarantee for American Families," United States Senate Finance Committee, May 20, 2026, https://www.finance.senate.gov/imo/media/doc/052026_dear_colleague_long_term_care.pdf; Senators Klobuchar and Markey joined the effort subsequently.

to live where they prefer, whether that is their own homes or a nursing home or other type of long-term care facility. However, without strong investments in the workforce, care will not be safe, accessible, or available to low- and middle-income families in need.

It has been decades since Congress enacted a comprehensive, system-level investment in long-term care infrastructure and financing. And a system-level investment is what is needed: a 2023 survey found that more than 60% of adults 50 and older were anxious about affording long-term care services like nursing homes and home health aides, and only 28% of 50- 64-year-olds and 45% of people 65 and older had been able to set aside funds to pay for long-term care.⁴ In addition, 45% of older adults mistakenly believed that Medicare would cover the cost of long-term care if they needed it. American families are asking for a simpler, more affordable long-term care system, and Senate Democrats plan to deliver.

American families deserve better than funding cuts, waiting lists, and kicking the can down the road. It's time to turn our current long-term care patchwork into a system that works for every family.

Sincerely,



Ron Wyden
United States Senator
Ranking Member, Committee
on Finance

⁴ Liz Hamel and Alex Montero, “The Affordability of Long-Term Care and Support Services: Findings from a KFF Survey,” KFF, November 14, 2023, <https://www.kff.org/health-costs/the-affordability-of-long-term-care-and-support-services/>.

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Executive Summary

As Senate Democrats continue to hold Republicans accountable for taking a sledgehammer to an already broken, fragmented long-term care (LTC) patchwork, we are also doing the work to make sure every family has safe and affordable choices when they need LTC. On May 20, 2026, Ranking Member Wyden, along with Senators Luján, Duckworth, Alsobrooks, Kaine, King, Kim, Blumenthal, Booker, Warren, Hirono, Murphy, Shaheen, Whitehouse, Gillibrand, Blunt Rochester, and Merkley, released a Dear Colleague letter outlining their vision for comprehensive LTC reform. Senators Klobuchar and Markey have also since joined this effort.⁵

In the months since the release of the Dear Colleague letter, Finance Committee Democratic staff have been joined by staff from participating Senate offices in more than 95 listening sessions involving 180 organizations and advocates representing older adults, people with disabilities, experts and researchers, labor unions, home care agencies, home health agencies, nursing homes and other facilities, LTC insurance providers, physicians, pharmacies, oral health providers, states, hospitals, patients with rare diseases, elder care attorneys, pharmaceutical manufacturers, health plans, administrative contractors, foundations, nurses, and more.

This Request for Information (RFI) reflects those listening sessions and solicits feedback on policy proposals designed to provide affordable and accessible LTC choices for American seniors, people with disabilities, and their families. This is the third in a series of long-term projects led by Senate Democrats on the next generation of transformational health reforms, following a June 2026 RFI focused on lowering prescription drug prices and reducing costs for patients and a July 2026 RFI focused on reining in insurance company abuses and making universal, affordable health coverage a guarantee for all Americans.⁶

This RFI is not intended to presuppose policy outcomes or reflect an exhaustive list of policy options that could be considered, but is a call for specific feedback, analysis, and proposals to address the topics and issues highlighted throughout. Senate Democrats are requesting feedback on these particular proposals because we believe that, taken together, they operationalize the following core principles for LTC reform:

1. **Universality.** A system of LTC must be universal, equitable, and supportive of all people in need of LTC.
2. **Simplicity.** LTC must be affordable and simple for families to access.

⁵ “Delivering an Affordable Home Care Guarantee for American Families.”

⁶ “Request for Information: Health Coverage That Works for Everyone,” United States Senate Committee on Finance, July 30, 2026, https://www.finance.senate.gov/imo/media/doc/073026_sfc_health_coverage_rfi.pdf; “Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients,” United States Senate Committee on Finance, June 16, 2026, https://www.finance.senate.gov/imo/media/doc/061626_sfc_drug_pricing_rfi.pdf.

3. ***Flexibility.*** People must have the option to receive safe, quality LTC in the setting of their choice.
4. ***Workforce Investment.*** Reforms must recognize and elevate the importance of care and those who perform the care, paid or unpaid. Investing in LTC means investing in the LTC workforce and informal caregivers.
5. ***Safeguards.*** A new system of LTC must keep people safe and root out corporate greed and systematic corruption from the outset.

Ranking Member Wyden, along with the Senators participating in this effort, invites detailed comments, feedback, data, and specific policy proposals that are responsive to some or all of the topics contained within this RFI. This Executive Summary includes a brief overview of each section of this RFI; please note in your response which section or sections you are responding to. These responses will be used to inform future policymaking efforts and legislative drafting.

Please submit written comments to homecare@finance.senate.gov no later than December 18, 2026.

Section I: Make Home Care Affordable and Accessible. In this section, Senate Democrats seek feedback on policies to establish a universal home care benefit that leverages the Medicare and Medicaid programs. These include:

- Establishing and defining the components of a universal benefit.
- Designing eligibility requirements for a universal benefit based on functional needs.
- Delivering a universal benefit and defining the roles of Medicare and Medicaid in providing the spectrum of benefits.
- Evaluating the role of cost-sharing in a universal benefit and assessing how buy-in programs can expand access to people beyond the defined eligibility categories.
- Ensuring legal rights and protections for beneficiaries.
- Incorporating participant-direction into a universal home care benefit.
- Assessing how the universal benefit will be administered and phased in, including the development of provider networks and payment rates, integration with managed care, and connections to other parts of the health care system.
- Ensuring a universal benefit includes simplifications to best support beneficiaries in navigating LTC access and support for adequate capacity-building at the state level.

Section II: Improve the Quality of Care in Nursing Homes. In this section, Senate Democrats seek feedback on policies to make nursing homes a safe, high-quality setting. These include:

- Ensuring taxpayer dollars are spent on direct care rather than siphoned off through profit-hiding shell games.
- Improving the transparency of nursing home ownership, operations, quality, and cost reporting.
- Aligning incentives to strengthen nursing home staffing standards so residents are safe and workers are supported.
- Updating the survey, certification, and quality measurement of nursing homes and available technical assistance and support to ensure facilities consistently meet high quality standards.

Section III: Strengthen the LTC Workforce. In this section, Senate Democrats seek feedback on policies to invest in the LTC workforce to support a newly integrated, universal system of LTC by treating direct care workers as essential, valued infrastructure. These include:

- Improving wages, benefits, training, and career pathways for home care and nursing home workers.
- Addressing workforce shortages by creating training incentives involving government, employers, labor unions, families, and beneficiaries.
- Protecting, retaining, and attracting legal immigrants to fill gaps in the domestic workforce.
- Supporting family and informal caregivers.
- Integrating both paid and unpaid family caregivers to create a unified LTC team.

Section I. Make Home Care Affordable and Accessible

Background

Decades of research affirm that LTC delivered at home and integrated in communities delivers higher quality, more cost-effective care.⁷ This is also the mode of care that the vast majority of American adults, nearly 88%, say they prefer.⁸ Yet the United States has no guaranteed universal home care benefit for older adults or people with disabilities in either Medicare or Medicaid.

Despite widespread public perception, Medicare does *not* cover comprehensive LTC. A limited home health benefit does exist in Medicare, and under this benefit, people with Medicare can access medical care, physical, occupational, and speech therapy, and limited help with activities of daily living (ADLs) at home *only* if they are homebound and require skilled nursing care.⁹ In 2022, more than a quarter (28%) of people with Medicare needed assistance with at least one ADL, but Medicare beneficiaries cannot access home care services like meal delivery or support with bathing through the current Medicare home health benefit.¹⁰ Medicare's home health coverage is only valid for 60 days at a time, making it an unsustainable option for ongoing support at home.¹¹ Absent a functioning LTC benefit in Medicare, Medicaid is the primary provider of LTC in America. However, Medicaid does not guarantee access to LTC for everyone who needs it.

Senate Democrats are committed to advancing a system that will make home care affordable and accessible to all who need it. For too long, we have ignored the hole in the nation's health care system that abandons people who need help with basic tasks of living. We envision a LTC system that:

- Determines coverage by a person's needs, not zip code, age, income, or wealth;
- Preserves access to services and benefits for those who currently have them;
- Is simple for families to navigate; and
- Appropriately values and compensates *all* care work.

⁷ Joe Caldwell et al., "Home and Community-Based Services Improve Outcomes While Reducing Costs," Brandeis University Community Living Policy Center, April 2026, <https://heller.brandeis.edu/community-living-policy/research-policy/publications/pdfs/briefs/hcbs-improve-outcomes-and-reduce-costs.pdf>.

⁸ "Long-Term Care in America: Americans Want to Age at Home," The Associated Press-NORC Center for Public Affairs Research, May 2021, https://apnorc.org/wp-content/uploads/2021/04/LTC_Report_AgingatHome_final.pdf.

⁹ "Home Health Services," Medicare.gov, accessed October 2026, <https://www.medicare.gov/coverage/home-health-services>.

¹⁰ "Health Policy 101: Medicare, Who is Covered by Medicare?" KFF, May 22, 2024, <https://www.kff.org/health-policy/101-medicare/?entry=table-of-contents-who-is-covered-by-medicare>; "Medicare and Home Health Care, (CMS Publication No. 10969)" Centers for Medicare and Medicaid Services, accessed October 2026, <https://www.medicare.gov/publications/10969-medicare-and-home-health-care.pdf>.

¹¹ 60 day approvals for home care can be renewed by doctors as necessary with medical documentation.

Over decades, countless advocates, experts, and members of Congress have attempted to build a LTC system like that contemplated here. Some concepts use a mandatory Medicaid framework, other policies build a new Medicare benefit, while some envision an entirely different framework. Often, the debate about the merits and downsides of these frameworks is oversimplified: Should it be Medicaid? Should it be Medicare? Or should it be something new altogether? This discussion often fails to acknowledge the vast, underfunded array of existing community-based supports offered through the aging and disability networks that bolster the existing patchwork of care. It also often disregards the massive amount of unpaid support provided by family and community members.

This debate also quickly devolves around questions of cost. Arguably, this question is what has stood in the way of making progress on LTC for decades. This RFI does not contemplate that question. The goal of this exercise is to determine what needs to be done for the growing number of American families who desperately need support to care for their loved ones. *Congress has an imperative to help these families.* We recognize that the entire health care system needs to work better for Americans, and these challenges cannot be fully addressed without system-wide reforms and cost-containment policies that will require *every industry in the health care sector* to provide constructive solutions.

As reflected in the Senators' Dear Colleague, Senate Democrats agree that a home care benefit should leverage the best aspects of the Medicare and Medicaid programs and build on existing infrastructure. At the same time, the fragmentation across these programs and systems has contributed to the gaps, inequities, and complexity families face today. Ultimately, a universal home care benefit that is phased in over time will require us to consider how existing and new aspects of the home care system interact.

As such, we solicit feedback on how Congress should design a benefit that utilizes the simplicity of the Medicare program's federal infrastructure while drawing on and strengthening the essential elements of Medicaid and other community-based supports that serve millions of beneficiaries today.

Centering Family Stories: Margaret

Nearly three decades ago, my parents moved from Indiana to Oregon to be closer to me so that I could serve as their caretaker. Because of my mother's cognitive impairment, she needed more supervision, and we started looking into home health care services. We contracted with an agency for care during the day, but before long, it became clear that she needed around-the-clock care.

At the time, the cost for these services was around \$17,000 per month, equating to \$33,000 per month in 2026. These costs were completely unsustainable for my family, so I searched for and found an adult foster home not far from me and moved my parents there. This situation lasted about two weeks, when the home informed me that my parents would have to move because my mother was wandering at night. They recommended a memory care facility, and I found one that seemed to be acceptable, although it was located about 45 minutes from my home. My father moved there as well, to be with my mother. They were there for a few months, and my mother's health deteriorated. Hospice care was recommended by my mother's physician, and a nurse came to the facility to do an assessment. She whispered to me that although my mother could remain where she was and receive hospice care from her team, she highly recommended moving my mother out of the facility as soon as possible, as my mother was not getting the daily care she needed.

Not only was it difficult to find proper long-term care for my parents, but this care was extremely expensive, and my parents paid completely out-of-pocket for it. I am extremely grateful that they were able to afford to do this, but this is not the norm. Moreover, in talking with the various home care and facility-based workers who helped to care for my parents, I learned of the low wages they receive and the overtime they are often forced to work due to the shortage of direct care workers. It is unacceptable that Medicare does not provide accessible long-term care coverage for its beneficiaries. As people age and need help with their daily needs, they deserve to have access to affordable, high-quality long-term care in the setting they choose, whether at home or in a nursing facility.

Current LTC System

Since Medicaid's creation in 1965, states have been required to cover nursing facility care and medically necessary home health services. In the 1970s, Congress authorized states to cover additional LTC services through Medicaid, including facility-based services for individuals with intellectual and developmental disabilities (I/DD) and personal care services.¹² In 1981, Congress authorized Section 1915(b) and (c) waivers that gave state Medicaid programs the ability to cover Home and Community-Based Services (HCBS) for individuals who are at risk of institutionalization.¹³ Over time, seniors and people with disabilities won the legal right to be in

¹² Sarah Barth, Sharon Lewis, and Taylor Simmons. "Medicaid Services for People with Intellectual or Developmental Disabilities - Evolution of Addressing Service Needs and Preferences: Report to the Medicaid and CHIP Payment and Access Commission," Health Management Associates, October 2020, <https://www.macpac.gov/wp-content/uploads/2021/01/Medicaid-Services-for-People-with-Intellectual-or-Developmental-Disabilities-%E2%80%93-Evolution-of-Addressing-Service-Needs-and-Preferences.pdf>.

¹³ "Long-Term Services and Supports Rebalancing Toolkit," Centers for Medicare and Medicaid Services, November 2020, <https://www.medicaid.gov/sites/default/files/2020-11/tss-rebalancing-toolkit-508.pdf>.

the most integrated setting appropriate through the passage of the Americans with Disabilities Act and the Supreme Court’s *Olmstead* decision. However, access to HCBS remains governed by a complex, fragmented web of statutory authorities split between state plan options and federal waiver mechanisms.

Some Medicaid statutory authorities require states to operate HCBS as open entitlements for specific populations.¹⁴ When states cover HCBS, they often choose to do so through Section 1915(c) waivers, which allow the Secretary of Health and Human Services (HHS) to waive standard Medicaid rules—specifically statewideness, service comparability, and income eligibility criteria. In addition, this waiver authority grants states the ability to establish hard numerical caps on total enrollment. States systematically leverage these caps as a primary fiscal lever to control Medicaid spending, resulting in long, pervasive waiting lists that leave hundreds of thousands of individuals stranded without needed home care, often for years. The best estimate of the number of people with disabilities and older adults waiting for HCBS is nearly 650,000, though that is likely an undercount, and the need is expected to grow exponentially in the next 20 years as the aging population is expected to double.¹⁵

Most people who are eligible for Medicaid HCBS qualify for Medicaid on the basis of having a disability or being 65 and older.¹⁶ Medicaid eligibility pathways based on age or disability typically impose asset limits, while eligibility pathways for children, adults, and pregnant women without disabilities do not. Today, state Medicaid programs provide a range of essential HCBS that allow approximately 5.1 million individuals with complex needs to live in their communities.¹⁷ In 2025, states operated over 300 different programs for individuals to gain access to Medicaid HCBS, many of which targeted a specific population.¹⁸ To gain access to these services, in addition to financial eligibility, Medicaid enrollees who need HCBS must demonstrate their functional needs (generally measured by ADLs).

¹⁴ These authorities include State Plan Option for Home and Community-Based Services for Elderly and Disabled Individuals; 42 U.S.C. § 1396n(i); 42 U.S.C. § 1396n(k).

¹⁵ Alice Burns, Abby Wolk, Molly O’Malley Watts, “A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2026,” KFF, October 5, 2026, <https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2026/>; “Global Older Adult Population Projected to Nearly Double by 2060: Population in the United States Will Age Slower Than in Other Countries,” United States Census Bureau, October 2026, <https://www.census.gov/newsroom/press-releases/2026/older-adult-population-projections.html>.

¹⁶ Alice Burns, Maiss Mohamed, and Molly O’Malley Watts, “Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025,” KFF, March 2025, <https://www.kff.org/medicaid/medicaid-eligibility-levels-for-older-adults-and-people-with-disabilities-non-magi-in-2025/>.

¹⁷ Burns et al., “A Look at Waiting Lists for Medicaid HCBS.”

¹⁸ Maiss Mohamed, Alice Burns, and Molly O’Malley Watts, “Medicaid Home Care (HCBS) in 2025,” KFF, January 5, 2026, <https://www.kff.org/medicaid/medicaid-home-care-hcbs-in-2025/>.

Personal care and attendant services form the core of HCBS, offering direct hands-on assistance with basic ADLs, such as bathing, dressing, eating, grooming, and personal mobility. Medicaid HCBS programs also support Instrumental Activities of Daily Living (IADLs), including meal preparation, laundry, housekeeping, medication management, and essential transportation, among other services like behavioral health, adult day care, respite care for family caregivers, home modifications, and assistive devices.¹⁹

The acute vulnerabilities of the Medicaid HCBS infrastructure were exposed during the COVID-19 pandemic, prompting unprecedented federal policy interventions aimed at stabilizing and expanding community care. Recognizing this, without a single Republican vote, Congressional Democrats delivered a major financial infusion to state HCBS programs in the American Rescue Plan Act (ARPA) of 2021.²⁰ This provision sent over \$12 billion in dedicated federal funds to state Medicaid HCBS programs, giving them the flexibility to bolster wages for direct care workers, provide pay retention bonuses, expand waiver slots, and invest in technology and care infrastructure.²¹ Accounting for the non-federal share and states' ability to free up previously obligated state funds to reinvest in HCBS, states spent over \$37 billion in state and federal funds on HCBS reinvestment activities thanks to ARPA.

Building on the momentum of ARPA, Congressional Democrats sought to make permanent, structural investments in Medicaid HCBS through the Build Back Better Act legislative framework.²² Proposals called for a \$150 billion to \$400 billion federal investment in Medicaid HCBS to permanently raise direct care worker wages, improve job quality, eliminate state waiting lists, and strengthen home care infrastructure. Although these provisions ultimately stalled during broader Senate negotiations, the efforts represented the most ambitious attempt to transform HCBS financing since 1981.

In contrast, Congressional Republicans and the Trump Administration chose to jeopardize access to HCBS by slashing nearly \$1 trillion from the Medicaid program in H.R.1.²³ Facing federal funding constraints, states routinely target optional HCBS programs for spending cuts before touching mandatory benefits, like nursing facility care, through rate reductions and other

¹⁹ Transportation outside the non-emergency medical transportation benefits afforded to all Medicaid beneficiaries, such as transportation for employment, day programs, essential errands, or community activities; Burns et al., "Medicaid HCBS Programs in 2025."

²⁰ American Rescue Plan Act of 2021 (Public Law 117-2).

²¹ "HHS Extends American Rescue Plan Spending Deadline for States to Expand and Enhance Home and Community-Based Services," Centers for Medicare & Medicaid Services, June 3, 2022, <https://www.cms.gov/newsroom/press-releases/hhs-extends-american-rescue-plan-spending-deadline-states-expand-enhance-home-community-based>.

²² An act to provide for reconciliation pursuant to Title II of S. Con. Res. 14 (Public Law 117-169).

²³ An act to provide for reconciliation pursuant to Title II of H. Con. Res. 14 (Public Law 119-21).

allowable changes.²⁴ Reductions in federal dollars mean that states may slash wages for direct care workers, exacerbating severe LTC workforce shortages, driving up staff turnover, and causing home care agencies to limit their ability to serve families in need. Fewer federal dollars may also push states to lower waiver enrollment caps, restrict functional eligibility thresholds, and trim authorized service hours per individual—furthering the long-standing institutional bias inherently embedded in current law. These cuts, combined with the Trump administration’s abandonment of the executive enforcement of the community integration mandates under Section 504, the ADA, and the Olmstead decision, put at risk services that allow people with disabilities to thrive in their communities.²⁵

Centering Family Stories: John and Janet

Our son Evan is 30. He has autism, an intellectual disability, ADHD, anxiety, very limited communication skills, and significant behavior issues. He is on Tennessee’s 1915(c) Statewide Waiver. Evan waited 11 years for services, and he had to reach a crisis state to be approved for the waiver. His behavior had escalated to the point that he posed risks to himself and to us. Although he got on the waiver at age 19 as a result of his crisis, it took us two years to find an agency willing to support Evan, given his behavior issues and his need to live near our family. (He requires an as-needed medication that only his father and I, as his conservators, can administer.)

Evan began to receive supported living services in 2017, at age 21, and those services include 24/7 staff in his apartment. The direct support professionals who work with him allow him to live safely in the community he grew up in, going for walks in familiar parks, swimming at the Rec Center he’s attended for years, and doing the things he enjoys. He’s much happier now, and we get to visit him several times a week.

²⁴ Jessica Schubel et al., “History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People,” *Health Affairs Forefront*, April 16, 2025, <https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled>.

²⁵ Jonaki Mehta, “Trump administration reverses stance on integration of people with disabilities,” *NPR*, October 1, 2026, <https://www.npr.org/2026/10/01/nx-s1-5981375/integration-mandate-disabilities-reversed-trump>; Mike Hixenbaugh and Colleen Long, “How Trump’s homelessness crackdown became a sweeping retreat from disability rights,” *NBC News*, October 2, 2026, <https://www.nbcnews.com/politics/justice-department/trump-homelessness-crackdown-retreat-disability-rights-olmstead-rcna600545>.

Vision for a New System

Throughout 95 listening sessions, Senate Democrats heard repeatedly about the importance of establishing universal coverage for LTC. Democrats' goal is to make sure that the LTC system serves all people across age and disability, and across diagnoses, functional needs, and life stages. Advocates for people with disabilities and older Americans emphasized that this is a group that is not a monolith, that the different service needs of different populations are critical to consider, and that Congress must avoid historic silos and carve-outs that leave people behind.

Consumers, advocates, providers, researchers, home care and home health agencies, and unions shared their ideas to expand access to home care services for everyone in need. There was broad agreement among advocates for seniors and people with disabilities, LTC providers, and labor unions that Congress should establish an LTC system that draws on essential elements of the Medicare and Medicaid programs to make it possible for all Americans in need of LTC to access high-quality, affordable home care, regardless of their income or geographic location.

Senate Democrats are interested in feedback on the following components that will deliver universal access to LTC:

- i. Universal Benefit**
- ii. Eligibility**
- iii. Covered Benefits**
- iv. Cost-Sharing**
- v. Rights and Protections**
- vi. Participant-Direction**
- vii. Administration**
- viii. Supports and Simplifications**

i. Establishing Universal Benefit

Leveraging Medicare and Medicaid

The Medicare program covers a range of medical services for adults 65 and older who have paid into the program through payroll taxes for at least 10 years, and it does not cover comprehensive LTC. **Senate Democrats seek feedback on how to design a universal home care benefit that can serve both existing Medicare beneficiaries who meet functional eligibility criteria and other eligible Americans in need of home care, regardless of their work history status.**

There is precedent in Medicare to serve people who do not meet the standard eligibility requirements. In 1972, Congress expanded Medicare to include people with end-stage renal disease (ESRD) regardless of age or work history.²⁶ In 2001, Congress allowed individuals with an ALS diagnosis to bypass the 24-month waiting period to enroll in the Medicare program.²⁷ In 2010, Congress allowed people exposed to asbestos in Libby, Montana, to access the Medicare program regardless of their age or work history.²⁸ In addition, under the Medicare program, disabled adult children (DAC) and spouses can access Medicare through a parent's earnings record after receiving Social Security Disability Insurance (SSDI) benefits for 24 months. Congress has repeatedly made the judgment that needs and circumstances outweigh the traditional eligibility pathway to access Medicare benefits.

Senate Democrats seek feedback on establishing a Medicare home care benefit that would allow individuals in need of home care to access these services. In addition, Senate Democrats seek feedback on where in the traditional Medicare program a new Medicare home care benefit could be established and on the role of Medicare Advantage in providing services under the new home care benefit.

An important factor to consider if Congress establishes a Medicare home care benefit is Medicaid's changing role in delivering these services. Some ways to construct a universal home care benefit may lead to individuals who access HCBS through Medicaid today receiving some or all of their needed home care services from a comprehensive benefit outside the Medicaid program. **Senate Democrats seek feedback on considerations for the populations who remain in Medicaid as well as requirements for reinvestment of any savings into expanding and enhancing coverage for low-income populations.**

Another approach to consider could be leveraging the current Medicaid framework to establish the universal home care benefit. The central policy proposal under consideration to transform Medicaid HCBS access is the HCBS Access Act (S. 5321) introduced by Senator Luján in 2026,

²⁶ Social Security Amendments of 1972 (Public Law 92-603).

²⁷ Consolidated Appropriations Act, 2001 (Public Law 106-554).

²⁸ Patient Protection and Affordable Care Act (Public Law 111-148).

which amends the Medicaid statute to convert HCBS from an optional state authority into a mandatory Medicaid benefit across all fifty states.²⁹ By establishing HCBS as a universal entitlement, the bill aims to prohibit the use of enrollment caps and waiting lists, reduce silos by creating a single cross-disability program, ensure equity in access, improve quality of services, and establish federal baseline standards for direct care workforce compensation and training. In addition, by eliminating the statutory distinction that makes nursing home care mandatory while keeping community care optional, the HCBS Access Act would outlaw the practice of capping waiver slots and maintaining multi-year waiting lists.

Senate Democrats seek feedback on leveraging the approaches included in the HCBS Access Act as part of a universal home care benefit. In addition, we seek feedback on how federal funding mechanisms can best support states in transitioning from capped waiver programs to a mandatory HCBS benefit under this type of structure without causing disruption to current Medicaid HCBS beneficiaries or overwhelming local provider capacity.

Beyond mandating coverage, improving access by building on the current Medicaid foundation necessitates reforming Medicaid's complex financial eligibility pathways, including potentially expanding and strengthening Medicaid buy-in programs for working individuals with disabilities.³⁰ These buy-in models demonstrate how individuals can access LTC while earning income without having to impoverish themselves, offering a policy template for broader Medicaid HCBS eligibility reform.³¹ **Senate Democrats seek feedback on whether individuals who need home care should be able to buy-in to the universal benefit to access needed services. In addition, we seek feedback on the specific income and asset thresholds, asset-disregard rules, or expansions of Medicaid buy-in models we should consider to ensure families do not have to divest from hard-earned assets or spend down into severe poverty to receive necessary home care.**

Medicare For All

As discussed in Ranking Member Wyden's July 2026 solicitation for public input on private health insurance reforms, many advocates, researchers, and health care workers voice support for a single-payer health care system that would leverage the resources of the federal government to provide a single source of universal coverage for all Americans.³² These proposals generally seek

²⁹ HCBS Access Act, S. 5321, 119th Congress. (2026).

³⁰ These authorities were created under the Medicaid Buy-In option of the Balanced Budget Act of 1997 (42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII)).

³¹ "Medicaid Eligibility Through Buy-In Programs for Working People with Disabilities," KFF, April 2026, <https://www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/>.

³² "Request for Information: Health Coverage That Works for Everyone."

to replace the existing financing of coverage that relies on a patchwork of taxes, subsidies, and cost-sharing with more uniform financing structure while also eliminating cost-sharing, prior authorization, and other such barriers for patients.³³

Senator Sanders' Medicare for All Act (S. 1506), introduced in 2025, relies on the Medicaid program's HCBS framework to define the home care benefits that would be available to Americans through a single-payer system. At the same time, the bill preserves Medicaid funding for care in nursing facilities and other LTC facilities. The bill prohibits states from restricting access to this institutional-based care through tightened income or asset restrictions and prescribes a growth formula for determining states' ongoing expenditures on this care.³⁴

As discussed above, the country's fragmented, patchwork approach to LTC suffers from an inherent bias towards institutional care, established through existing Medicaid and Medicare payment and benefit structures as well as insufficient workforce capacity to meet demand. In other words, many families in the United States default to nursing home care for a loved one simply because it's all they qualify for through Medicaid, and because they can't access Medicaid HCBS or find or afford a home care worker. Proponents argue the approach included in the Medicare for All Act flips this bias on its head, ensuring home care becomes the default, universally guaranteed option.³⁵ **Senate Democrats seek input on LTC proposals like those included in the Medicare for All Act. We also invite the submission of alternative proposals to incorporate comprehensive LTC benefits as part of a single-payer framework that offers American families more choices, including home care and care in LTC facilities.**

Finally, as envisioned in the Medicare for All Act, the transition to a single-payer system would occur over a four-year period. During that time, a progressively larger population would become eligible for the Medicare program. **Senate Democrats invite feedback on how access to affordable LTC benefits, including home care and care in LTC facilities, should be considered as part of a transition plan to a single-payer health care system. In particular, we are interested in the interplay and phasing of a home care benefit in a single-payer health care system relative to how a universal home care benefit that leverages the Medicare and Medicaid programs should approach that phasing.**

³³ "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Congressional Budget Office, December 2020, <https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf>.

³⁴ Medicare for All Act, S. 1506, 119th Congress, (2025).

³⁵ Ricardo Alonso-Zaldivar, "Sanders' 'Medicare for All' Expands Long-Term Care Benefits," *Associated Press*, March 8, 2019, <https://apnews.com/united-states-presidential-election-6a1b6a26372a490c8a854310fdbae2a8>.

Drawing on International Models

In many developed nations, LTC systems provide home care to those who need it as a standard public benefit primarily financed through dedicated mandatory social insurance or tax-funded universal health care systems.³⁶ Countries like Germany, Japan, Denmark, and Sweden assess eligibility based on standardized functional and cognitive needs assessments.³⁷ Beneficiaries generally receive comprehensive, person-centered support - including a dedicated number of hours of LTC provided by personal care aides, adult day services, short-term respite care for family caregivers, home modifications, like chair lifts and roll-in showers, and medical equipment like wheelchairs.³⁸ Almost all of these systems decouple LTC eligibility from strict income or asset impoverishment tests, instead assessing eligibility purely on functional or cognitive needs – a stark contrast to the patchwork LTC system in the United States. As Senate Democrats explore options to establish a universal home care benefit, we seek feedback on how we can leverage aspects of international models to guarantee access in the United States.

³⁶ “Long-term care financing: lessons for low- and middle-income settings, Brief 3: How countries finance long-term care,” World Health Organization Centre for Health Development, 2024,

<https://iris.who.int/server/api/core/bitstreams/610ad65d-565e-4e21-83a6-daaff3df743e/content>.

³⁷ Erica Schulz, “The Long Term Care System for the Elderly in Germany,” European Network of Economic Policy Research Institutes, June 2010,

https://cdn.ceps.eu/wp-content/uploads/2010/07/ENEPR1%20-ANCIEN_%20RR%20No%2078%20Germany.pdf;

John Creighton Campbell, Naoki Ikegami, and Mary Jo Gibson, “Lessons From Public Long-Term Care Insurance In Germany And Japan” *Health Affairs*, Vol. 29, no.1 (2010), <https://doi.org/10.1377/hlthaff.2009.0548>.

³⁸ Francesca Colombo et al., “Help Wanted? Providing Long-Term Care with Limited Resources,” OECD Health Policy Studies, 2011, <https://doi.org/10.1787/9789264097759-en>.

ii. Determining Eligibility

Defining Access

As previously mentioned, eligibility for Medicaid HCBS is based on income, assets, and level of need. If Congress develops a universal home care benefit that is based on LTC need, then it will be necessary for Congress to define eligibility. Senate Democrats heard from advocates for seniors and people with disabilities as well as LTC researchers that eligibility should be based on a functional assessment of need rather than a specific diagnosis, age, or category of disability so that the benefit can be tailored to each individual's need, including people with physical disabilities, I/DD, autism spectrum disorders, traumatic brain injuries, and mental illness or substance use disorders, who all may need LTC but require different services and levels of service.

Senate Democrats also heard from advocates for seniors and people with disabilities and LTC researchers that eligibility for LTC should be based on whether it is determined that an individual needs assistance with both ADLs and IADLs.³⁹ This is because IADLs better capture certain populations, including those with cognitive impairments. The previously mentioned HCBS Access Act sets the eligibility threshold for HCBS at satisfying one of the following options: (1) two or more ADLs; (2) two or more IADLs; or (3) a combination of at least one ADL and one IADL to be eligible to receive HCBS. **Senate Democrats seek feedback on whether the threshold for eligibility for a universal home care benefit should follow this or an alternative approach. We are interested in how we should prioritize needs based on ADLs, IADLs, or other measures of cognitive impairment.**

Eligibility Assessments

Given that Medicare does not currently cover comprehensive LTC services, we are evaluating Medicaid's process for determining functional eligibility criteria as a guide for establishing the universal home care benefit. For most existing Medicaid HCBS waivers, federal law requires applicants to meet an Institutional Level of Care (LOC) standard. This means the state must evaluate whether, in the absence of community-based services, the individual would require care in a nursing home, intermediate care facility for individuals with intellectual disabilities, or a hospital.

Under Section 1915(i) State Plan options, states may establish functional criteria that are less stringent than the institutional LOC threshold, allowing individuals to access home supports

³⁹ "Functional Assessments for Long-Term Services and Supports," Medicaid and CHIP Payment and Access Commission, June 2016, <https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf>.

before reaching the point of needing institutional care.⁴⁰ Because federal rules grant broad discretion in defining level-of-care criteria, assessment processes and tools vary significantly by state and population. States use standardized assessment instruments to score functional impairment, cognitive decline, behavioral support needs, and medical complexity.⁴¹ Depending on the state, the entity responsible for conducting the Medicaid eligibility functional assessment may be the state or local health department, an Area Agency on Aging (AAA), an Aging and Disability Resource Center (ADRC), or a contracted vendor.⁴² In states operating Managed Long-Term Services and Supports (MLTSS) models, functional assessments are often conducted by care coordinators employed by the contracted Managed Care Organizations (MCOs).⁴³ The functional assessment is typically conducted in a face-to-face interview in the individual's home.

Once functional eligibility is established, the assessment results directly drive the creation of a Person-Centered Service Plan (PCSP). The PCSP outlines the specific scope, frequency, and duration of covered HCBS authorized for the individual based on their documented clinical and daily living needs. Re-assessments are required at least annually, or whenever a beneficiary experiences a significant change in condition, aimed at ensuring authorized care levels remain aligned with current needs for that individual. In recent years, some states have used secretive algorithms to make HCBS authorizations that have reduced needed services for people relying on these services.⁴⁴ **Senate Democrats seek feedback on state best practices for a standard functional eligibility assessment process for a universal home care benefit. In addition, we seek feedback on ways to improve the current Medicaid process, including appropriate triggers for reassessing needs, including if there are circumstances that don't require annual regular reassessments, scheduled annual reviews, significant changes in health or functional status, major life transitions (like the loss of a primary caregiver), or beneficiary requests. Further, we seek feedback on the best approach to ensure transparency of functional assessments.**

Advocates for seniors and people with disabilities noted that the current rules regarding conflicts of interest for the entities that conduct functional assessments for Medicaid HCBS could be strengthened. **Senate Democrats seek feedback on strengthening the current Medicaid conflict of interest requirements in addition to feedback on how to improve the**

⁴⁰ H.R. 1 also established a 1915(c)(11) state option that allows states to provide HCBS to individuals who do not meet an institutional level of care, but gives states the ability to cap enrollment, an option not previously provided to states.

⁴¹ 42 C.F.R. § 441.720, <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.720>.

⁴² "Functional Assessments for Long-Term Services and Supports," Medicaid and CHIP Payment and Access Commission, June 2016, <https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf>.

⁴³ "Functional Assessments for Long-Term Services and Supports."

⁴⁴ "Nebraskan with Disabilities Backed by Four Nonprofits Sues State Over New Disabilities Assessment System," National Health Law Program, May 8, 2026, <https://healthlaw.org/news/nebraskan-with-disabilities-backed-by-four-nonprofits-sues-state-over-new-disabilities-assessment-system>.

requirements and tools states use to make LOC and service level decisions for Medicaid beneficiaries.

In the same vein, Senate Democrats seek feedback on whether we should pursue a model that involves the federal government directly contracting with nurses and social workers to conduct an independent eligibility assessment for individuals seeking LTC through a universal home care benefit. We seek comment on which agency should be responsible for this direct contracting, including whether this requires the establishment of a new agency with regional offices, or whether the existing Medicare home health benefit eligibility process could be expanded for this purpose. We also seek comments on the oversight structure, recruitment strategies, and training process that the government should use to make sure that eligibility assessments across the country are consistent. Finally, Senate Democrats seek comment on alternative models for conducting eligibility assessments that maintain the independence of the assessment.

Advocates for people with disabilities and seniors, as well as LTC researchers, also noted that, although it is important to use IADLs in addition to ADLs to determine eligibility for LTC, the IADLs are still not perfect. These are task-based measures that do not reliably capture the judgment and safety risks that come with intellectual disabilities, early dementia, or significant mental health conditions. Furthermore, an individual's spouse or caregiver might mask the assistance they require with IADLs. **Senate Democrats seek feedback on the recommended tools and instruments that reliably capture cognitive impairment and functional need to support assessments of eligibility for LTC. We seek evidence on which tools are best able to determine the need for LTC.**

iii. Identifying Covered Benefits

As previously discussed, Medicaid HCBS provides a wide range of supports from help with everyday activities to care coordination. **Senate Democrats seek feedback on the scope of home care services that should be covered by a universal home care benefit.**

One option that advocates and researchers raised would be for Medicare to cover a subset of HCBS as a baseline, and Medicaid would cover additional HCBS. **For this option, Senate Democrats seek feedback on whether a phased or smaller-scale approach is preferred, and which specific Medicaid HCBS should be included as the baseline services in a potential Medicare home care benefit.** In addition, we are interested in whether there should be a mechanism for the federal government or states to regularly re-evaluate covered services. We seek feedback on whether Medicare or Medicaid should provide the option to access additional services beyond the baseline benefit. Finally, we seek feedback on whether in this type of model, individuals could be allowed to “buy in” to the Medicare or Medicaid programs by paying additional cost-sharing or other out-of-pocket costs to cover additional HCBS.

A second option could be for the Medicare program to prescribe certain HCBS based on functional need. Advocates for seniors and people with disabilities as well as LTC researchers expressed that a universal home care benefit should cover a broad range of services in order to serve the needs of all people in need of HCBS. It is not likely that each individual would ultimately receive all of the services outlined in a comprehensive benefit, and the amount of services provided would vary by need. However, it is important to include a robust list of services in order to make sure all populations with different LTC needs are adequately served by the benefit. **Senate Democrats seek feedback on whether a universal home care benefit should cover the broad scope of services included in the HCBS Access Act.⁴⁵ We also seek feedback on whether Medicaid should align its coverage of HCBS with the services included in the HCBS Access Act.** In particular, we seek feedback on whether this list of services aligns with need and use patterns of people seeking HCBS to make the benefit

⁴⁵ The HCBS Access Act includes:

“(iii) Services that enhance independence, inclusion, and full participation in the broader community; “(iv) Non-emergency, non-medical transportation services to facilitate community integration; “(v) Respite services provided in the individual’s home or broader community; “(vi) Caregiver and family support services; “(vii) Case management, including intensive case management, fiscal intermediary, and support brokerage services; “(viii) Services that support person-centered planning and self-direction; “(ix) Direct support services during acute hospitalizations; “(x) Necessary medical and nursing services not otherwise covered that are necessary in order for the individual to remain in their home and community, including hospice services; “(xi) Home and community-based intensive behavioral health and crisis intervention services; “(xii) Peer support services; “(xiii) Housing and tenancy support services, including transitional housing or transitional support services for individuals who are unhoused, and wrap-around services; “(xiv) Necessary home modifications and assistive technology, including those that substitute for human assistance; “(xv) Transition services to support an individual who is transitioning from an institutional setting to the community, including appropriate services for individuals who are unhoused or at risk of becoming unhoused, and including such transition services provided while the individual resides in an institution; “(xvi) Nutrition Services; “(xvii) Assisted living services; “(xviii) Any other service approved by the Secretary, pursuant to the recommendation of the panel convened pursuant to subparagraph (B).”

sufficiently comprehensive for those who need it. In addition, we seek feedback on appropriate pathways to create access to services not traditionally covered by HCBS that could significantly improve an individual's ability to live in their community. **Furthermore, Senate Democrats seek information on state experiences covering services provided in the assisted living setting as an HCBS benefit.** We are also interested in feedback on the effectiveness of the Department of Housing and Urban Development Section 202 Supportive Housing for the Elderly Program and Section 811 Supportive Housing for Persons with Disabilities Program, whether to expand these programs to increase the supply of service-enriched housing for people in need of LTC, and whether and how to integrate these services into a universal home care benefit.⁴⁶

In addition, if the universal home care benefit covers a broad range of services, **Senate Democrats seek feedback on whether it should cover tiers of benefits based on functional need or based on the services that are most in demand for people in need of LTC.**

Specifically, we are interested in feedback on whether the Medicare program should cover a certain subset of HCBS based on whether an individual needs assistance with a certain number of ADLs, IADLs, or a combination. We seek feedback on whether this coverage should be further categorized based on whether an individual does or does not have a cognitive need.

A third option to structure universal coverage of home care would be for the benefit to cover a certain number of hours of home care services per week, month, or year. For example, advocates for seniors and people with disabilities, unions, and some nursing homes expressed support for the Medicare at Home Act (S. 5270), introduced by Senator Kim in 2026, which would provide up to 20 hours per week of services to assist with ADLs and IADLs.⁴⁷ **Senate Democrats seek feedback on whether a universal home care benefit should guarantee a specific number of hours of home care services are provided.** In addition, Senate Democrats seek feedback on the number of hours that should be provided and whether that should vary based on functional status.

⁴⁶ “Section 202 Supportive Housing for the Elderly Program,” United States Department of Housing and Urban Development HUD Exchange, accessed October 2026, <https://www.hudexchange.info/programs/section-202/>; “Section 811 Supportive Housing for Persons with Disabilities Program,” U.S. Department of Housing and Urban Development, accessed October 2026, <https://www.hud.gov/hud-partners/multifamily-grants-section811ptl>.

⁴⁷ Medicare at Home Act, S. 5270, 119th Congress (2026).

iv. Making Home Care Affordable

Cost-Sharing Structure

In general, cost-sharing and out-of-pocket costs are limited for Medicaid HCBS. The federal Medicaid statute requires that any out-of-pocket costs be limited to a nominal amount, but states determine the appropriate level of cost-sharing. However, the income and asset thresholds required to be eligible for Medicaid HCBS are extremely low and keep HCBS out of reach for middle-income families. Frequently, people qualify for Medicaid only after spending their assets on care and reducing their financial resources to this low asset threshold, a process known as “spending down” into Medicaid. Out-of-pocket costs on LTC before spending down can easily exceed \$100,000.⁴⁸

While an individual’s or couple’s home is excluded from the calculation of a beneficiary’s assets, the Medicaid program requires states to recover certain Medicaid costs after a beneficiary dies by repossessing their home, a process known as Medicaid estate recovery. All states must recover the costs of HCBS, nursing home care, and related hospital and prescription drug services for people with Medicaid ages 55 and older who are using LTC.

Because a home is often a beneficiary’s or family’s sole asset, Medicaid estate recovery entrenches generational poverty and exacerbates the racial wealth gap without delivering any meaningful financial gain to state budgets.⁴⁹ There are only limited circumstances in which a state is not required to repossess Medicaid costs for LTC through estate recovery.⁵⁰ In Senate Democrats’ listening sessions, lawyers representing Medicaid beneficiaries and their families expressed that Medicaid estate recovery scares people away from even applying for Medicaid HCBS, and suggested eliminating it or making it optional for states. **Senate Democrats seek feedback on proposals to improve cost-sharing and out-of-pocket costs for Medicaid HCBS by raising or revising asset limits and ending or amending Medicaid estate recovery.** We seek analysis on how these proposals would impact and benefit the economic security of families who benefit from the Medicaid program.

Senate Democrats heard from health economists and researchers that any universal home care benefit should incorporate cost-sharing in order to control program spending. Researchers recommended using the ACA marketplace premium design as a model to establish cost-sharing by income, under which people up to a certain income would have services fully financed, and

⁴⁸ Alice Burns, Maiss Mohamed, and Molly O’Malley Watts, “What Is Medicaid Estate Recovery?,” KFF, September 13, 2024, <https://www.kff.org/medicaid/what-is-medicaid-estate-recovery/>.

⁴⁹ David Pavlak, “Three Decades of Medicaid Estate Recovery,” Princeton School of Public and International Affairs, September 15, 2025, <https://spia.princeton.edu/news/2025/09/15/three-decades-medicaid-estate-recovery>.

⁵⁰ Alice Burns, Maiss Mohamed, and Molly O’Malley Watts, “What Is Medicaid Estate Recovery?,” KFF, September 13, 2024, <https://www.kff.org/medicaid/what-is-medicaid-estate-recovery/>.

people with higher incomes would pay a rising share, up to an out-of-pocket spending cap. **Senate Democrats seek feedback on whether a universal home care benefit should use a similar cost-sharing structure.**

Specifically, we seek analysis and comment on how to best structure cost-sharing to make sure the universal home care benefit is affordable for families. Given that many seniors have low income and high assets, we seek feedback on how affordability standards should depend on both income and assets. In addition, given that much of asset holdings for seniors are in their homes, we seek feedback on whether housing wealth should be incorporated at all into the calculation of affordability and how this can be done in an equitable manner that protects generational wealth while discouraging shifting assets into housing in order to avoid cost-sharing.

We seek feedback on the specific income and cost-sharing tiers as well as the out-of-pocket cap that should be considered to achieve the goal of making sure that middle-income families do not deplete their savings in order to access home care. We also seek feedback on other models to approach cost-sharing protections, such as the Medicare Savings Programs and Medicare Part D Low-Income Subsidy. **Finally, Senate Democrats seek feedback on how an out-of-pocket cap in a universal home care benefit would interact with out-of-pocket caps that exist in current insurance programs or could be established in other parts of the Medicare program, such as The Medicare Cost Cap Act (S. 4886), introduced by Senator Blunt Rochester and Ranking Member Wyden in 2026.⁵¹**

Option to Buy-in

In order to establish a universal system of home care in which everyone who needs LTC can access the care that they need, it is important to consider how to make sure that people who cannot access home care because they do not meet the eligibility requirements - be that established based on functional status, income, age, or other factors - can access this benefit through another mechanism. Most Medicaid programs allow working people with disabilities to buy-in to Medicaid when their income exceeds eligibility limits but falls below a certain percentage of the FPL.⁵² Around half of states currently set this limit at 250% of the FPL, while some states like Connecticut and Idaho have increased the income eligibility limit in their buy-in programs to 500% of the FPL or more.⁵³ **Senate Democrats seek feedback on whether Congress should provide families with the ability to similarly buy-in to this universal home care benefit. We seek feedback on whether individuals should have the option to “buy-in”**

⁵¹ Medicare Cost Cap Act of 2026, S. 4886, 119th Congress (2026).

⁵² “Ticket to Work,” Medicaid.gov, accessed October 2026, <https://www.medicaid.gov/medicaid/long-term-services-supports/medicaid-employment-initiatives/ticket-work>.

⁵³ “Medicaid Eligibility Through Buy-In Programs for Working People with Disabilities.”

to the universal home care benefit if they do not meet eligibility criteria, and, if so, how Congress should structure the ability to buy-in so that it is an affordable option and that there are sufficient providers to meet the need.

v. Defining Rights and Protections

As with other federal health care benefits, a universal home care benefit will require thoughtful consideration to make sure that it includes rights and protections for individuals who are applying for or who are eligible for LTC. The patient protections, services, and guardrails that govern the Medicaid HCBS benefit are instructive for outlining the kinds of protections that would be required to make a universal home care benefit a true guarantee for eligible beneficiaries. Core among these is a constitutional due process right, which ensures that beneficiaries have a right to receive a notice and obtain a hearing when benefits are denied or reduced.⁵⁴ True due process rights to receive adequate notice and obtain a hearing are supported by such provisions like “aid paid pending,” where beneficiaries who are experiencing a reduction in services have the right to request that the services continue during an appeal, until a hearing decision is issued.⁵⁵ There are also protections in the Medicaid program to ensure that HCBS settings are truly home and community-based.⁵⁶

The HCBS Access Act also proposes substantially strengthened consumer protection and accountability standards, including nationwide quality oversight and evaluation measures. States can access enhanced federal funding by collecting and reporting rigorous quality data, which must include beneficiary demographics for policymakers to be able to act on disparities if they are identified. In addition, the legislation requires that each state has an independent HCBS Ombudsman program to serve as a dedicated consumer advocate to investigate grievances, ensure beneficiaries can safely navigate their services, and hold providers accountable.⁵⁷

Senate Democrats request feedback on whether the HCBS Access Act should be the roadmap for how to improve on beneficiary protections in the Medicaid program as well as how to integrate these and other appropriate rights and protections for beneficiaries who will be eligible under the universal home care benefit. We also seek feedback on best practices and evidence to measure and monitor HCBS quality.

⁵⁴ Kimberly Lewis, Wayne Turner, and Skyler Rosellini. “What Makes Medicaid Medicaid: Consumer Protections and Due Process,” National Health Law Program. April 17, 2023,

<https://healthlaw.org/resource/what-makes-medicare-medicare-consumer-protections-and-due-process/>.

⁵⁵ 42 C.F.R. § 431.230 (“the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing”)

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-E/subject-group-ECFR8f26a68cc25862f/section-431.230>.

⁵⁶ 42 C.F.R. § 441.301 (“The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.”)

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301>

⁵⁷ HCBS Access Act, S. 5321, 119th Congress (2026).

Specifically, we seek feedback on the appeals process and due-process rights that should apply to eligibility denials and service-level determinations under a new Medicare home care benefit. We seek comment on whether the fair-hearing framework in the Medicaid program should be extended into a universal home care benefit. **In addition, Senate Democrats seek feedback on how policies conferring rights and protections to beneficiaries who access services through the new universal home care benefit should be designed given the Supreme Court’s rulings in *Health and Hospital Corporation of Marion County v. Talevski*, 599 U.S. 166 (2023), and *Medina v. Planned Parenthood*, 606 U.S. 357 (2026).**

Ensuring Program Integrity

Senate Democrats are serious about fighting fraud and ensuring program integrity. Trump and Congressional Republicans are falsely maligning HCBS—the very services that keep people out of institutions—as inherently fraudulent. Their characterization of spending growth in personal care and HCBS as evidence of program integrity risk is not based in fact. More people and families utilizing HCBS is evidence of states successfully implementing the federal mandate to shift away from institutional care toward community-based care.⁵⁸ This is a success story, not a scandal. This growth is not evidence of weak oversight: it is the predictable, intended, and celebrated result of decades-long federal and state rebalancing of policies.

Moreover, individual direct support providers and family caregivers who provide Medicaid HCBS are already subject to a number of fraud prevention and quality assurance measures to promote program integrity.⁵⁹ Specific measures currently in place include provider credentialing and enrollment, i.e. criminal background checks; financial management services; data analysis to identify unusual billing patterns for specific services, states, or providers; and documentation of caregiving hours with electronic visit verification entries that include location tracking and daily note logs.⁶⁰

Numerous advancements in program integrity controls for Medicaid HCBS could provide guidance and templates on mechanisms to prevent fraud in the universal home care benefit. Other considerations to explore include training direct support providers to use existing fraud prevention tools. **Senate Democrats request feedback on these and other measures to ensure**

⁵⁸ Alexandra Carpenter et al., “Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures, 2023,” Mathematica, October 17, 2025.

<https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf>

⁵⁹ Ryan Levi and Dan Gorenstein, “States Weigh In on Medicaid Fraud,” Tradeoffs, September 24, 2026,

<https://tradeoffs.org/2026/09/24/states-weigh-in-on-medicaid-fraud/>; Alice Burns, Abby Wolk, and Robin Rudowitz,

“Understanding Medicaid Home Care Amid CMS Focus on Potential Fraud and Abuse,” KFF, February 24, 2026,

<https://www.kff.org/medicaid/understanding-medicaid-home-care-amid-cms-focus-on-potential-fraud-and-abuse/>.

⁶⁰ 42 CFR § 441 <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441>; Abby Wolk, Alice Burns, and Molly O’Malley Watts, “States’ Use of Program Integrity Tools in Medicaid Home Care,” KFF, October 5, 2026,

<https://www.kff.org/medicaid/states-use-of-program-integrity-tools-in-medicaid-home-care/>.

beneficiaries of the universal home care benefit are sufficiently protected from bad actors and systematic corruption without compromising their access to care.

Keeping Out Corporate Greed

While Republicans are peddling the narrative that older adults, people with disabilities, and their families who use HCBS are fraudsters, Senate Democrats are focused on protecting Americans who need home care from greedy corporate actors. The expansion of access to home care proposed in this request for information will lead to an increased investment in and expansion of the home care sector. As private equity firms have increased their footprint in American health care by buying up hospitals, nursing homes, and independent doctors' offices, there is a risk that a home care expansion could exacerbate this trend and create perverse incentives for private equity and other corporate investors.⁶¹

Private equity has already developed a significant presence in the home care sector. In Medicaid HCBS and Medicare home health, private equity investment has grown significantly in the last ten years, with multiple studies finding an increase in private equity purchases of home care agencies between 2017 and 2022.⁶² A study of the New York home health care sector, focusing heavily on agencies funded through Medicaid HCBS, found that more than half of the state's home care agencies had been consolidated by private equity firms by the end of 2025.⁶³ The same study found that private equity-backed home care agencies had participated in labor and compliance violations, such as wage theft and serious safety violations. **Senate Democrats request feedback on system-level safeguards across a new home care infrastructure to prevent the siphoning of taxpayer dollars by corporate entities.**

⁶¹ Erin C. Fuse Brown and Erin C. Hall, "Private Equity and the Corporatization of Health Care," *Stanford Law Review* Vol. 76, (March 2024): 527–602,

<https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf>.

⁶² David T. Zhu, et al, "Private Equity Acquisitions of Home Health Agencies," *JAMA Health Forum* Vol. 6, no. 11 (November 2025), <https://doi.org/10.1001/jamahealthforum.2025.4922>; Tessa Jones, et al, "Private Equity Acquisitions of Home Health Care Agencies," *Journal of Pain and Symptom Management* Vol 71, no. 6 (June 2026), <https://doi.org/10.1016/j.jpainsymman.2026.04.500>.

⁶³ Zoë West, et al., "Private Equity Pathways into Home Care: The Case of New York State," Cornell University ILR Worker Institute, July 22, 2026, <https://www.ilr.cornell.edu/worker-institute/report-summary/private-equity-pathways-home-care-case-new-york-state>.

vi. Addressing Participant-Direction

Participant-direction in Medicaid

Currently, beneficiaries can access participant-directed (or self-directed) care for Medicaid HCBS in a number of state programs. Participant-directed care means that individuals have the decision-making authority and responsibility to manage the delivery of their services.⁶⁴ Rather than having their services managed or delivered by an agency, individuals who use participant-direction have the “employer authority” to, “recruit, hire, train and supervise the individuals who furnish their services.”⁶⁵ Individuals may also have the “budget authority” to decide how Medicaid funds are spent on their LTC.⁶⁶ States can decide which programs use participant direction.

All states allow seniors and people with physical disabilities in some programs to direct their care, and 90% allow individuals with I/DD to direct their care.⁶⁷ Under participant direction, states have the authority to determine the requirements for who can be hired to provide HCBS under participant-directed care. Most states allow beneficiaries to hire their family, friends, and other informal caregivers, and over 50% of beneficiaries pursuing participant-directed care choose to do so.⁶⁸

States provide access to administrative services and supports for beneficiaries who are directing their care. Financial Management Services (FMS), support brokers, and case managers support beneficiaries as they develop and manage budgets for their care.⁶⁹ FMS act as fiscal intermediaries that provide payment from state Medicaid agencies to the workers who provide care to a Medicaid beneficiary. In addition, FMS perform tax and employment benefits services, monitor participant-directed budgets, and educate beneficiaries about their billing responsibilities.⁷⁰ **Senate Democrats request feedback on how the administration of participant-direction in Medicaid HCBS can continue to ensure beneficiaries attain high-quality care while preserving their autonomy and decision-making.**

⁶⁴ “Self-Directed Services,” Centers for Medicare and Medicaid Services, accessed October 2026, <https://www.medicare.gov/medicaid/long-term-services-supports/self-directed-services>.

⁶⁵ “Self-Directed Services.”

⁶⁶ “Self-Directed Services.”

⁶⁷ Gabby Ballweg and Brian O’Gara, “Self-Direction for Home and Community-Based Services,” Medicaid and CHIP Payment and Access Commission, December 12, 2024,

https://www.macpac.gov/wp-content/uploads/2024/12/05_December-Slides_Self-Direction-for-Home-and-Community-Based-Services.pdf.

⁶⁸ Ballweg, “Self-Direction for HCBS.”

⁶⁹ Ballweg, “Self-Direction for HCBS.”

⁷⁰ Ballweg, “Self-Direction for HCBS.”

How to structure participant-direction in a universal home care benefit

Senate Democrats heard from advocates for people with disabilities and seniors as well as disability policy researchers about the important role of participant-direction in Medicaid in helping people seeking HCBS maintain their autonomy and independence as they remain in their own homes and communities. In addition, we heard about the important role of participant-directed care in making sure there is sufficient capacity to provide people with affordable home care.

Senate Democrats seek feedback on whether we should establish a participant-directed care model in a universal home care benefit. Specifically, we seek comment on what type of entity should certify and pay workers who provide home care under the participant-direction model, including whether this model should provide services provided by an FMS, support broker, or case manager. We are interested in feedback on whether the universal program should utilize the same entities that certify and pay workers in the Medicaid program. Further, we seek guidance on whether there should be minimum national standards, including for training, for the individuals who provide HCBS through participant-directed care. We seek comment on who should set these standards and whether they should vary by worker or type of service. Finally, we seek feedback on how to best incorporate family members into the participant-directed model in a way that fairly compensates them for their efforts while maintaining standards of care.

vii. Administering the Benefit

Managing Benefits

Today, all but 11 states use MLTSS to provide at least some HCBS to Medicaid beneficiaries. Under MLTSS, states pay a capitation payment for each person enrolled, and the managed care plans are responsible for providing all services to enrollees. Use of MLTSS plans to provide home care has been growing over time, with states using managed care to make their Medicaid spending more predictable and to help coordinate the services enrollees use.⁷¹

The operational challenge of coordinating care for Americans with complex needs is already heightened for individuals who currently qualify for both Medicare and Medicaid. Recognizing this, the federal government has worked with states to test innovative targeted integration models such as:

- Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs): A single health plan holds both the Medicare Advantage and Medicaid MLTSS contracts, allowing beneficiaries to rely on one health card, one care team, and one streamlined set of benefits.⁷²
- Programs of All-Inclusive Care for the Elderly (PACE): PACE is a capitated, fully-integrated model that uses an interdisciplinary team—doctors, nurses, physical therapists, and social workers—to manage all medical and social needs for frail older adults (age 55+), centered around local adult day health centers.⁷³
- Medicare-Medicaid Plans (MMPs): Originally established under CMS Financial Alignment Demonstrations, these capitated plans created a single, unified process for enrollment, customer service, and appeals across both programs.⁷⁴ MMPs fully sunset as a demonstration in 2025, but between 2013 and 2025 these programs provided evidence

⁷¹ Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. “Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019,” Mathematica, December 9, 2021, <https://www.medicaid.gov/sites/default/files/2022-01/ltssexpenditures2019.pdf>.

⁷² “Medicare Advantage dual eligible special needs plans,” Medicaid and CHIP Payment and Access Commission, September 8, 2023, <https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/>.

⁷³ Neva Kaye, “State Approaches to Expanding PACE,” National Academy for State Health Policy, May 3, 2022, <https://nashp.org/state-approaches-to-expanding-pace/>.

⁷⁴ Kyle J. Caswell and Timothy Waidmann, “What We Know About Medicare Enrollment for Dual Enrollees,” Urban Institute, May 30, 2024, <https://www.urban.org/data-tools/medicare-medicaid-dual-enrollment-available-plans>.

for the importance of administrative simplifications for creating smooth enrollment, beneficiary communication and protections, and program oversight.⁷⁵

Senate Democrats are committed to making sure that people experience the new home care system as seamless, even if financing and administration are complex behind the scenes. A new system should avoid proliferating overlapping benefits, waivers, and eligibility pathways. **Senate Democrats seek feedback on proposals to make sure that home care is an integrated part of the health care system that is seamless for individuals and families to access.** We seek feedback on the entities that should be responsible for managing benefits, what administrative features should be considered to reduce beneficiary complexity, and whether the universal home care benefit should leverage state expertise by contracting directly with states for certain functions, such as provider screening and enrollment.

Specifically, Senate Democrats heard from PACE providers, health plans that offer services through the PACE model, and trade associations about the success of the PACE model for Americans with complex needs. **We are soliciting feedback on how to leverage the robust consumer protections, clinical integration, and person-centered care coordination embedded in the PACE model to inform our work to transform and modernize the LTC system.** We are seeking input on strategies to scale the PACE model—including mechanisms to lower high upfront capital entry barriers for prospective provider organizations, streamline state-federal regulatory approval processes, expand geographic service areas into rural and underserved communities, and broaden eligibility criteria to reach younger individuals with disabilities who could benefit from integrated, community-based care. We seek input on the current barriers that are impacting the ability to expand the PACE program. We also note that the PACE model must be updated to reflect all other changes that Congress makes to the Medicare program: this has not happened consistently in the past.

Provider Networks

Establishing a universal home care benefit may require building a new provider network while carefully managing its interaction with existing Medicaid provider networks. Given national workforce shortages, it is critical that Senate Democrats consider the importance of compensation parity for direct care workers who may provide services through different programs.⁷⁶ To avoid exacerbating these disparities, new workforce and reimbursement policies

⁷⁵ “Retaining the Successes of the Medicare-Medicaid Plan Model,” ATI Advisory, October 2022, https://atiadvisory.com/resources/wp-content/uploads/2022/11/20221031_Retaining-the-Successes-of-the-Medicare-Medicaid-Plan-Model.pdf.

⁷⁶ Lauren Block et al., “Addressing Wages of the Direct Care Workforce through Medicaid Policies,” National Governor’s Association, November 1, 2022, <https://www.nga.org/publications/addressing-wages-of-the-direct-care-workforce-through-medicaid-policies/>.

should be carefully aligned with Medicaid and broader post-acute care settings, encouraging overall capacity expansion rather than shifting existing labor from one program to another.

Senate Democrats seek feedback on how the universal home care benefit should consider establishing payment rates for home care services and how Medicaid programs can ensure their rates reflect adequate compensation. Respondents are invited to include details of the efficacy and structure of a single network regardless of whether there are multiple programs providing home care, and how managed care plans fit into that structure. **Specifically, we seek feedback on whether to determine payment rates by program or by agency, whether there should be a payment benchmark, whether there should be geographic variation in payment rates, and how to structure payment to reflect variations in skills, training, and experience. We seek comment on how payment rates can be structured to ensure there is a sufficient workforce to care for beneficiaries of the universal benefit.**

viii. Assessing Other Supports and Needed Simplifications

Administrative Simplification

Beyond addressing the role of managed care and provider networks, effective delivery of a universal home care benefit requires a deliberate focus on easing the administrative friction and operational complexity that beneficiaries, families, and providers face daily. Navigating the current Medicaid HCBS landscape often feels like managing a labyrinth: families must contend with disjointed application channels, redundant level-of-care assessments, separate waiver authorities with conflicting eligibility rules, and opaque annual renewal processes. These systemic barriers impose a heavy "administrative tax" on individuals already managing complex health conditions or caregiving responsibilities.

Modernizing the home care experience demands comprehensive process improvements—such as establishing single-point-of-entry ("No Wrong Door") intake portals, standardizing cross-waiver assessment tools, leveraging existing state data to auto-populate eligibility forms, and streamlining workflows—to ensure that navigating the care system does not become a barrier to receiving care itself. **Senate Democrats seek feedback on how to simplify administrative structures and eliminate system-level friction. Specifically:**

- How could fragmented, population-specific waiver silos be collapsed or simplified into unified, streamlined state plan authorities or comprehensive waiver frameworks without scaling back specialized services or reducing beneficiary protections?
- What concrete operational reforms—such as cross-agency data sharing, presumptive eligibility determinations, multi-year authorization windows for stable conditions, or simplified self-direction management tools—would yield the greatest reduction in stress and paperwork for families and care staff?
- How could the system be strengthened to ensure that people with disabilities and their families can transfer employment or residences between states?
- What role can navigators and case managers play in helping beneficiaries navigate this complicated landscape, and what are the best practices for doing so?
- How can digital care planning portals, integrated case management technology, and transparent status tracking be best deployed to keep beneficiaries fully informed about their eligibility status, service authorizations, and care plan updates in real time, and what is needed to ensure accessibility of such public-facing tools?

- How can a universal home care benefit be structured to avoid adding complexity, duplicative paperwork, or delayed authorizations for beneficiaries and providers?
- How should a universal home care benefit create streamlined coverage experiences for people currently dually eligible for Medicare and Medicaid?
- How should a universal home care benefit reduce administrative burden for people who may qualify for Supplemental Security Income (SSI) benefits and who are also eligible for Medicaid?

Community-Based Supports

In order to advance a universal home care benefit, it will be critical to invest in the entities that currently operate a strong network of person-centered services for seniors and people with disabilities. Senate Democrats are interested in building on these agencies and authorities to support integrated, coordinated home care and LTC.

Programs funded by the Older Americans Act (OAA) provide crucial supports to adults 50 and older with and without Medicaid coverage. This includes the Aging Network's regional AAAs that provide services, such as home-delivered meals, respite care, case management, and evidence-based health and wellness programs, and more, to more than 14 million Americans⁷⁷ ADRCs are also a critical part of this network, providing a single point of entry to the confusing LTC system with unbiased, reliable information and counseling.⁷⁸ Notably, this network has been chronically underfunded for years.⁷⁹ **Senate Democrats request feedback on how to leverage the existing support services infrastructure for these populations and integrate them with services provided through a universal home care benefit.**

In addition, Centers for Independent Living (CILs), Family-to-Family Health Information Centers (F2Fs), and University Centers for Excellence in Developmental Disabilities (UCEDDs) currently serve as vital hubs for information and support for individuals with disabilities receiving Medicaid HCBS. CILs provide support for individuals transitioning from institutionalized settings to community living, train beneficiaries to self-direct personal care

⁷⁷ "Celebrating 60 Years of the Older Americans Act Advancing Health and Independence" United States Department of Health and Human Services Administration for Community Living, July 15, 2025, <https://acl.gov/news-and-events/announcements/celebrating-60-years-older-americans-act-advancing-health-and>.

⁷⁸ "Aging and Disability Resource Centers," United States Department of Health and Human Services Administration for Community Living, March 18, 2026, <https://acl.gov/programs/aging-and-disability-networks/aging-and-disability-resource-centers>.

⁷⁹ Meredith Freed, Juliette Cubanski, and Tricia Neuman, "What to Know About the Older Americans Act and the Services It Provides to Older Adults," KFF, June 3, 2025, <https://www.kff.org/medicare/what-to-know-about-the-older-americans-act-and-the-services-it-provides-to-older-adults/>.

assistance, and understand their rights to transportation and residential support.⁸⁰ F2Fs provide peer-to-peer support to help parents and family caregivers navigate complex HCBS in each state, offer guidance and support to families on waiting lists for services, and provide assistance to families preparing eligibility documentation and functional assessments.⁸¹ UCEDDs perform a number of functions to support individuals with disabilities, families, caregivers, and providers and to improve program integrity.⁸² **Senate Democrats request feedback on how to build on these models or develop new models to support applicants and beneficiaries with benefit counseling, care management, and other services.**

State Supports

Making Medicaid HCBS a mandatory service or other HCBS expansions would require significant state resources. States may no longer be able to utilize waiting lists or other restrictions on access to HCBS to manage their budgets. Past Medicaid coverage expansions have provided enhanced federal dollars to support states to be able to meet this guarantee.⁸³ However, the landscape for state Medicaid financing has changed dramatically since 2021. Trump and Congressional Republicans passed almost \$1 trillion in cuts to the Medicaid program in H.R.1, the largest in history, as part of their reconciliation law during the summer of 2025.⁸⁴ Numerous states are already reducing coverage of HCBS in light of these cuts.⁸⁵

Anticipating these financial headwinds for states, **Senate Democrats request feedback on what federal resources or supports, including realistic timelines for phasing-in new features, can be paired with strong maintenance of effort protections to ensure states can deliver on the pent-up demand for Medicaid HCBS.**

Care Transitions

Coordination between the current Medicaid HCBS structure and a universal benefit must be designed so that no one ends up worse off than they were before the new benefit. Further, coordination between programs will be paramount as individuals transition across settings. As an individual's functional needs change, they may choose to shift from home-based care into a nursing home or other institutional setting, and vice versa. These barriers can accelerate

⁸⁰ "Centers for Independent Living," United States Department of Health and Human Services Administration for Community Living, September 29, 2026, <https://acl.gov/programs/aging-and-disability-networks/centers-independent-living>.

⁸¹ "How Do F2Fs Help Families?," Family Voices, accessed October 2026, <https://familyvoices.org/felsc/howf2fshelpfamilies/>.

⁸² "University Centers for Excellence in Developmental Disabilities Education, Research, and Services (UCEDDs)," United States Department of Health and Human Services Administration for Community Living, October 2, 2026.

⁸³ For instance, Congress has established higher FMAP percentages specific to benefits like mobile crisis response and HCBS in ARPA.

⁸⁴ An act to provide for reconciliation pursuant to Title II of H. Con. Res. 14 (Public Law 119-21).

⁸⁵ "Home and Community-Based Services Impacts Tracker Project," George Washington University Hirsh Health Law and Policy Program, accessed October 2026, <https://hpmatters.publichealth.gwu.edu/HCBS-impacts-tracker-project>.

unnecessary institutionalization rather than support individuals who wish to remain safely in their homes and communities.

We are interested in strategies that create a seamless continuum of care by focusing on aligning home care benefits across programs (e.g., Medicare, Medicaid, community-based supports), strengthening transitions between care settings, and rebalancing financial incentives that currently favor Medicaid-financed nursing homes over home-based care. **Senate Democrats seek feedback on specific policy mechanisms to harmonize coverage rules between new and existing programs and make sure that federal and state financing structures prioritize home-based care over institutional placement while still giving beneficiaries and their families the choice of where to receive their care.** Specifically:

- How should case management and care coordination responsibilities transfer when a beneficiary wishes to leave institutional care and receive home-based care, or when their needs cross from home care into an institution? Which program should be responsible for facilitating the move and how should payment be structured?
- Should the assessment used for the universal home care benefit also serve as the basis for state institutional level-of-care determinations to reduce inconsistency and avoid a second, separate state-level determination at the point of transition?
- Should the new benefit include incentives to assist with the up-front costs associated with transitioning nursing home residents back into their homes and communities, such as through the Money Follows the Person program?
- How should community-based services offered through aging and disability networks factor into this continuum and support care transitions?

ix. Concepts Out of Scope

During the 95 listening sessions Senate Democrats engaged in this summer, we heard a number of proposals that, while important to consider, are out of scope of the Dear Colleague letter supported by 19 Senators. For instance, Senate Democrats heard from home health agencies, hospitals, nursing homes, and LTC researchers about the need to improve transitions across the care continuum and create better incentives so people can access a range of services in their own homes. During listening sessions with providers and researchers, we heard about a number of models that would help beneficiaries stay in their homes for as long as possible: expanding the hospital at home program, creating a skilled nursing facility at home program, improving care transitions from hospitals to post-acute settings, and amending the existing Medicare home

health benefit, particularly with regards to payment rates. **These concepts are largely outside the scope of this policymaking exercise and the three-point framework outlined in the Senators' Dear Colleague. Proposals submitted in this category will be reviewed outside of this initiative at a later date.**

During listening sessions, Senate Democrats also heard about several additional proposals to establish a public LTC insurance program rather than a universal home care benefit that leverages the best features of Medicare and Medicaid. **These proposals are not aligned with the direction of this effort, so proposals submitted in this category will also be reviewed outside of this initiative at a later date.**

Section II: Improving the Quality of Care in Nursing Homes

Background

Over 1.2 million Americans reside in nearly 15,000 nursing homes in the United States and depend on them for skilled health care, including nursing and rehabilitative services.⁸⁷ When considering the number of nursing home residents served over a year, six out of ten residents stay for a short amount of time (typically less than a month) and may be recovering from major surgery or a fall.⁸⁸ Nearly four out of ten nursing home residents are long-stay residents and may spend the rest of their lives in that home.⁸⁹ All nursing home residents require 24/7 monitoring, complex medical care, and assistance with ADLs.

Despite the long-term trend toward de-institutionalization and advances that allow more skilled care to be delivered at home, nursing homes are still a crucial part of the nation's LTC infrastructure. Seniors and people with disabilities should be able to receive care in the setting of their choice, and for some, a nursing home is the preferable, or only, option.

Congress passed the Nursing Home Reform Act of 1987 to raise the standard of the quality of care provided in America's nursing homes. Specifically, the law established the Nursing Home Resident Bill of Rights and core nursing home quality and safety standards.⁹⁰ These standards require a physician's supervision of each resident's care, 24-hour nursing services provided by a range of clinical staff, a personalized plan of care for each nursing home resident, and pharmaceutical, dietician, dental, and other supportive services to implement that plan of care. The landmark law also established safeguards for nursing home resident rights, state licensure and oversight requirements, and state training standards for Certified Nursing Assistants (CNAs) in nursing homes.

As the 40th anniversary of these federal standards nears, there has been no comprehensive statutory update since its passage.⁹¹ These standards must be updated to reflect the growing and changing needs of nursing home residents and the increasing role of private equity and corporate ownership of nursing homes. Shorter stays in nursing homes are more common, yet nursing home residents are presenting with more complicated diagnoses that require high-acuity

⁸⁷ Priya Chidambaram and Alice Burns, "A Look at Nursing Facility Characteristics in 2025," KFF, December 17, 2025, <https://www.kff.org/medicaid/a-look-at-nursing-facility-characteristics/>.

⁸⁸ "Fast Facts," American Health Care Association and National Center for Assisted Living, accessed October 2026, <https://www.ahcancal.org/Data-and-Research/facts/Pages/default.aspx>.

⁸⁹ "Fast Facts."

⁹⁰ Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203).

⁹¹ The laws governing Medicare and Medicaid nursing home coverage have not been updated since the passage of the Nursing Home Reform Act of 1987, but there have been regulatory updates to nursing home regulations since then.

interventions, like intravenous (IV) care and complex wound care, requiring more skilled care, more frequent monitoring, and more hours of direct staffing time.⁹²

In addition, ownership structures of all types of health care entities have changed dramatically since the 1980s. In the wave of corporate restructuring during the 2000s, for-profit nursing homes were frequent investments for private equity firms and other corporate owners.⁹³ Today, complex corporate ownership structures can be set up to shield bad actors from financial liability and divert taxpayer dollars away from direct care of nursing home residents and into profits.

Nursing homes are a core part of the LTC delivery system, and any LTC reform effort must address the current outdated and ineffective regulatory nursing home landscape. **Senate Democrats are interested in feedback on policy proposals that ensure taxpayer dollars are spent on direct care, that align incentives to improve staffing, and that ensure nursing homes meet high quality standards for resident care.**

Centering Family Stories: Anonymous⁹⁴

My parents were each in a long-term care facility/nursing home for several weeks near the end of their lives. They had the benefit of my and my siblings' frequent presence and intensive advocacy. Even so, the "care" they received was inexcusably inadequate. My heart continues to break for their experiences and for those of other people in similar circumstances, and for those folks who do not have loved ones there with them and fighting the battles that need fighting for them.

Mom was right up front next to the elevators [at her facility] where everyone arriving on the floor would pass by her room. One time I arrived to find her at a right angle across her bed, with her head and legs off opposite sides of the bed. No one was checking on her.

Another time, she was scheduled to leave that horrible - but highly rated! - facility. But my sister and I were with her and found her largely unresponsive. I kept going to the nurse to get them to try and figure out what was going on. They insisted she did not have a fever, etc. It

⁹² "The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff," National Academies of Science, Engineering, and Medicine, 2022, <https://doi.org/10.17226/26526>; Elizabeth Langer et al., "Readmissions and Acuity in the Nursing Home: How Will the Nursing Homes Manage?," *Journal of Gerontological Nursing* Vol. 17, no. 7 (1991): 15–19, <https://doi.org/10.3928/0098-9134-19910701-06>; Amy Vogelsmeier et al., "Repeat hospital transfers among long stay nursing home residents: a mixed methods analysis of age, race, code status and clinical complexity," *BMC Health Services Research*, Vol. 22, no. 626, (2022), <https://doi.org/10.1186/s12913-022-08036-9>.

⁹³ Yasmin Rafiei, "When Private Equity Takes Over a Nursing Home," *The New Yorker*, August 25, 2022, <https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home>.

⁹⁴ This story is excerpted from a public comment letter submitted in response to the proposed rule on minimum staffing standards in long term care facilities submitted on September 6, 2023. Identifying information has been removed.

turned out she was so dehydrated that her temperature was not registering on the thermometer. Her fever was well over 100 degrees. It was finally determined that she needed to go to the hospital. They said it would take about half an hour “to get the paperwork ready” for the ambulance when it arrived, and it did take that long. At the hospital it turned out she had a serious infection and she was put in an isolation room. There, in the hallway I saw a notice about sepsis, and how 30 minutes can make all the difference in someone being treated in time and being saved or not.

Dad had a stroke and could not speak consistently well enough to be understood. Having his dentures put in for him increased his speaking capabilities. So often, no one bothered to put them in for him. Sometimes they put them in badly and they kept slipping. Dad was left unable to speak up for himself, even had he been willing to do so. But he was quick to conclude that they did not want to hear from him.

We went to a family care planning meeting at the facility. I was there with Dad and one of my sisters. The whole meeting lasted 20 minutes and then unceremoniously ended. The physical therapist representative was not Dad’s primary PT, and did not know him. He said that that day, Dad had walked up and down the hallway, using a walker and being accompanied by a PT. We knew that was not true. And when I spoke with his actual PT again, that PT said that Dad could not have done that unless he was actually being held up by two people, one on each side of him. At that same meeting, it was reported that Dad had eaten 60% of his breakfast! But just the day before, I had spoken with his speech therapist and she told me he was consistently eating 0-25% of his food. Part of the problem was that the therapists working with Dad, whom we had met and interacted with, were not at the meeting. We did not have time to engage with the substitute PTs at the meeting or to ask questions or challenge what they were presenting. They were clearly not putting Dad’s needs first.

The facility where Dad was supposedly meets a staffing standard of 4.4 hours per patient per day (now). I don’t know if that was true when Dad was there almost two years ago. The abysmal care Dad received proves that the current staffing standards are not adequate. I wish everyone involved in [the] decision making relevant to this issue would consider, what if it was your mom, your dad, your loved one?

i. Protecting Taxpayer Dollars for Direct Care in Nursing Homes

Medicare and Medicaid are the largest payers of nursing home and skilled nursing facility services in the United States, covering 77% of all nursing facility residents and 59% of all

nursing home care expenditures.⁹⁵ While Medicare and Medicaid pay for the vast majority of care in nursing homes, very few nursing homes are publicly owned. Nearly three-quarters of nursing homes are for-profit, and the vast majority of those for-profit facilities belong to nursing home chains.⁹⁶ Beyond these broad categories, data on nursing home ownership is lacking, significantly hindering oversight and accountability.⁹⁷

Private equity (PE) firms and other corporate entities invest in the nursing home sector, but government watchdogs, regulators, and researchers lack the data to obtain an accurate understanding of their presence.⁹⁸ The Government Accountability Office (GAO) estimated that 5% of the nation's nursing homes enrolled in Medicare had PE ownership in 2022, and the Medicare Payment Advisory Commission (MedPAC) found as much as 11% of the sector may be PE-owned.⁹⁹ Senate Democrats heard from nursing home resident advocates and researchers about the concerns associated with the increasing role of private equity in nursing homes. The private equity playbook of buying distressed assets, cutting costs, and quickly turning the facility around to sell for a profit often comes at the expense of resident care and working conditions.¹⁰⁰ When reimbursement for the vast majority of patients is fixed by Medicare and Medicaid, cost-cutting often means dramatic cuts to labor costs, sacrificing the health and well-being of patients.¹⁰¹

Real estate investment trusts (REITs) are also embedded in the nursing home sector. REITs are tax-advantaged vehicles that own or finance real estate, and REITs have investments in one in six nursing homes in the United States.¹⁰² Health care REITs generally act as landlords.¹⁰³ In the nursing home context, to the extent facilities owned by health care REITs serve the 63% of nursing home residents covered by Medicaid and 14% covered by Medicare, those REITs rely in

⁹⁵ Matthew Dougherty, Joanne Levine, "Medicare and Medicaid Remain Central to U.S. Nursing Home Care," Legis1, September 14, 2026, <https://legisl.com/news/nursing-facilities-14693-participate-medicare-or>.

⁹⁶ W. Pete Welch et al., "Ownership of Skilled Nursing Facilities: An Analysis of Newly-Released Federal Data," U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, December 2022, <https://aspe.hhs.gov/sites/default/files/documents/fd593ae970848e30aa5496c00ba43d5c/aspe-data-brief-ownership-snfs.pdf>.

⁹⁷ "Nursing Homes: Limitations of Using CMS Data to Identify Private Equity and Other Ownership, GAO-23-106163" Government Accountability Office, September 2023, <https://www.gao.gov/products/gao-23-106163>.

⁹⁸ "Limitations of Using CMS Data."

⁹⁹ "Congressional Request: Private Equity and Medicare," Medicare Payment Advisory Commission, June 2021, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf; "Limitations of Using CMS Data."

¹⁰⁰ Atul Gupta et al., "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," *National Bureau of Economic Research*, February 2021, https://www.nber.org/system/files/working_papers/w28474/revisions/w28474.rev0.pdf.

¹⁰¹ Atul Gupta et al., "Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes," *National Bureau of Economic Research*, Revised August 2023, https://www.nber.org/system/files/working_papers/w28474/w28474.pdf.

¹⁰² Dunc Williams et al., "Nursing home finances associated with real estate investment trust and private equity investments" *Health Affairs Scholar* Vol. 2, no. 4 (2024), <https://doi.org/10.1093/haschl/qxae037>.

¹⁰³ Jordan Rau, "Real Estate Investors Profit From Long-Term Care While Residents Languish," *KFF Health News*, April 21, 2026, <https://kffhealthnews.org/health-industry/real-estate-investment-trusts-senior-housing-nursing-homes-profit/>.

part on the taxpayer dollars that flow to a nursing home’s operator to charge those operators rent.¹⁰⁴

Ownership structure and profit incentives matter when it comes to care for nursing home residents. PE-owned facilities are associated with higher health deficiency scores and lower inspection and staffing ratings than other ownership types.¹⁰⁵ PE-owned nursing homes are also associated with an 11% higher rate of mortality compared to non-PE-owned homes.¹⁰⁶ Nonprofit and government-owned nursing homes are more likely to meet federal minimum staffing thresholds than for-profit facilities.¹⁰⁷ Higher levels of staffing are associated with better resident outcomes.¹⁰⁸

Understanding that nursing home ownership structures impact the safety and quality of care in nursing homes and that accurate and detailed data on ownership structures and costs are difficult to obtain, **Senate Democrats request input on proposals to ensure taxpayer dollars are spent on direct care and not siphoned off through profit-hiding shell games.**

The Biden administration required states to report to CMS the percentage of Medicaid payments for services in nursing homes that is spent on compensation for direct care workers and support staff in nursing homes.¹⁰⁹ The intent of this proposal was to hold nursing homes accountable for investing taxpayer dollars in the LTC workforce. Ranking Member Wyden successfully defended this important data collection when Congressional Republicans attempted to repeal it in H.R. 1. To build on these advances, **Senate Democrats request feedback on extending this requirement to Medicare and requiring nursing homes to spend a specific percentage of Medicare and Medicaid reimbursement on the direct care of nursing home residents.** Several states, including Massachusetts, New York, and New Jersey require nursing homes to spend a certain share of their revenue, including revenue from Medicare and Medicaid, on direct patient care.¹¹⁰ During listening sessions, Senate Democrats heard from advocates for nursing home residents and nursing home researchers that Congress should expand state-level policies

¹⁰⁴ Chidambaram, “A Look at Nursing Facility Characteristics in 2025.”

¹⁰⁵ Welch et al, “Ownership of Skilled Nursing Facilities.”

¹⁰⁶ Gupta et al., “Does Private Equity Investment in Healthcare Benefit Patients?”

¹⁰⁷ Priya Chidambaram and Alice Burns, “A Closer Look at the Final Nursing Facility Rule and Which Facilities Might Meet New Staffing Requirements,” KFF, May 21, 2024, <https://www.kff.org/medicaid/a-closer-look-at-the-final-nursing-facility-rule-and-which-facilities-might-meet-new-staffing-requirements/>.

¹⁰⁸ “Nursing Home Staffing Studies Showing a Positive Relationship Between Nurse Staffing and Quality Outcomes,” National Consumer Voice for Quality Long Term Care, March 2025, <https://theconsumervoice.org/wp-content/uploads/2025/03/Nursing-home-staffing-studies-2024-updated.pdf>.

¹⁰⁹ “Biden-Harris Administration Takes Historic Action to Increase Access to Quality Care and Support Families and Caregivers,” Centers for Medicare & Medicaid Services, April 22, 2024, <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-historic-action-increase-access-quality-care-support-families-care>.

¹¹⁰ Susan Jaffe. “3 States Limit Nursing Home Profits in Bid to Improve Care.” *KFF Health News*. October 25, 2021. <https://kffhealthnews.org/aging/3-states-limit-nursing-home-profits-in-bid-to-improve-care/>.

that require nursing homes to spend a certain percentage of their revenue on the direct care workforce. **Senate Democrats request information on the effectiveness of state-level proposals and how to apply them at the federal level. Senate Democrats are also interested in feedback on the specific percentage thresholds that are linked to improved outcomes for nursing home residents.**

Senate Democrats heard from nursing home researchers that federal regulators need additional information about nursing home ownership structures and transactions. **As such, Senate Democrats request input on the following policies:**

- Reinstating requirements for nursing homes to submit detailed ownership and management information to CMS that the Trump administration indefinitely postponed.¹¹¹
- Limiting PE involvement in nursing home care by restricting the ability of PE and corporate owners to inappropriately influence nursing home operations that impact resident care, based on Senators Warren and Wyden’s bill, the Stop Corporate Takeovers of Physicians Act of 2026 (S. 5419). This bill would restrict the ability of PE funds, for-profit corporations, and insurance companies to control medical practices.¹¹² We seek feedback on federal policy proposals to restrict similar activity in nursing homes. We also seek feedback on how to define PE and corporate owners as well as information on which types of ownership structures raise concerns about the quality of care delivered in nursing homes.
- Reinstating the requirements of the Corporate Transparency Act, which was enacted in 2021 and includes provisions that create a central repository of beneficial ownership information for business entities, including those operating nursing homes and related entities.¹¹³ The Treasury Department recently published a final rule exempting more than 99% of corporations and LLCs from the Corporate Transparency Act’s reporting requirements. We seek feedback on whether renewed enforcement of the bill’s beneficial ownership reporting rules would be helpful to regulators and law enforcement investigating financial misconduct, fraud, and abuse. We also seek feedback on how to streamline reporting requirements under the Corporate Transparency Act with the reporting requirements to CMS contemplated above, reducing the burden on nursing home operators to the greatest extent practicable.
- Requiring CMS to evaluate the track record of nursing home operators, including the financial stability of and quality of care provided by health care entities they previously

¹¹¹ Senator Cory Booker, Senator Ron Wyden, et al. “Letter to Mehmet Oz, Administrator, Centers for Medicare & Medicaid Services,” June 3, 2026. https://www.booker.senate.gov/imo/media/doc/cms_to_nursing_homes.pdf.

¹¹² Stop Corporate Takeovers of Physicians Act of 2026, S. 5419, 119th Congress (2026).

¹¹³ National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283).

invested in, during the Change in Ownership (CHOW) or Change of Operator (CHOP) processes. This could require CMS to review every prior nursing home or other health care facility an individual or entity operated, use existing quality metrics to evaluate CHOW/CHOP approval, or require beneficial ownership disclosure as a condition of CHOW/CHOP approval. **Senate Democrats are particularly interested in feedback on the success of state-level proposals to do this in Ohio and Virginia.**

Nursing homes are required to file cost reports with CMS disclosing how they spend Medicare and Medicaid dollars on an annual basis.¹¹⁴ These filings, known as the Healthcare Cost Report Information System (HCRIS), are the primary data source regulators use to assess nursing homes' financial health, set nursing home reimbursement rates, and evaluate whether facilities can afford to comply with quality standards. **Senate Democrats request feedback on the sufficiency of HCRIS and what additional information nursing homes should disclose to federal regulators in consolidated cost reports to make sure Medicare and Medicaid funds are being spent on direct care, not hidden in complex ownership structures and other opaque arrangements. Specifically, Senate Democrats are interested in the effectiveness of consolidated cost reporting requirements in California and Illinois, and how these can be paired with ownership reporting requirements.**

Senate Democrats request feedback on policies to increase regulation of related party transactions in nursing homes. These include:

- Establishing market-rate benchmarks for common related party services like management fees, pharmacy services administration, lease payments, and home office costs, against which reported related party costs can be evaluated, and allowing CMS to recover charges for costly related party transactions without clear justification.¹¹⁵ Current federal regulations require that related party costs incurred by nursing homes be “reasonable”, but as the HHS Office of Inspector General (HHS-OIG) has documented, neither CMS nor Medicare administrative contractors (MACs) currently enforce this requirement.¹¹⁶

¹¹⁴ 42 C.F.R. § 413.20(b) (“Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year.”); 42 C.F.R. § 413.24(a) (“Providers receiving payment on the basis of reimbursable cost must provide adequate cost data.”)

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-B>.

¹¹⁵ Reasonable exceptions to this requirement could be provided for related party costs that are already subject to strict penalties for inappropriate transfer pricing, such as that found in IRC §857(b)(7).

¹¹⁶ 42 C.F.R. § 413.9 (“All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.”)

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-A/section-413.17>;

42 C.F.R. § 413.17 (“costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization.”)

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-A/section-413.17>

- Requiring nursing homes to report how the payment of related party rent and management fees would result in an improvement in the long-term health outcomes of Medicare and Medicaid beneficiaries who receive care at a given nursing home in order to receive Medicare and Medicaid reimbursement.
- Modernizing the definition of “related party.” Under current regulations, CMS defines related party costs in a manner that lacks specificity and can be difficult to oversee.¹¹⁷ We request feedback on updating these definitions to provide explicit examples of common relationships between nursing homes and other entities that rise to the levels of possessing “significant ownership or equity” and having the power to “significantly...influence or direct” a nursing home’s actions or policies.

Complex ownership structures put distance and layers of opacity between nursing home residents and the people who are ultimately responsible for their care.¹¹⁸ During listening sessions, advocates for nursing home residents, LTC ombudsman programs, and nursing home researchers expressed concerns over corporate ownership and its correlation with lower quality and higher costs. Transparency requirements alone cannot completely close this distance, and recognizing this, **Senate Democrats request feedback on other regulatory and legislative frameworks to limit the ability of PE firms, REITs, and other complex corporate ownership arrangements to be shielded from liability for the care of nursing home residents.** Potential avenues for this accountability could include, but are not limited to, creating a private right of action for individuals to hold firms and corporations liable for violations of the federal Nursing Home Reform Act and defining nursing home owners and legally responsible fiduciaries as responsible for nursing home resident care.

ii. Strengthening Nursing Home Staffing Standards

Adequate staffing is a critical factor in ensuring quality care in nursing facilities.¹¹⁹ Higher registered nurse (RN) staffing levels are associated with a number of positive health outcomes for residents, including fewer hospitalizations and decreased mortality.¹²⁰ Higher levels of total direct care staffing are associated with improved resident outcomes and better working

¹¹⁷ 42 C.F.R. § 413.17 (Under current regulations, CMS defines related party costs in a manner that lacks specificity and can be difficult to oversee. Specifically, regulations define parties related to the provider as meaning “that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.” Such parties have common ownership “if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider,” and control if “an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.”) <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-A/section-413.17>.

¹¹⁸ “The National Imperative to Improve Nursing Home Quality.”

¹¹⁹ “Nursing Home Staffing Studies.”

¹²⁰ Mary Ellen Dellefield, “The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014),” *Nursing Economics*. Vol. 33, no. 2 (2015), <https://pubmed.ncbi.nlm.nih.gov/26281280/>.

conditions for nursing home workers.¹²¹ Low staffing, by contrast, is tied to poor quality, patient safety violations, higher rates of antipsychotic drug use, and high burnout and turnover among workers.¹²² A 2025 survey by the National Consumer Voice for Quality Long-Term Care found that over one-third of nursing home residents reported that there are not enough staff to meet their needs in a reasonable amount of time.¹²³ Nearly all voters 50 and older (94%) support minimum nursing home staffing standards as a basic safeguard.¹²⁴ Understaffed nursing homes create difficult environments for staff to provide the care residents deserve, and they make it difficult to recruit and retain the workers that nursing homes and their residents need.¹²⁵

For nearly 40 years, the federal standard for staffing nursing homes has required the equivalent of just 18 minutes of direct care per resident per day.¹²⁶ In April 2024, the Biden administration finalized a rule that would have raised that floor to 3.48 hours per day and required a registered nurse on-site 24/7 — a standard researchers projected would save 13,000 lives per year.¹²⁷ Congressional Republicans delayed it by nine years in H.R. 1, and the Trump administration rescinded the rule in December 2025. The federal floor remains at 18 minutes.

Under staffing in nursing homes was a frequent topic that came up during the listening sessions that Senate Democrats held with nursing home trade associations, individual nursing homes, labor unions, consumer advocates, and nursing home quality researchers. Advocates for nursing home residents, researchers, and labor unions emphasized the importance of increasing nursing home staffing levels beyond the current standard in order to improve the quality of nursing home

¹²¹ Charlene Harrington et al., “Appropriate Nurse Staffing Levels for U.S. Nursing Homes,” *Health Services Insights* Vol. 13 (2020): 1–14, <https://doi.org/10.1177/1178632920934785>.

¹²² Nancy Ochieng, Priya Chidambaram, and MaryBeth Musumeci, “Nursing Facility Staffing Shortages During the COVID-19 Pandemic,” KFF, April 4, 2022, <https://www.kff.org/medicaid/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/>; David C. Grabowski et al., “Private Equity Acquisition and Nursing Home Quality of Care,” *Journal of the American Medical Directors Association* 25, no. 6 (2024): 1045–1052, <https://pubmed.ncbi.nlm.nih.gov/38656575/>; Nicholas G. Castle et al., “Nursing Home Deficiency Citations for Safety,” *Journal of Aging & Social Policy* Vol. 23, no. 1 (2010): 34–57, <https://doi.org/10.1080/08959420.2011.532011>; Geyskens, L. et al. “Burnout levels among nursing home care workers and its associations with workplace and individual factors: Results from a multicenter cross-sectional study.” *International Journal of Nursing Studies*, <https://doi.org/10.1016/j.ijnurstu.2026.105367>.

¹²³ “Behind Closed Doors: Understanding the Resident Experience: A Survey of Residents Living in Long-Term Care Facilities,” National Consumer Voice for Quality Long Term Care, December 22, 2025, <https://theconsumervoice.org/news/2025-resident-report/>.

¹²⁴ Teresa A. Keenan, “Support for Nursing Home Staffing Requirements Likely to Lead to Votes at the Ballot Box” AARP, July 23, 2024, <https://www.aarp.org/pri/topics/ltss/nursing-homes/nursing-home-staffing-standards-views>.

¹²⁵ “Historic Staffing Shortages Continue To Force Nursing Homes To Limit New Admissions, Creating Bottlenecks at Hospitals,” American Health Care Association and National Center for Assisted Living, July 14, 2022, <https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Historic-Staffing-Shortages-Continue-To-Force-Nursing-Homes-To-Limit-New-Admissions.-Creating-Bottlenecks-at-Hospitals-and-.aspx>;

Atul Gupta et al., “Private Equity Acquisition of Nursing Homes and Impairment of Direct Care Staffing: Evidence from Administrative Medicare and Payroll Data,” *Health Services Research* 58, no. 2 (2023): 312–324, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9894029/>.

¹²⁶ “State Policy Levers to Address Nursing Facility Staffing Issues,” Medicaid and CHIP Payment and Access Commission, March 2022, <https://www.macpac.gov/wp-content/uploads/2022/03/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf>.

¹²⁷ Rachel Werner and Norma Coe, “Letter to Senator Elizabeth Warren,” July 8, 2024, https://www.warren.senate.gov/imo/media/doc/letter_from_researchers_to_sen_warren_070824.pdf.

care and the quality of nursing home jobs. At the same time, nursing home trade associations and individual nursing homes emphasized that staffing regulations would be very difficult to meet without significant workforce investments and improvements, and they predicted that nursing homes, particularly those in rural areas, would close if higher federal nursing home standards went into effect.

Nursing home quality researchers, LTC ombudsmen, and nursing home consumer advocates emphasized the need to make sure there are strong oversight and enforcement tools to make sure nursing homes comply with additional federal standards. Evidence from states with numeric nursing home staffing standards bears this out: Massachusetts raised its state staffing standard in 2021, but by the end of 2025, only half of nursing homes in the state were compliant with the new standard.¹²⁸ However, broader national evidence on nursing home staffing levels and closures between 2010 and 2023 has shown that state-level staffing mandates successfully boosted direct care staffing levels without harming nursing homes' overall financial viability or likelihood of closure, because the increases in labor expenses were offset by higher net patient revenues.¹²⁹

Recognizing the important role that adequate staffing plays in ensuring nursing home residents receive the highest standard of care that meets their medical, physical, psychological, and social needs, Ranking Member Wyden, alongside Senators Kim, Booker, Warren, Luján, Murphy, and Blumenthal, introduced the Nurses Belong in Nursing Homes Act (S. 3886) in 2026. **Senate Democrats request feedback on the following proposals included in the legislation:**

- Requiring an RN to be in a nursing home 24/7.
- Setting an initial federal minimum staffing standard to make sure that each resident receives at least three and a half hours of nursing care per day.
- Ensuring regular, evidence-based updates to staffing standards to reflect resident needs.
- Providing permanent funding for nursing home inspections, surveys, and enforcement to ensure compliance with staffing requirements.
- Bolstering the nursing home workforce by reinvesting civil monetary penalties imposed on nursing homes into supporting recruitment and retention of nursing home workers.
- Holding nursing homes accountable for investing taxpayer dollars into the frontline nursing home workforce rather than increasing their own profits.

¹²⁸ Grace Ferguson, “Half of all nursing homes in Massachusetts are understaffed,” *WBUR*, July 31, 2026, <https://www.wbur.org/news/2026/07/31/massachusetts-nursing-homes-staffing-penalties-care>.

¹²⁹ Rachel M. Werner et al., “State Nursing Home Minimum Staffing Mandates: Increased Staff Levels, Minimal Impact On Finances And Closures, 2010–23,” *Health Affairs* Vol. 45, no. 3 (2026): 358–367, <https://doi.org/10.1377/hlthaff.2025.01223>.

In evaluating these proposals, Senate Democrats request specific feedback on how the federal government can best continually update federal staffing standards so they reflect emerging technology and new standards of care. Senate Democrats specifically request feedback on the following questions:

- What frequency and with what standard of evidence should CMS update staffing standards for nursing homes? Should this evidence base account for specific populations, such as individuals with Alzheimer’s disease and other forms of dementia?
- How should patient acuity factor into CMS’ update of staffing standards?
- What quality measures and outcomes should be considered when updating and evaluating the effectiveness of nursing home staffing standards?
- What is the evidence that technologies like remote monitoring and telehealth can improve the quality of care delivered in nursing homes? How can these technologies be deployed along with sufficient staffing to keep residents safe?

Senate Democrats are also interested in soliciting feedback on whether there can be policy proposals to ensure adequate staffing absent a federal staffing standard. Respondents are encouraged to submit evidence demonstrating the effectiveness of alternative proposals in achieving the results that a staffing standard delivers, such as lower patient mortality, lower worker burnout, or other patient and worker well-being metrics.

Finally, recognizing the important role workforce investments play in effective, durable nursing home staffing standards, Senate Democrats request information on proposals to pair staffing standards with workforce investments. In tandem with stronger minimum nursing home staffing standards, the Biden administration announced a \$75 million campaign to provide financial incentives for nurses to work in nursing homes and state agencies while also improving training.¹³⁰ The Trump administration continued this initiative, providing \$5 million in additional funding for a total of \$80 million and releasing a notice of funding opportunity (NOFO) to recruit RNs and Licensed Practical Nurses (LPNs) to work in nursing homes through financial incentives.¹³¹ Building on that work, Senate Democrats seek feedback on the amount of funding provided by this initiative, the allowable use of grant funds outlined in the NOFO, and any projections on the number of LTC workers that could be trained with this funding. **In**

¹³⁰ “CMS Nursing Home Staffing Campaign,” Centers for Medicare & Medicaid Services, accessed October 2026, <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/cms-nursing-home-staffing-campaign>.

¹³¹ “Nursing Home Staffing Campaign Notice of Funding Opportunity No. CMS-2V2-26-001, rev. 2,” Centers for Medicare & Medicaid Services, February 9, 2026, https://files.simpler.grants.gov/opportunities/2b0aea3d-4706-4508-8a8f-ae605d033e0d/attachments/fcf53538-6056-41ba-bbe0-26bfa622c9ce/cms-2v2-26-001_rev2.pdf.

addition, Senate Democrats seek feedback and comment on more expansive, systemic investments into the nursing home workforce in light of the LTC workforce crisis (see Section III).

In addition, there is promising evidence from states that pair increased staffing standards with workforce investments. For example, Illinois implemented a value-based payment model in its Medicaid program to provide incentive payments to nursing homes that meet a higher staffing ratio, CMS's Staff Time Resource Intensity Verification (STRIVE) ratio.¹³² Since 2022, Illinois has seen an 11% increase in nursing home staffing ratios, rising four times faster than the rest of the country in the same time period.¹³³ **Senate Democrats are interested in evaluating similar models that incentivize nursing homes to invest in their workforce and solicit feedback on how these can be effectively applied at the federal level.**

¹³² "Proposed Measure Specifications: Total Nursing Staffing Hours per Resident Day Quality Measure," Centers for Medicare & Medicaid Services, April 2022, <https://www.cms.gov/files/document/proposed-specifications-skilled-nursing-facility-value-based-purchasing-snf-vbp-program-total.pdf>.

¹³³ "Report on Nursing Facility Rate Reform and Staffing Mandates Pursuant to 2026 State Legislation," Illinois Department of Healthcare and Family Services, May 2026, <https://hfs.illinois.gov/content/dam/soi/en/web/hfs/nursinghomeupdate/nfreport2026legislation.pdf>.

iii. Improving the Quality of Care at Nursing Homes

Congress worked to comprehensively reform the quality of care in nursing homes due to decades of documented resident abuse and neglect as reported in a seminal, groundbreaking 1986 Institute of Medicine report.¹³⁴ Based on the report's recommendations, Congress passed sweeping updates to federal regulations through the Nursing Home Reform Act of 1987.¹³⁵ The Nursing Home Reform Act established statutory requirements for individualized care planning and secured extensive protections for residents, explicitly including the right to dignity and freedom from abuse. Enforcement of these statutory mandates relied on routine, unannounced nursing home surveys and inspections and compliance certifications. The law also introduced several intermediary sanctions for non-compliant facilities. Beyond termination from Medicare and Medicaid, nursing homes were newly subject to additional penalties, including civil monetary penalties and withheld payments for new admissions.

Decades later, the nursing home industry faces an entirely new landscape shaped by the rise of corporate and private equity ownership, and complex medical needs that the 1987 congressional framework had not anticipated.¹³⁶ While the foundational law successfully shifted the focus of LTC toward resident dignity and safety, the blatant regulatory gaps exposed by modern needs reveal an urgent imperative to update these nearly 40-year-old standards to meet the realities of today's nursing home environment.¹³⁷ **Senate Democrats invite detailed feedback on proposals and reforms to comprehensively update the Nursing Home Reform Act.** Specifically, Senate Democrats are interested in proposals to improve transparency and accountability, survey and certification activities, and the nursing home quality rating system, as outlined below.

Transparency and Accountability

Research consistently demonstrates quality across nursing homes can vary widely.¹³⁸ Despite existing nursing home reporting and transparency requirements, quality standards are hard to

¹³⁴ Rachel M. Werner et al., “Reforming Nursing Home Financing, Payment, and Oversight,” *New England Journal of Medicine* Vol. 386, no. 20 (2022): 1869–1871, <https://doi.org/10.1056/NEJMp2203429>.

¹³⁵ Tara A. Cortes, “Essential Reform in Long-Term Care,” *Nursing Clinics of North America*, Vol. 57, no. 2, (2022): 207-215, <https://doi.org/10.1016/j.cnur.2022.02.003>.

¹³⁶ “Historic Staffing Shortages Continue To Force Nursing Homes To Limit New Admissions;” Gregory Orewa et al., “The effects of private equity ownership in U.S. nursing homes quality and financial performance: A systematic review,” *Health Policy*, Vol. 161, (2025), <https://doi.org/10.1016/j.healthpol.2025.105388>; Rachel M. Werner et al., “Reforming Nursing Home Financing, Payment, and Oversight.”

¹³⁷ “The National Imperative to Improve Nursing Home Quality.”

¹³⁸ “Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, Report No. OEI-06-11-00370” United States Department of Health and Human Services Office of Inspector General, February 2014, <https://resourcesforrisk.com/docs/oei-06-11-00370.pdf>; Joshua M. Wiener, Marc P. Freiman, and David Brown, “Nursing Home Care Quality Twenty Years After The Omnibus Budget Reconciliation Act of 1987,” *KFF*, December 2007, <https://www.kff.org/wp-content/uploads/2013/01/7717.pdf>; Elizabeth M. White et al., “Nursing home work environment, care quality, registered nurse burnout and job dissatisfaction,” *Geriatric Nursing* Vol. 41, no. 2 (2020): 158–164, <https://doi.org/10.1016/j.gerinurse.2019.08.007>.

enforce due to a lack of oversight.¹³⁹ Due to a lack of enforcement, lower-performing nursing homes are often not held accountable for their wrongdoings and negligence, including instances involving resident abuse and neglect.¹⁴⁰

Address inaccurate reporting

The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to evaluate the health status of residents in Medicare- or Medicaid-certified nursing homes.¹⁴¹ The tool measures health indicators under the cognitive, functional, medical, and psychosocial domains. MDS assessments are performed and reported by nursing home staff every three months or more often if necessary.

Additionally, as described above, it is mandatory for nursing homes to submit cost reports to CMS annually. Each facility's comprehensive report includes financial statement data, Medicare settlement data, and utilization data.¹⁴² The reports are then compiled into a publicly available dataset, which can be used by lawmakers to analyze trends.

To incentivize improvements to the quality of care delivered in nursing homes, CMS awards payments to nursing homes based on their performance in the Value-Based Purchasing (VBP) Program, which uses data elements from the MDS.¹⁴³ The Program assesses operations based on eight quality measures, which include discharge and readmission rates.¹⁴⁴

Transparent, accurate data reporting is an essential mechanism for making sure that nursing homes receive appropriate reimbursement and are held accountable for the quality of care they deliver.¹⁴⁵ Ranking Member Wyden introduced the Nursing Home Improvement and Accountability Act (S. 2694) in 2021 to establish reporting and other quality control requirements for nursing homes and facilities. **Senate Democrats invite comments on proposals, some of which were included in the legislation, to improve the accuracy of the data reported by nursing homes, including the following:**

¹³⁹ “The Accountability Gap: How Weak Oversight and Unenforced Penalties Undermine Nursing Home Quality and Resident Safety,” The Long Term Care Community Coalition, September 2026,

<https://nursinghome411.org/wp-content/uploads/2026/09/LTCCC-Report-The-Accountability-Gap-2026.pdf>.

¹⁴⁰ “Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse, Report No. GAO-19-433” Government Accountability Office, September 2019, <https://www.gao.gov/assets/gao-19-433.pdf>.

¹⁴¹ “Minimum Data Set (MDS) Data,” UCSF Claude D. Pepper Older Americans Independence Center, accessed October 2026, <https://peppercenter.ucsf.edu/minimum-data-set-mds-data>.

¹⁴² “Cost Reports,” Centers for Medicare & Medicaid Services, accessed October 2026, <https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports>.

¹⁴³ The formal name of the program is the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP); “Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program,” Centers for Medicare & Medicaid Services, accessed October 2026, <https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing>.

¹⁴⁴ “Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program.”

¹⁴⁵ Vincent Mor et al., “Environment of Nursing Homes and the Quality of End-of-Life Care,” *Health Affairs* 28, no. 1 (2009): 145–154, <https://doi.org/10.1377/hlthaff.28.1.145>.

- Reducing payments to nursing homes by a certain percentage for submitting inaccurate data through the MDS or quality measures included in the nursing home VBP Program.
- Requiring the HHS Secretary to regularly audit a representative sample of the Medicare cost reports submitted by nursing homes.
- Requiring HHS-OIG to conduct reviews and analyses of the relationship between the cost report functional accounts and nursing home quality.

Senate Democrats welcome additional proposals to improve the accuracy and transparency of nursing home data reporting on costs, care quality, and other dimensions, including feedback on how to best support whistleblowers in the nursing home setting.

Improve accountability by strengthening surety bonds

In nursing homes, surety bonds are required agreements meant to assure the facility protects residents and their funds, should a resident choose to deposit their funds with the facility.¹⁴⁶ The bond covers potential mismanagement of resident funds, such as embezzling or commingling, and unpaid claims or penalties to CMS.¹⁴⁷ If mismanagement of funds occur, the bond may serve as a form of restitution for the affected resident.¹⁴⁸ **Senate Democrats invite feedback on policies that would strengthen surety bonds, such as setting a bond minimum of \$500,000, a policy that was also included in the Nursing Home Improvement and Accountability Act.** By setting a bond minimum, corrupt providers are deterred from purchasing nursing homes, exploiting them for profit, and ultimately abandoning them.

Prohibiting pre-dispute arbitration agreements to protect nursing home residents

To prevent potential abuse and neglect lawsuits, some nursing homes ask potential and current residents (or their representatives) to sign binding pre-dispute arbitration agreements, meaning the residents lose their right to have a dispute decided in a public court of law before the dispute even occurs.¹⁴⁹ These arbitration agreements can also be used in HCBS settings. In 2016, the Obama administration announced that they were banning these agreements between facilities and nursing home residents (or their representatives).¹⁵⁰ The first Trump administration rolled this

¹⁴⁶ “Clarification on Nursing Homes Requiring Promissory Notes or Deposit Fees as a Condition of Admission, and Implications Related to Surety Bonds, Survey and Certification Letter S&C-04-17,” Centers for Medicare and Medicaid Services, January 8, 2004,

<https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/scletter04-17.pdf>.

¹⁴⁷ “Nursing Home Patient Bond Claims Guide,” Jet Insurance Company, March 25, 2022,

<https://jetsurety.com/articles/detail/nursing-home-patient-bond-claims-guide>.

¹⁴⁸ “Nursing Home Patient Bond Claims Guide.”

¹⁴⁹ “Arbitration Agreements: Why You Should NOT Sign Them,” California Advocates for Nursing Home Reform, February 27, 2026, <https://canhr.org/arbitration-agreements-dont-sign-agreements/>.

¹⁵⁰ “CMS Finalizes Rollback of Pre-Dispute Arbitration Protections,” Center for Medicare Advocacy, July 18, 2019, <https://medicareadvocacy.org/cms-finalizes-rollback-of-pre-dispute-arbitration-protections/>.

protection back in 2019, though it maintained the prohibition on requiring residents to sign an arbitration agreement as a condition of facility admission.¹⁵¹

Patients and advocacy groups have voiced their concerns about pre-dispute arbitration agreements and have urged Congress to prohibit these agreements in nursing home and HCBS settings. Ranking Member Wyden included this prohibition in the Nursing Home Improvement and Accountability Act. The Fair Arbitration Injustice Repeal Act (S. 2799), introduced in 2025 by Senator Blumenthal, also eliminates forced arbitration clauses.¹⁵² **Senate Democrats request feedback on this approach and invite additional policy proposals to address other unjust conditions of admission to a nursing home.**

Improving data tools for oversight of nursing homes

Several states have convened to establish the National Academy for State Health Policy's (NASHP) State Nursing Home Learning Collaborative.¹⁵³ NASHP, in partnership with West Health, supports these states' efforts to address quality of care in nursing homes, including by improving oversight of these facilities. States are implementing innovative methods to leverage data for effective oversight. For example:

- Minnesota's Department of Health, Department of Human Services, and Office of Ombudsman for LTC are developing a dashboard to identify at-risk nursing homes by leveraging data to flag indicators like CMS G harm level or Immediate Jeopardy citations, four or more on-site complaint visits per quarter, and indicators of high risks from the State Nursing Home Report Card.
- The Ohio Department of Aging and Innovate Ohio Platform collaborated on the LTC Quality Navigator, a dashboard that uses CMS nursing home data and other resources to help nursing home residents and their families make informed decisions. The Navigator allows users to compare facilities side-by-side and discover nursing homes based on their chosen set of quality criteria.
- New Jersey's Office of LTC Resiliency monitors and assists the lowest rated nursing homes in the state, including those on the CMS Special Focus Facility candidate list. The level of support provided is decided according to the facilities' risk scores. Nursing homes receive operational guidance, resources, and training to help them improve their star rating and the quality of care they deliver.

¹⁵¹ "Arbitration Agreements at Nursing Home Admission: Your Rights and How to Opt Out," Bed Sore Law, accessed October 2026, <https://www.bedsore.law/arbitration-agreements-at-nursing-home-admission-your-rights-and-how-to-opt-out/>.

¹⁵² Fair Arbitration Injustice Repeal Act, S. 2799, 119th Congress, (2025).

¹⁵³ Ella Taggart, Kimberly Hodges, and Wendy Fox-Grage, "Promising Practices from NASHP's State Nursing Home Learning Collaborative," March 2, 2026, <https://nashp.org/promising-practices-from-nashps-state-nursing-home-learning-collaborative/>.

Senate Democrats invite comments on the outcomes and lessons learned from these and other state efforts that are leveraging data to improve the quality of care in nursing homes.

We invite comments on the scaling of effective programs. We also request input on whether additional federal flexibilities or data collection are needed to support innovative approaches at the state level. Finally, we seek suggestions for additional improvements to the collection of quality data, including how to best solicit feedback from residents and their families as well as nursing home staff.

Protecting residents' rights

The Nursing Home Reform Act of 1987 requires nursing homes to “promote and protect the rights of each resident.”¹⁵⁴ Among the rights listed in the law is the right to a dignified existence, and the requirement that nursing homes provide equal access to quality care.

However, in listening sessions, Senate Democrats heard concerns from advocacy organizations that certain populations, like LGBTQ+ older adults, fear discrimination and harassment due to their identities. An AARP survey found that more than 60% of LGBTQ+ participants were concerned about abuse, neglect, limited access to services, and verbal or physical harassment when considering moving into LTC facilities.¹⁵⁵ These fears are justified: in a survey of instances of reported abuse against LGBTQ+ residents, more than one-third of incidents involved physical or verbal harassment from nursing home staff or other residents.¹⁵⁶ An additional 20% were incidents of denied admission or re-admission, or an abrupt or attempted discharge.¹⁵⁷ Advocacy groups that met with Senate Democrats also shared stories of discrimination due to HIV stigma.

During listening sessions, advocates and consumers shared their request for Congress to develop an LGBTQ+ LTC Bill of Rights to further protect vulnerable nursing home residents. The bill of rights could, for example, make it against the law for a nursing home to deny admission to a potential resident based on their sexual orientation, gender identity, or HIV status. **Senate Democrats request comments on this proposal, and seek ideas for other improvements to the rights of nursing home residents.**

Another pillar of residents' rights and quality care is linguistic and cultural responsiveness. For older people with English language barriers, preventable miscommunication can lead to a number of adverse health and care outcomes, like higher hospitalization rates and lower

¹⁵⁴ “Nursing Home Residents' Rights Fact Sheet,” The National Consumer Voice for Quality Long-Term Care, accessed October 2026, https://theconsumervoice.org/wp-content/uploads/2025/08/CV_ResRightsFactSheet.pdf.

¹⁵⁵ Angela Houghton and Nii-Quartelai Quartey, “Maintaining Dignity: Understanding and Responding to the Challenges Facing Older LGBT Americans,” AARP Research, March 2018, <https://doi.org/10.26419/res.00217.006>.

¹⁵⁶ “LGBT Older Adults in Long-Term Care Facilities: Stories from the Field,” National Resource Center on LGBTQ+ Aging, June 27, 2024, <https://lgbtagingcenter.org/resource/lgbt-older-adults-in-long-term-care-facilities-stories-from-the-field/>.

¹⁵⁷ “LGBT Older Adults in Long-Term Care Facilities.”

screening rates.¹⁵⁸ Senate Democrats heard from nursing home resident advocates and an organization representing Asian American, Native Hawaiian, and Pacific Islander older adults about the need to define cultural and language competency as a core quality metric of the care delivered in nursing homes. **Senate Democrats invite feedback on this proposal and welcome feedback on additional proposals to improve linguistic and cultural responsiveness in nursing homes.**

Survey and Certification Activities

Nursing homes must comply with federal nursing home regulations in order to receive reimbursement from the Medicare and Medicaid programs. These requirements, including federal staffing requirements, are enforced through survey and certification activities. CMS contracts with state survey agencies to conduct in-person standard surveys of nursing homes to determine whether they are complying with federal requirements every 9 to 15 months.¹⁵⁹ During these unannounced surveys, state inspectors observe patient care, conduct staff and resident interviews, and review staffing data through the Payroll Based Journal (PBJ) system.

Improve nursing home surveys

Senate Democrats heard from researchers about the need to change the frequency and predictability of nursing home surveys. Though nursing homes are not given exact dates that surveys may occur, surveys are required to occur at regular intervals, meaning that their timing is often at least partially predictable. Research studies conclude that nursing homes, especially for-profit facilities, increase staffing and care effort when they anticipate a survey or inspection is imminent.¹⁶⁰ During periods when inspections are not likely, these nursing homes will often revert to pre-survey staffing numbers. Researchers also found that nursing home residents are more likely to die during time periods when surveys are unlikely. Experts recommend making nursing home surveys more unpredictable to incentivize facilities to be properly staffed to provide sufficient services at all times. Even with fixed inspection frequency, increasing unpredictability would save 10% more lives.¹⁶¹ **Senate Democrats seek feedback on the best approaches to decrease the predictability of nursing home surveys. In addition, we seek comments on the additional resources needed to make nursing home surveys more unpredictable, including additional tools to recruit and retain the nursing home survey workforce.**

¹⁵⁸ Sylvia E. Twersky et al., “The Impact of Limited English Proficiency on Healthcare Access and Outcomes in the U.S.: A Scoping Review,” *Healthcare* Vol. 12, no. 3 (2024): 364, <https://doi.org/10.3390/healthcare12030364>.

¹⁵⁹ “Nursing Home Enforcement,” Centers for Medicare & Medicaid Services, accessed October 2026, <https://www.cms.gov/medicare/health-safety-standards/enforcement/nursing-home-enforcement>.

¹⁶⁰ Ashvin Gandhi, Andrew Olenski, and Maggie Shi, “Predictably Unpredictable Inspections,” *National Bureau of Economic Research*, November 2025, <https://doi.org/10.3386/w34491>.

¹⁶¹ Gandhi et al., “Predictably Unpredictable Inspections.”

Beyond timing and frequency, there are long-standing recommendations to improve the thoroughness and accuracy of nursing home surveys. To bolster these processes, one approach from the Nursing Home Improvement and Accountability Act is to require the HHS Secretary to review plans to improve the extent to which existing surveys and enforcement processes improve compliance with nursing home regulations. **Senate Democrats seek comments on the approach to involve the HHS Secretary in survey improvements.**

Finally, Senate Democrats heard from nursing home trade associations about proposals to shift the responsibility of nursing home survey and certification activities from state survey agencies to accrediting organizations (AOs). Specifically, nursing homes are interested in receiving “deemed status” through the Joint Commission, which would allow AOs like the Joint Commission to survey nursing homes for compliance with federal nursing home requirements rather than state survey agencies. **Senate Democrats request comments on proposals to provide nursing homes with “deemed status” through the Joint Commission. We seek feedback on whether AOs should replace or supplement nursing home oversight activities conducted by state survey agencies. We seek feedback on the downstream impacts of transitioning public nursing home survey and certification activities to a private entity. Finally, we seek comment on whether providing nursing homes with “deemed status” would address the backlog in nursing home surveys without additional federal funding for survey and certification activities.**

Increase funding for survey and certification

CMS suspended standard nursing home surveys for five months during the COVID-19 pandemic and replaced them with targeted infection control surveys. Since standard surveys resumed in August 2020, the average interval between surveys increased from the pre-COVID 16 months to over 20 months.¹⁶² Delays have been exacerbated by a lack of proper funding for survey agencies.¹⁶³ These delays, which are occurring in both low- and high-quality nursing homes, have resulted in a backlog of uncompleted surveys. A 2023 investigation by the Senate Special Committee on Aging found that decades of underfunding of state survey agencies have resulted in significant staffing shortages and inadequate oversight.¹⁶⁴ The investigation found nearly a third of the nation’s nursing homes are behind on annual inspections and that 32 inspection agencies have vacancy rates of 20% or higher.¹⁶⁵ Senate Democrats heard from advocates of nursing home residents and LTC ombudsmen about the need to provide mandatory, predictable

¹⁶² Robert Skinner and David Stevenson, “Nursing Home Oversight Trends During COVID-19 and the Current Survey Backlog in the United States,” *Journal of Aging and Social Policy*, Vol. 36 no. 6, (2024), <https://doi.org/10.1080/08959420.2024.2384335>.

¹⁶³ “Uninspected and Neglected: How State Survey Agencies Are Failing Nursing Home Residents,” United States Senate Special Committee on Aging, May 2024, <https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf>.

¹⁶⁴ “Uninspected and Neglected.”

¹⁶⁵ “Uninspected and Neglected.”

funding for nursing home survey and certification activities. **We seek feedback on proposals outlined in Ranking Member Wyden’s Nurses Belong in Nursing Homes Act that would increase and provide mandatory funding for nursing home survey and certification activities. In addition, we seek feedback on the amount of funding that is needed to ensure appropriate survey and certification of nursing homes in the United States.**

Relatedly, earlier this year, CMS announced an expansion of a risk-based survey approach that would allow 12% of all nursing homes, those deemed “higher-performing,” to be subject to a “streamlined” survey process due to limited resources for survey and certification activities.¹⁶⁶ Notably, the CMS proposal lacks any corresponding enhanced scrutiny of low-performing nursing homes, like candidates and participants in the Special Focus Facility program (described further below) or a similar percentage of poorly performing nursing homes to the 12%. **We seek feedback on the impact of this risk-based survey approach, whether CMS should continue this approach, and whether Congress should entertain this or other risk-based survey frameworks to maximize limited survey and certification resources.**

Increased funding for other nursing home oversight activities

LTC Ombudsman programs and Protection and Advocacy Systems

All 50 states, the District of Columbia, Puerto Rico, and Guam have LTC ombudsman programs, which advocate for the health, safety, welfare, and rights of over 3 million residents of nursing homes and other LTC facilities.¹⁶⁷ Ombudsmen regularly visit residents; respond to, investigate, and resolve complaints; and assist with transitions back to the community. They also play a critical role in identifying harmful patterns in LTC facilities, educating residents and families about their rights, and recommending improvements to LTC.

LTC ombudsman programs have a large, ever-growing mandate as the number of older adults living in LTC facilities increases, but these programs face a small and shrinking budget. LTC ombudsman programs are funded through federal, state, and local sources, but the share of federal contributions has decreased from 58.8% of the total program’s budget in 2000 to 46.9% in 2019.¹⁶⁸ Senate Democrats heard from nursing home resident advocates that ombudsmen are

¹⁶⁶ “CMS Modernizes Nursing Home Oversight with New Risk-Based Survey Approach Designed to Highlight High Performance, Encourage Improvement,” Centers for Medicare & Medicaid Services, July 16, 2026, <https://www.cms.gov/newsroom/press-releases/cms-modernizes-nursing-home-oversight-new-risk-based-survey-approach-designed-highlight-high>.

¹⁶⁷ “Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse.”

¹⁶⁸ Katherine A. Kennedy et al., “Trends in Long-Term Care Ombudsman Program Funding and Its Relationship to Nursing Home Resident Care,” *The Milbank Quarterly* Vol. 103, no. 4 (2025): 1204–1223, <https://doi.org/10.1111/1468-0009.70061>.

vital advocates for residents, and they need additional funding. Research shows that states that invest in their LTC ombudsman programs see measurably better nursing home outcomes.¹⁶⁹

Without a strong enforcement apparatus, bad actors will continue to skirt regulations, putting residents and workers at risk. As proposed in Ranking Member Wyden’s Elder Justice Reauthorization and Modernization Act (S. 1198) in 2023 and Nurses Belong in Nursing Homes Act, increasing and establishing mandatory funding for nursing home survey and certification activities and LTC ombudsman programs is a key step in strengthening oversight and compliance reviews. **Senate Democrats request feedback on proposals to increase and establish mandatory funding to ensure that there are enough inspectors and advocates to identify and address harm. We also seek evidence on the efficacy of different forms of nursing home enforcement, including audits and LTC ombudsmen.**

In addition, Protection and Advocacy (P&A) systems serve as a critical safety net in institutional oversight, exercising unique federal statutory authority to access facilities, review records, and investigate allegations of abuse, neglect, and rights violations among residents with I/DD in LTC facilities, as well as to assist nursing home residents with legal remedies to abuse, neglect, and exploitation.¹⁷⁰ While P&As can monitor and investigate nursing homes, several factors shift their daily priorities to other types of institutional settings. Because LTC ombudsmen are dedicated specifically to nursing home residents, P&As often focus their constrained resources on settings where no other dedicated advocate exists. Like LTC ombudsmen, P&A agencies remain severely constrained by flat or modest federal appropriations that have failed to keep pace with the growing volume of institutional populations.¹⁷¹ **Senate Democrats seek feedback on the appropriate level of additional funding for LTC ombudsmen and P&As to be able to adequately conduct these critical oversight functions. We also seek feedback on how the distinct roles of LTC ombudsmen, P&A systems, and State Survey Agencies should be coordinated or streamlined to protect resident safety, investigate abuse or neglect, and enforce quality of care in nursing homes, as well as alternative proposals to improve oversight of nursing homes.**

Improve CMS Special Focus Facility Program

CMS’s “flagship program” to raise the quality of care in poor-performing nursing homes, the Special Focus Facility (SFF) program, places the nation’s worst-performing nursing homes under

¹⁶⁹ Katherine Kennedy, Cyrus Kosar, and Thomas Kali. “The Relationship Between Long-Term Care Ombudsman Program Spending and Nursing Home Outcomes.” *Innovation in Aging* Vol. 7 (2023): 642, <https://doi.org/10.1093/geroni/igad104.2090>.

¹⁷⁰ “Protection & Advocacy Systems (P&As),” Administration for Community Living, accessed October 2026, <https://acl.gov/programs/pa-programs>.

¹⁷¹ Michelle Diamant, “Nation’s Disability Services System Begins To Buckle As Funding Threats Intensify,” Disability Scoop, May 5, 2025, <https://www.disabilityscoop.com/2025/05/05/nations-disability-services-system-begins-to-buckle-as-funding-threats-intensify/31439/>.

increased inspection frequency and progressive enforcement, with the goal of graduating facilities to compliance within two years. A 2025 HHS-OIG report found that 88% of facilities selected were for-profit and that most graduates did not sustain the improvements they made while in the SFF program.¹⁷²

As of now, the SFF program only has 88 slots across the United States for nursing homes.¹⁷³ Each state, besides Alaska and the District of Columbia, is assigned between one and six slots. The number of slots that each state has is determined according to the number of nursing homes in each state.¹⁷⁴ **Senate Democrats request comments on a proposal to redetermine slot allocation based on a state's nursing home population rather than the number of nursing homes in the state.**

SFFs are selected from the state's candidate list, which is made up of five candidates for each slot. In January 2026, CMS released a memorandum citing changes to the SFF program, including that candidate selection will focus more on prevalence of falls. Additionally, survey predictability will be reduced.¹⁷⁵

Fewer than 0.6% of the country's nursing homes (88 of nearly 15,000) are a part of the SFF program, though a much higher percentage of facilities are struggling.¹⁷⁶ To address nursing home shortcomings on a larger scale, one approach would be to require that the HHS Secretary ensures that no fewer than 5% of nursing homes participate in the SSF program, a reform also included in the Nursing Home Improvement and Accountability Act. **Senate Democrats invite comments on the impacts of expanding the percentage of nursing homes that should be included in the Special Focus Facility program.**

Beyond expansion of the SFF program, there is a need to make sure that the program helps nursing homes improve the quality of care they deliver over the long term. Almost two-thirds of nursing homes that have graduated from the SFF program received a serious deficiency within 3 years of graduating.¹⁷⁷ HHS-OIG found that the penalties associated with the SFF program account for over half of the enforcement remedies and do not mandate that the facilities change

¹⁷² "Special Focus Facility Program Nursing Homes, 2013–2022," United States Department of Health and Human Services Office of Inspector General, October 2025, <https://oig.hhs.gov/documents/evaluation/11252/OEI-01-23-00052.pdf>

¹⁷³ "CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements," United States Department of Health and Human Services Office of Inspector General, October 2025, <https://oig.hhs.gov/documents/evaluation/11250/OEI-01-23-00050.pdf>

¹⁷⁴ Jordan Rau, "Poor Patient Care at Many Nursing Homes Despite Stricter Oversight," *The New York Times*, July 5, 2017, <https://www.nytimes.com/2017/07/05/health/failing-nursing-homes-oversight.html>

¹⁷⁵ "REVISED: Revisions to the Special Focus Facility (SFF) Program, Ref: QSO-23-01-NH REVISED," Centers for Medicare and Medicaid Services, January 28, 2026, <https://www.cms.gov/files/document/qso-23-01-nh-revised-2026-01-28.pdf>

¹⁷⁶ "State Of The Sector: Nursing Home Staffing Shortages Persist Despite Unprecedented Efforts To Attract More Staff," American Health Care Association and National Center for Assisted Living, March 5, 2024, <https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/State-Of-The-Sector-Nursing-Home-Staffing-Shortages-Persist-Despite-Unprecedented-Efforts-To-Attract-More-Staff-.aspx>

¹⁷⁷ "CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements."

aspects of their operations and practices.¹⁷⁸ Additionally, ownership is not considered by CMS when selecting nursing homes for the SFF program, despite some owners displaying patterns of poor performance across multiple nursing homes that they own.¹⁷⁹ Proposals to address these challenges could include:

- Requiring CMS to adopt additional enforcement tools that are nonfinancial and promote reform and compliance.
- Establishing a compliance assistance program for nursing homes to receive educational programming and on-site consultation.
- Requiring CMS to consider nursing home ownership information during SFF program selection.

Senate Democrats seek detailed feedback on these proposals to make sure that facilities in the SFF program make substantive, sustainable improvements.

Nursing Home Five-Star Quality Rating System

CMS established the Five-Star Quality Rating System (Rating System) for nursing homes to help potential residents and their families compare and contrast facilities and decide which home is right for them. The system has an Overall Quality Rating of one to five stars, which is based on three domains: health inspections, staffing, and quality measures.¹⁸⁰ Each of these domains also has its own rating. The health inspection domain is the predominant domain and considers the number, scope, and severity of deficiencies found during the two most recent annual state inspection surveys. For staffing, three nurse staffing level measures and three measures of staff turnover are analyzed. Lastly, the quality measures rating is based on the facility's performance on 15 of the claims-based quality measures that are on the Care Compare website, including nine long-stay and six short-stay measures.

Senate Democrats heard from nursing home quality researchers that there is a need to improve the Rating System, and nursing home quality experts suggested many options to improve this system. First, quality measures are based on self-reported data, which is provided by nursing home managers and operators. A survey found that many homes that received one star for the inspection domain rated themselves as four or five stars for clinical quality.¹⁸¹ This suggests that

¹⁷⁸ "CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements."

¹⁷⁹ "CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements."

¹⁸⁰ "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide," Centers for Medicare and Medicaid Services, September 2026,

<https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/usersguide.pdf>.

¹⁸¹ "Consumers Reveal Obstacles to Using Nursing Home Quality Ratings," UChicago Medicine Forefront, April 4, 2016, <https://www.uchicagomedicine.org/forefront/news/consumers-reveal-obstacles-to-using-nursing-home-quality-ratings>.

some nursing home operators may be misrepresenting the true quality of their facilities. Experts suggest increased scrutiny of self-reported performance data.¹⁸² Additionally, improvements in star ratings do not necessarily mean a nursing home has improved the quality and safety of the care it delivers. Rather than improving their facilities and services, nursing homes can improve their scores by changing coding practices, avoiding sicker residents, and other tactics that do not directly improve the quality of care they deliver.¹⁸³

Adjustments within the Rating System's staffing domain is another approach that has strong support from consumer advocates and labor unions. As of now, the staffing rating plays a minor role in determining the overall star rating despite there being a significant relationship between staffing and quality.¹⁸⁴ Experts recommend increasing the weight of the staffing domain when calculating a nursing home's overall star rating.¹⁸⁵ Additionally, the staffing rating is based on the average hours per resident-day and staff turnover measures; however, there are other measures that could contribute to capturing the effect that staffing has on nursing homes. Researchers found that day-to-day staffing variation, or staffing instability, was associated with resident health outcomes, and recommended that it be added to the Five-Star staffing ratings.¹⁸⁶ **Senate Democrats request comments on proposals to modify how the ratings system weights staffing.**

During Senate Democrats' listening sessions, some advocates proposed building more variables into the nursing home star rating system to better reflect the resident experience. This could include measures of the social environment, meals, and daily activities. For example, some nursing homes emphasize service to certain religious or ethnic groups, which positively affects the comfort level and social life of residents.¹⁸⁷ **Senate Democrats invite feedback on what additional measures should be considered as part of the nursing home star rating system.** Senate Democrats invite comments and feedback on other approaches to reform the Rating System and the Nursing Home Care Compare website that uses the Rating System to help consumers and families compare and contrast the quality of nursing homes.

¹⁸² Kira L. Ryskina, R. Tamara Konetzka and Rachel M. Werner, "Association Between 5-Star Nursing Home Report Card Ratings and Potentially Preventable Hospitalizations," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* Vol. 55 (2018): 1–14, <https://doi.org/10.1177/0046958018787323>.

¹⁸³ R. Tamara Konetzka et al., "Nursing Home 5-Star Rating System Exacerbates Disparities In Quality, By Payer Source," *Health Affairs* Vol. 34, no. 5 (2015): 819–827, <https://doi.org/10.1377/hlthaff.2014.1084>.

¹⁸⁴ "Skilled Nursing Facility Services," Medicare Payment Advisory Commission, March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch7_MedPAC_Report_To_Congress_SEC.pdf.

¹⁸⁵ "Skilled Nursing Facility Services."

¹⁸⁶ Dana B. Mukamel et al., "Incorporating staffing instability in the nursing home Five-Star Staffing Composite," *Health Affairs Scholar* Vol. 2, no. 12 (2024), <https://doi.org/10.1093/haschl/qxae159>.

¹⁸⁷ "Consumers Reveal Obstacles to Using Nursing Home Quality Ratings."

Section III: Strengthening the LTC Workforce

Background

Expanding and investing in the LTC system in the United States is not possible without a strong LTC workforce. This is a particularly critical challenge because there is currently both a shortage of LTC workers and a shortage of high-quality LTC jobs. These shortages will only be exacerbated as the overall demand for workers in LTC settings is projected to grow by 40%, from 2.35 million to 3.29 million workers, by 2038, driven primarily by the aging of the United States' population.¹⁸⁸ By 2034, the number of adults over 65 will exceed the number of individuals under 18, and 52% of these older Americans will have a need for LTC.¹⁸⁹ Further, use of LTC is not restricted to older adults. Of the 5.1 million people who currently use Medicaid HCBS, more than half are people with disabilities under age 65.¹⁹⁰ This workforce crisis demands a purposeful investment, coupled with thoughtful policy reforms.

There are many factors driving the shortage of LTC workers. High turnover rates of 40% to 60% for workers in the home and community-based setting and 53% for nursing homes are driven by low wages, limited advancement opportunities, and challenging working conditions.¹⁹¹ The LTC workforce is also a disproportionately immigrant-dependent workforce. Though immigration pathways for LTC workers are extremely limited, there is strong evidence that a boost in the direct care workforce from increased immigration would result in lower mortality and increase the likelihood that people are served in their setting of choice.¹⁹² There are clear benefits to a strong LTC workforce, but currently, LTC workers are overworked, underpaid, and burned out at precisely the moment America needs their skillset and labor force participation more than ever.

The LTC workforce includes workers of many different certifications, training levels, and workplace settings. In nursing homes, a combination of LPNs/Licensed Vocational Nurses (LVNs) and CNAs support residents under the supervision of a RN. Nursing home staff are overseen by a Medical Director, who is a physician. In these settings, workers provide more intensive medical services, like IV care and ventilation, in addition to assistance with ADLs. In home care settings, CNAs, home health aides, and personal care aides (PCAs) provide the bulk of care, usually assisting with ADLs but sometimes providing round-the-clock medicalized

¹⁸⁸ "Long-Term Services and Support: Demand Projections, 2023-2038," Health Resources and Services Administration, December 2025, <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/ltss-projections-factsheet.pdf>.

¹⁸⁹ Katherine Miller et al., "Long-Term Care Services and Supports Needed for Successful Aging-in-Place: A Critical Review," *Annual Review of Public Health* Vol. 26, (2025): 487-505, <https://doi.org/10.1146/annurev-publhealth-071823-113604>.

¹⁹⁰ Burns et al., "A Look at Waiting Lists for Medicaid HCBS."

¹⁹¹ Britainy Barnes and David Grabowski, "Foreign-Born Workers Made Up Half The Increase In The Direct Care Workforce In Home And Community Settings, 2012-22," *Health Affairs* Vol. 44 no. 8 (2025), <https://doi.org/10.1377/hlthaff.2024.01495>.

¹⁹² David C. Grabowski, Jonathan Gruber, and Brian E. McGarry, "Is Immigration Good for Health? The Effect of Immigration on Older Adult Mortality in the United States," *National Bureau of Economic Research*, February 2026, <https://www.nber.org/papers/w34791>.

care.¹⁹³ Many in the direct care workforce are part of larger private home- and community-based services agencies, but direct care workers increasingly operate as independent contractors.

All LTC jobs are physically and emotionally demanding and involve heavy workloads, scheduling challenges, inadequate supervision, and limited training and career advancement.¹⁹⁴ Finally, paid and unpaid family caregivers are also a key part of the LTC workforce, often because the availability of high quality, affordable care is limited for so many. In our broken LTC patchwork, unpaid care work is an unfortunate necessity for some, but the preferred mode of care for others. In addition, family caregivers may prefer to be the primary service providers, and can also be important bridges between individuals and their direct service providers, whether at home or in facility-based settings.

Centering Worker Stories: Joy'e

I have been a Homecare/Personal Support Worker (PSW) for the past 28 years, but I have been doing care work for most of my life as I have several family members with disabilities. These budget cuts [in H.R. 1.] will impact over 60,000 people in this state. If consumer hours are cut or consumers are cut off the programs they depend on, how will they get the help they need? The client I used to work for is now 80 years old... if [he] loses any services, he will be in dire straits. He can't even get out of bed without help. His worker moves him from bed onto his electric chair so he can get around, but he still needs help taking medication, eating, and working.

But I want to speak about the worker side of things. If consumers lose services or hours, workers lose income too. Now keep in mind, the consumers in some cases must work, so they are paying into society. The workers who take care of them also pay into society. That is a financial loss to Oregon. This is especially true when you consider the number of caregivers in Oregon. So, consumers won't get their needs met and workers won't be able to pay their bills. Families will have to quit working to care for their family members, or those with no family, like Laddie, could end up in a care facility at a much higher cost to Medicaid. If family members have to quit working to cover hours that caregivers can no longer work, they too will stop being paying members of society.

¹⁹³ Priya Chidambaram, Drishti Pillai, and Alice Burns, "Who Are Direct Care Workers and How Might Federal Policy Changes Impact the Workforce?" KFF, July 9, 2026,

<https://www.kff.org/medicaid/who-are-direct-care-workers-and-how-might-federal-policy-changes-impact-the-workforce/>.

¹⁹⁴ "Understanding the Direct Care Workforce," PHI, accessed October 2026, <https://www.phinational.org/policy-research/direct-care-workforce-key-facts/>.

I can almost guarantee you that a lot more people will become homeless, both consumers and caregivers, as they won't be able to keep up with their bills or rent. Many of us are already one crisis away from that now. We would also lose our health care and so would our families. Then how many people will have to start depending on receiving all their health care in the emergency room? I want to do more, we need to do more. These cuts will be so devastating to so many; we must stop them now. I am a proud member of SEIU Local 503 OPEU and I know we will do everything we can to help.

i. Improving Wages, Benefits, Training, and Career Pathways

The current employment landscape for LTC workers actively deters individuals from entering the field. First and foremost, low wages and part-time status keep roughly half of nursing assistants and home health aides living in or near poverty.¹⁹⁵ According to the Bureau of Labor Statistics, the median hourly wage for home health aides is \$16.78 an hour.¹⁹⁶ These low wages, combined with lack of benefits and limited career advancement options, deter individuals from becoming LTC workers and lead to low retention rates.¹⁹⁷

Poor job quality likely contributes to high turnover rates, which imposes high costs on employers. For 2025 to 2026, the rate of turnover among CNAs working in nursing homes was 42%.¹⁹⁸ In other words, nearly half of CNAs in the nursing home workforce left their jobs after less than a year. Considering this workforce more broadly, turnover rates are even higher, with the latest research indicating turnover in 2024 was nearly 75% among direct care workers overall.¹⁹⁹

There are opportunities to ensure the direct care workforce is adequately compensated and that taxpayer dollars are used to compensate high-quality care. The Medicaid Access Rule, finalized by the Biden administration in 2024, includes a landmark "80/20 policy" requiring that at least 80% of Medicaid fee-for-service and managed care payments for home care services be directed into the compensation of direct care workers, rather than administrative overhead or profits.²⁰⁰ By mandating that the vast majority of reimbursement flows to frontline staff, the policy aims to increase direct care wages, address severe workforce shortages, and ensure these critical positions become sustainable, high-quality jobs. While aging and disability advocates as well as labor unions praise the provision as a crucial mechanism to guarantee fair pay and stabilize access to HCBS, some home care provider associations and state agencies have raised concerns about the appropriateness of the federal standards, timeframes for implementation, and availability of data needed to realize this requirement.²⁰¹ **Senate Democrats seek feedback on**

¹⁹⁵ Janie McDermott and Annelies Goger, "The health care workforce needs higher wages and better opportunities," Brookings, March 23, 2022, <https://www.brookings.edu/articles/the-health-care-workforce-needs-higher-wages-and-better-opportunities/>.

¹⁹⁶ U.S. Bureau of Labor Statistics, "Occupational Outlook Handbook: Home Health Aides and Personal Care Aides," Bureau of Labor Statistics, accessed October 2026, <https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm>.

¹⁹⁷ McDermott, "The health care workforce needs higher wages."

¹⁹⁸ Lisa Hohenemser, "2025–2026 Nursing Home Report Reveals Lower Turnover," *AHCA/NCAL Blog*, September 9, 2025, <https://www.ahcancal.org/News-and-Communications/Blog/Pages/2025%E2%80%932026-Nursing-Home-Report-Reveals-Lower-Turnover.aspx>.

¹⁹⁹ "Understanding the Direct Care Workforce."

²⁰⁰ 42 C.F.R. § 441.302(k)(3)(i) ("require that at least 80 percent of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to the following services be spent on compensation to direct care workers: homemaker services, home health aide services, and personal care services.") <https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf>.

²⁰¹ Martha A. Roherty, Mary P. Sowers and Kate McEvoy, "Letter to CMS Administrator Chiquita Brooks-LaSure," July 3, 2023, <https://medicaidirectors.org/wp-content/uploads/2023/07/State-Associations-Comments-on-Access-NPRM-HCBS-Provisions-FINAL.pdf>.

this and other related approaches, aiming to guarantee living wages for essential caregivers while supporting the overall stability of the HCBS ecosystem. Senate Democrats are also interested in understanding how to leverage reimbursement rates to increase wages.

Beyond the direct care compensation requirement, the Medicaid Access Rule includes several key provisions designed to enhance rate transparency, access monitoring, and accountability across HCBS. Specifically, the rule mandates that states publicly disclose fee-for-service HCBS payment rates converted into average hourly equivalents, establish an advisory group on payment rates, track access metrics such as HCBS waiver waiting lists and service delivery delays, and enforce heightened oversight when states propose rate reductions or restructurings.²⁰² These mechanisms directly impact provider payment rates by creating public accountability and establishing data-driven benchmarks; making payment methodologies and hourly payments transparent can help to ensure baseline rates are adequate to maintain a sufficient workforce. **Senate Democrats seek feedback on how to build upon these policies to ensure that state Medicaid rates are structurally adequate to support provider viability, competitive workforce pay, and expanded access to HCBS.** Specifically, and as discussed in Section I, we seek feedback on whether to determine payment rates by program or by agency, whether there should be a payment benchmark, whether there should be geographic variation in payment rates, and how to structure payment to reflect variations in skills, training, and experience.

The home care sector specifically will need tailored strategies to address the increase in demand for home care generated by the establishment of a universal home care benefit , as discussed in Section I. **Senate Democrats therefore seek feedback on proposals to establish a strong network of home care providers and invest in this workforce. Specifically, we seek feedback on how to construct effective payment incentives to develop the home care workforce.**

The Trump Administration has exacerbated challenges related to recruitment and retention of the LTC workforce. Most notably, in 2025, the Department of Labor (DoL) rolled back minimum wage and overtime protections for home care workers,²⁰³ reinstating exemptions that allow third-party agencies to classify home health aides and companions as exempt from federal minimum wage and overtime requirements. In addition, DoL recently introduced a rule that makes it easier for employers to classify direct care workers as independent contractors, barring

²⁰² 42 C.F.R. § 447.203(b)(2) and (3) (“requires States to publish the average hourly Medicaid FFS fee schedule payment rate for personal care, home health aide, homemaker, and habilitation services.”); 42 § C.F.R. 447.203(b)(6)(i) (“The State agency must establish an advisory group for interested parties to advise and consult on provider rates with respect to service categories under the Medicaid State plan, 1915(c) waiver, and demonstration programs, as applicable, where payments are made to the direct care workers for the self-directed or agency-directed services.”); 42 § CFR 441.303(f)(6) (“If the State has a limit on the size of the waiver program and maintains a list of individuals who are waiting to enroll in the waiver program, the State must meet the reporting requirements”); 42 § CFR 447.203(c)(1) (“Initial State analysis for rate reduction or restructuring.”))
<https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf>

²⁰³ 29 C.F.R. § 552.100 (Application of minimum wage and overtime provisions.)
<https://www.ecfr.gov/current/title-29/subtitle-B/chapter-V/subchapter-A/part-552>.

them from certain benefits such as health insurance, leave, and sick pay.²⁰⁴ Already, approximately one in six direct care workers in nursing homes and home health settings are uninsured and a sizable proportion are reliant on the very same Medicaid coverage Republicans slashed by almost \$1 trillion in H.R.1.²⁰⁵ Noting the Republican attacks on LTC workers and their access to basic workplace protections, **Senate Democrats request feedback on the reversal of the Trump administration’s rules to roll back minimum wage protections and prevent large corporations from classifying home health aides and direct care workers as independent contractors.**

Congress has successfully improved wages and working conditions for LTC workers in the recent past through flexibilities. As discussed above, ARPA provided states with additional funding for HCBS through a 10% Federal Medical Assistance Percentage (FMAP) enhancement.²⁰⁶ Some states, such as Iowa, opted to provide one-time bonuses for direct care workers, while other states used additional FMAP funding to increase wages for this workforce.²⁰⁷ Colorado used ARPA funding to guarantee a wage of at least \$15 per hour, which benefited approximately 35,000 home care workers.²⁰⁸ Colorado’s decision to increase worker compensation by setting a new permanent base wage helped to ensure that increased federal funding went to home care workers faster than if the state had simply set a higher home care agency reimbursement rate. For example, Colorado’s approach contrasts with Florida’s approach, in which home care agencies had to apply for funding, describe how they would use it, and then distribute it to the workers.

Aside from the HCBS investments facilitated by ARPA, states are undertaking their own efforts to create better jobs for direct care workers. Illinois used flexibilities in its state Medicaid program to improve wages for CNAs. The CNA Pay Scale Subsidy Program supplements existing wages for CNAs working in nursing homes based on years of experience. Under the program, CNAs at participating nursing homes with six or more years of experience earn an additional increase of up to \$6.50 an hour. While not a training program, the subsidies were

²⁰⁴ “Notice of Proposed Rule: Employee or Independent Contractor Status Under the Fair Labor Standards Act, Family and Medical Leave Act, and Migrant and Seasonal Agricultural Worker Protection Act, RIN 1235-AA46,” United States Department of Labor, February 26, 2026, <https://www.dol.gov/agencies/whd/flsa/misclassification/2026rulemaking>; Molly Kinder, “Essential but undervalued: Millions of health care workers aren’t getting the pay or respect they deserve in the COVID-19 pandemic,” Brookings, May 28, 2020, <https://www.brookings.edu/articles/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/>.

²⁰⁵ “Direct Care Workers in the United States: Key Facts 2025,” PHI, September 15, 2025, <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2025/>.

²⁰⁶ “ARPA HCBS Initiative,” ADvancing States, accessed October 2026, <https://www.advancingstates.org/state-technical-assistance/arpa-hcbs-initiative>.

²⁰⁷ “The American Rescue Plan and the Need to Strengthen the Home Care Workforce: Chapter IV, How States Are Using ARPA,” New America Foundation, July 6, 2022, <https://www.newamerica.org/insights/the-american-rescue-plan-and-the-need-to-strengthen-the-home-care-workforce/>.

²⁰⁸ “How States Are Using ARPA.”

enacted specifically to improve retention of the LTC workforce. Since early 2022, the number of hours worked by employed CNAs increased by more than 26%, while the number of hours provided by CNAs who contract with staffing agencies decreased. This indicates LTC is being delivered more frequently by permanent staff rather than temporary contractors. **Senate Democrats request feedback on the effectiveness of these state initiatives and whether they can be expanded to apply to additional LTC workforce classifications. We also seek feedback on federal proposals to support these state innovations or expand these initiatives on a national scale.**

As discussed above, during the Biden Administration Senate Democrats entertained a \$150 to \$400 billion investment in Medicaid HCBS, coupled with workforce reforms like those included in ARPA, in order to build on Medicaid's existing infrastructure to expand and grow the direct care workforce. **Senate Democrats are interested in this model and seek input on how to phase in access to a universal home care benefit order to assure there is an adequate supply of workers to meet the demand for care.**

Another existing solution to developing a qualified and accessible home care workforce is the use of home care registries, which featured prominently in the Biden Administration approach described above. These registries typically match LTC consumers with direct care workers and sometimes provide additional services like case management, background checks, program integrity activities, and workforce training.²⁰⁹ **Senate Democrats request feedback on the role of home care registries in developing and delivering a home care workforce adequate to meet a higher demand. We seek feedback on whether registry services should be a covered benefit for Medicare and Medicaid beneficiaries who receive home care, how a registry could support the creation of a network of home care workers, which entities should be permitted to operate a registry, and what other options to consider, like whether to establish a national registry or state-based registries.**

²⁰⁹ "Matching Service Registries," PHI, accessed October 2026, <https://www.phinational.org/advocacy/matching-service-registries/>.

ii. Creating Training Incentives

Recruiting new LTC workers via attractive wages and benefits is only one side of the workforce equation. Retaining these workers is equally important. High rates of turnover in LTC professions are a symptom of the difficult working conditions and pervasive burnout. The lack of a dedicated pipeline to recruit and retain LTC workers is a result of the relatively high barrier to entry. LTC workers seeking to advance often face challenges such as entrance exams, high tuition and fees, and school attendance while working full time. They also tend to have difficulty receiving credit for their prior learning and often need to start from scratch in order to progress within a career pathway.²¹⁰

Several states have implemented promising practices for improving retention of the LTC workforce via workforce training programs:

- **Massachusetts:** Launched the Career Ladder Program in partnership with multiple state nonprofits, providing weekly stipends, exam fee coverage, and one-on-one coaching for CNAs training to become LPNs.²¹¹ To be eligible, CNAs must enroll at an approved Massachusetts community college and pledge to continue working for their current employer for 2 years after receiving their LPN certification.
- **Virginia:** Implemented the Earn to Learn (ETL) program. Virginia's ETL program provides funding to educational institutions that offer Virginia Board of Nursing-approved nursing education programs for pre-licensure RNs and LPNs to foster collaborative clinical training arrangements between grant recipients, hospitals, and health providers. Through these partnerships, RN and LPN students participate in a paid clinical apprenticeship that enables them to earn a wage comparable to their current level of practice while training to obtain a higher certification level.
- **New York:** Created the Direct Caregiver Flexibility Training Program. The New York State Department of Health's (DOH) Direct Caregiver Flexibility training program is an initiative designed to create opportunities for New Yorkers to receive free training and employment referrals for work in LTC. The Direct Caregiver program creates accessible training and certification as a personal care aide, home health aide or CNA, as well as support for those entering employment.²¹²

²¹⁰ McDermott, "The health care workforce needs higher wages."

²¹¹ "Massachusetts Career Ladder Program: Program Information," Social Finance, accessed October 2026, <https://socialfinance.org/massachusetts-career-ladder-program/>.

²¹² "Direct Caregiver Flexibility Training Program," New York State Department of Health, accessed October 2026, https://www.health.ny.gov/facilities/long_term_care/direct_caregiver_grant/.

- **Iowa:** Implemented the Iowa Health Careers Registered Apprenticeship Program, which funds new or expanded high school-based registered apprenticeships in health care, combining virtual reality simulations with hands-on placements at local nursing homes and hospitals. Students can earn certification as a CNA before graduating high school and they can participate in pathways to further credentials such as medical surgical tech, phlebotomist, or RN, all while receiving compensation. Grant funds cover equipment, training materials, and uniforms, with the state also supplying simulation software and hardware to participating schools.²¹³

Senate Democrats request data on the effectiveness of these state grant programs that recruit LTC workers and ensure they have opportunities for high quality training and career advancement. We seek feedback on how the federal government can support these innovative state programs and scale them to the national level. In addition, we invite feedback on how federal training incentives can train LTC workers on how to care for people with Alzheimer’s disease and other forms of dementia, a more common diagnosis amongst individuals in need of home care.

Further, provider associations shared promising results of facility-level training and LTC workforce models. The SkillSpring program operating across several health facilities in New York trains young adults to become CNAs over a 3-month period and guarantees them a position at a nursing home upon completion of the program.²¹⁴ Another example is DoL’s Jobs Corps programs that provide upfront scholarships to young people who commit to training as CNAs and working in nursing homes for five years.²¹⁵ **Senate Democrats also request data on the effectiveness of these types of facility-level programs in bolstering the LTC workforce.**

While states retain the authority to regulate medical and professional licensure, there are some instances where Congress has designated training requirements for certain categories of LTC workers, such as for CNAs working in nursing homes.²¹⁶ **Senate Democrats are interested in evidence and feedback on policy proposals to update federal training requirements in order to provide rewarding career pathways for workers, ensure safe working environments, and deliver a high standard of care.** In addition, we seek feedback on the effectiveness of proposals to expand the training of the LTC workforce compared with proposals to address existing

²¹³ “Governor Reynolds Announces Iowa Health Careers Registered Apprenticeship Grant Program,” Office of the Governor of Iowa, January 12, 2022, <https://governor.iowa.gov/press-release/2022-01-12/governor-reynolds-announces-iowa-health-careers-registered-apprenticeship-grant>.

²¹⁴ “SkillSpring Program to Bolster the Direct Care Workforce,” New York State Master Plan for Aging, <https://planforaging.ny.gov/skillspring-program-bolster-direct-care-workforce>.

²¹⁵ “Job Corps Training Areas,” United States Department of Labor, accessed October 2026, <https://www.jobcorps.gov/explore/training-areas>.

²¹⁶ 42 C.F.R. § 483.152 (Requirements for approval of a nurse aide training and competency evaluation program.) <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152>.

restrictions on the training of these workers in order to develop the LTC workforce needed to meet demand. These proposals could build on the Long Term Care Workforce Support Act (S. 4120) led by Senator Casey in 2024 and could include, but are not limited to:²¹⁷

- Improving training for CNAs by adjusting federal requirements for individuals qualified to train CNAs and by improving CNA training to reflect evidence-based standards about the balance of clinical and non-clinical training hours. Currently, the standard is 75 total hours of training, 16 of which are in clinical settings. Nursing home trade associations and educational institutions emphasized the need to change these training requirements. **Senate Democrats request feedback on the recent Trump administration guidance on CNA training flexibilities.**²¹⁸
- Promoting high quality training to effectively grow the pipeline of CNAs. This may include the Ensuring Seniors' Access to Quality Care Act (S. 4467), introduced in 2026 by Senator Warner, which makes changes to the two-year CNA training lockout, which restricts the ability of certain nursing homes to continue training CNAs and was raised as a priority LTC workforce proposal by nursing home trade associations.²¹⁹ This may also include the Nurse Faculty Shortage Reduction Act (S. 3707) introduced in 2026 by Senator Durbin, which supports the hiring and retention of nursing school faculty members, which nursing home trade associations identified as a key bottleneck in the training of CNAs and other LTC workers.²²⁰
- Making sure home care workers aren't excluded from federal labor protections and are covered by the Workforce Innovation and Opportunity Act, a proposal recommended by organizations representing direct care workers.²²¹ We also seek feedback on further protections for direct care workers, such as those included in the Domestic Workers Bill of Rights Act (S.3396), introduced in 2025 by Senator Gillibrand.²²²
- Developing a portable, universal care worker credential that captures Direct Support Professionals (DSPs), PCAs, and CNAs, and creating a universal, competency-based training framework that states can apply for direct care workers, another proposal recommended by organizations representing direct care workers.

²¹⁷ Long-Term Care Workforce Support Act, S. 4120, 118th Congress (2024).

²¹⁸ "Clarification regarding Nurse Aide Training Competency Evaluation Program (NATCEP) and Nurse Aide Competency Evaluation Program (CEP) requirements and allowable flexibilities" Centers for Medicare & Medicaid Services, QSO-26-08-NH," Centers for Medicare and Medicaid Services, April 8, 2026, <https://www.cms.gov/files/document/qso-26-08-nh-original-release-date-2026-04-08.pdf>.

²¹⁹ Ensuring Seniors' Access to Quality Care Act, S. 4467, 119th Congress (2026).

²²⁰ Nurse Faculty Shortage Reduction Act of 2026, S. 3707, 119th Congress (2026).

²²¹ "Workforce Innovation and Opportunity Act," United States Department of Labor Employment and Training Administration, accessed October 2026, <https://www.dol.gov/agencies/eta/wioa>.

²²² Domestic Workers Bill of Rights Act, S. 3396, 119th Congress (2025).

- Requiring the HHS Secretary to review and update training and certification requirements for LTC workers every 2-4 years, a proposal recommended by LTC workforce researchers. Senate Democrats seek feedback on whether this update should include consideration of changes in acuity of people in need of LTC, including the increasing prevalence of people with Alzheimer’s disease and other forms of dementia.
- Instructing the Office of Management and Budget to create a standard occupational classification for different types of home care workers to track who they are and the quality of care they provide, a proposal recommended by organizations representing direct care workers. This may include the bipartisan Recognizing the Role of Direct Support Professionals Act (S. 3211), introduced in 2025 by Senator Hassan.²²³

²²³ Recognizing the Role of Direct Support Professionals Act, S. 3211, 119th Congress (2026).

iii. Protecting and Investing in the Immigrant Workforce

Due to the country's aging population, there will be fewer working-age people available to fill gaps in the LTC workforce. While recruiting and retaining LTC workers is an essential part of the solution to addressing the LTC workforce shortage, there is a need to legally protect, retain, and attract immigrants to fill the gaps in the domestic workforce. The Trump administration's ongoing anti-immigrant campaign to restrict immigration pathways and target lawfully-present immigrants exacerbates current workforce shortages and may harm the United States' ability to meet workforce demands in the future.

Immigrants make up 30% of the overall direct care workforce providing LTC in the United States.²²⁴ The share of immigrant LTC workers is as high as 60% in states such as New York and 53% in Florida and New Jersey.²²⁵ Foreign-born domestic workers make up nearly one-third of all LTC workers and they also account for the majority of growth in the LTC workforce. Foreign-born workers accounted for approximately half of the increase in the direct care workforce in HCBS settings from 2012 to 2022. While the number of native-born direct care workers in HCBS settings grew by 16.8%, the number of foreign-born direct care workers increased by 43.9%.²²⁶ Immigrants from 13 countries make up 65% of all immigrant direct care workers providing LTC in the United States. The most common countries of origin for immigrant LTC workers are Mexico (14%), the Dominican Republic (7%), the Philippines (7%), Jamaica (6%), China (6%), and Haiti (6%).²²⁷

Employers who hire foreign-born workers and immigrants continue to face challenges with the current immigration system. Under the Immigration and Nationality Act (INA), there are no visa categories that provide a viable means for entering the home care industry.²²⁸ Home care workers are currently classified under EB-3, the third-preference visa tier, which covers both skilled and unskilled workers. Under the INA, only 10,000 EB-3 visas per year are allocated to unskilled applicants. Since home care work typically does not require a post-secondary degree or specialized training, most home care workers fall into this unskilled category. This tight annual cap makes it difficult for prospective LTC workers to obtain entry into the United States through the EB-3 pathway. For some positions in the LTC workforce, employers look to hire immigrants who entered the United States through humanitarian pathways, such as refugees, asylees, Temporary Protected Status (TPS) holders, and other related visa categories. Employers also rely upon temporary workers to fulfill certain administrative, maintenance, and custodial roles,

²²⁴ Chidambaram, "Who Are Direct Care Workers."

²²⁵ Chidambaram, "Who Are Direct Care Workers."

²²⁶ Barnes, "Foreign-Born Workers Made Up Half The Increase in In The Direct Care Workforce."

²²⁷ Chidambaram, "Who Are Direct Care Workers."

²²⁸ Abigail S. Rosenfeld, "Consider the Caregivers: Reimagining Labor and Immigration Law to Benefit Home Care Workers and their Clients," *Boston College Law Review* Vol. 62, no. 1 (2021): 315–356, <https://bclawreview.bc.edu/articles/77>.

largely depending on H-2B nonimmigrant visas— a visa category where employer demand consistently surpasses the legal limit.

The Trump administration’s anti-immigrant policies worsen challenges specific to the LTC workforce. Notably, at least one in five immigrant direct care workers is from a country that was included in the Trump administration’s disruptive January 2026 immigrant visa pause policy.²²⁹ Additionally, the Trump administration’s efforts to end TPS for immigrants from 13 countries, including a complete termination of TPS for Haiti, has placed significant strain on the already strained LTC workforce. Thousands of Haitian nationals with TPS who were CNAs and home care workers have lost their legal status to work and are at risk of deportation, causing sudden staffing crunches in nursing homes and home health agencies in states with large Haitian communities like Florida, New York, and Massachusetts.²³⁰ The Trump administration’s efforts to expand the use of deportations, suspend refugee resettlement efforts, terminate humanitarian parole programs, and revoke legal permanent residency for immigrants has sparked fear among law-abiding immigrants, and may encourage foreign workers to go to other countries where they are welcomed and needed.²³¹

Senate Democrats heard repeatedly from nursing home trade associations, individual nursing homes, labor unions, nursing home consumer advocates, and LTC researchers about the need to reform immigration pathways for direct care workers. **Noting the vast contributions immigrants provide in direct caregiving, Senate Democrats request feedback on policies to protect and retain immigrants already present in the United States, as well as policies to lawfully recruit foreign-born workers into the LTC workforce. Senate Democrats seek feedback on policies that would support a sustainable supply of foreign-born workers, which may include modifying current visa pathways and/or establishing new pathways for immigrants, with details around eligibility and credentialing, annual caps, pathways to lawful permanent residence, treatment of dependents, and wage and non-wage requirements of employers. We also seek feedback on any alternative proposals to support strengthening the LTC workforce using immigration levers.**

²²⁹ Drishti Pillai and Samantha Artiga, “Potential Impact of the Federal Pause on Immigrant Visas from 75 Countries on the U.S. Health Care Workforce,” KFF, January 29, 2026, <https://www.kff.org/immigrant-health/potential-impact-of-the-federal-pause-on-immigrant-visas-from-75-countries-on-the-u-s-health-care-workforce/>.

²³⁰ Samantha Putterman, “Will the end of Temporary Protected Status for Haitians mean a caregiving crisis?” *The 19th*, July 9, 2026, <https://19thnews.org/2026/07/temporary-protected-status-haitians-impact-caregiving/>.

²³¹ Vanessa G. Sánchez and Daniel Chang, “Immigration Crackdowns Disrupt the Caregiving Industry. Families Pay the Price,” *KFF Health News*, April 4, 2025, <https://kffhealthnews.org/aging/immigration-crackdowns-foreign-workers-caregiving-industry-workforce-shortage/>.

iv. Supporting Working Family Caregivers

Americans spend an average of 245 hours a year on caregiving. Roughly 63 million Americans, or about one in four adults, currently care for an aging parent, spouse, or other loved one, and two-thirds of caregivers are women. Informal caregivers provide an estimated \$600 billion to \$1 trillion in unpaid care each year that keeps family members living independently and connected to their communities.²³² Providing care requires time, and such time often comes at the cost of paid employment, contributing to lower lifetime earnings. In listening sessions, Senate Democrats heard from advocates for seniors and people with disabilities as well as LTC researchers that a critical element of expanding affordable home care is providing sufficient support for family caregivers.

While all states allow family caregivers to be paid for providing LTC through one or more HCBS authorities, most family caregivers are uncompensated.²³³ The federal government has compensated parent caregivers of dependent children through the Child Tax Credit in various forms since 1997.²³⁴ Congress has introduced legislation to extend this model to families caring for dependent seniors or family members with disabilities, such as the bipartisan Credit for Caring Act (S. 925) led by Senators Capito and Bennet, which provides a \$5,000 nonrefundable tax credit to qualifying caregivers of dependent seniors.²³⁵ In addition, states such as Oklahoma provide tax credits for unpaid caregivers. Oklahoma's Caring for Caregivers tax credit provides up to \$2,000 to offset out-of-pocket expenses incurred by unpaid family caregivers for eligible caregiving activities.²³⁶ Advocates for seniors and people with disabilities shared their support for these policies to financially support family caregivers. **Senate Democrats request information on these and other proposals to compensate family caregivers, including expansions like lowering or eliminating the earned income minimum to qualify and expanding the categories of taxpayers who should benefit.**

States also support family caregivers through paid family leave. While federal law protects some employees with 12 weeks of unpaid leave to care for an immediate family member (child,

²³² "New Analysis Shows Unpaid Care Work in the U.S. is Worth More Than \$1 Trillion Each Year," National Partnership for Women and Families, June 27, 2024, https://nationalpartnership.org/news_post/new-analysis-americans-unpaid-care-work-worth-more-than-1-trillion-each-year/; "Women and Caregiving: Facts and Figures," National Center on Caregiving at Family Caregiver Alliance, accessed October 2026, <https://www.caregiver.org/resource/women-and-caregiving-facts-and-figures/>; Ari Houser, et al., "Valuing the Invaluable 2026 Update: The Economic Value of Family Caregiving," AARP Public Policy Institute, March 26, 2026, <https://www.aarp.org/pri/topics/ltss/family-caregiving/valuing-the-invaluable-2026-update/>.

²³³ Kirsten Colello, "Overview of Long-Term Services and Supports," Congressional Research Service, August 28, 2025, <https://www.congress.gov/crs-product/IF10427>.

²³⁴ Margot Crandall-Hollick, "The Child Tax Credit: Legislative History," Congressional Research Service, December 23, 2021, <https://www.congress.gov/crs-product/R45124>.

²³⁵ Credit for Caring Act of 2025, S. 925, 119th Congress (2025).

²³⁶ "Caring for Caregivers Tax Credit Eligibility Tool," AARP Oklahoma, accessed October 2026, <https://www.aarp.org/states/oklahoma/Caring-for-Caregivers-Tax-Credit-Eligibility-Tool/>.

spouse, or parent), paid leave is not federally guaranteed.²³⁷ Fourteen states and the District of Columbia have paid family leave policies that are funded through social insurance programs, but most are designed and primarily used for childbirth-related leave.²³⁸ Benefit eligibility and generosity also vary across states. Some states use progressive benefit schemes to allow lower-income earners to retain a larger share of their income.²³⁹ **Senate Democrats are interested in feedback on proposals to provide more paid and unpaid family leave to family caregivers of seniors and people with disabilities who need LTC.** These include, but are not limited to:

- Establishing a universal, comprehensive paid family leave benefit at the federal level, building on the proposal in the Family and Medical Insurance Leave Act (FAMILY Act) (S. 2823), introduced by Senator Gillibrand in 2025, to provide 12 months of paid leave to individuals caring for a family member with a serious health condition.²⁴⁰
- Extending job security, health insurance benefits, and retirement savings protections in existing federal laws like the Family and Medical Leave Act (FMLA) to more categories of eligible employees.
- Supporting families through longer-term caregiving responsibilities, including support for transitions to more flexible work arrangements.

²³⁷ 29 C.F.R. § 825, “Family and Medical Leave Act of 1993 (FMLA)”

<https://www.ecfr.gov/current/title-29/subtitle-B/chapter-V/subchapter-C/part-825>.

²³⁸ Emily Wielk, “State Paid Family Leave Laws Across the U.S.,” Bipartisan Policy Center, April 10, 2026, <https://bipartisanpolicy.org/explainer/state-paid-family-leave-laws-across-the-u-s/>.

²³⁹ Molly Weston Williamson, “The State of Paid Family and Medical Leave in the U.S.,” Center for American Progress, January 15, 2025, <https://www.americanprogress.org/article/the-state-of-paid-family-and-medical-leave-in-the-u-s/>.

²⁴⁰ FAMILY Act, S. 2823, 119th Congress (2025).

v. Integrating Caregivers into the Care Team

Informal care workers and family caregivers are all important parts of the LTC workforce.²⁴¹ Informal caregiving is not confined to any one life stage: 22% of adults 65 and older are themselves active caregivers, nearly matching the 20% rate among younger adults.²⁴² For many, the role of caregiver is not short-term. Caregiving responsibilities may extend for years, and caregivers usually provide personal care and handle household responsibilities simultaneously, often without training, paid support, or respite. Research shows that informal caregivers experience high rates of stress, depression, and physical health problems due to the demanding nature of their caregiving responsibilities, often without adequate preparation or ongoing support.²⁴³

There is limited federal data collection in national surveys that include family caregivers.²⁴⁴ These data gaps both overlook essential caregiving functions and make it more difficult to identify emerging trends and tailor policy solutions for this segment of the workforce. **Senate Democrats request feedback on efforts to collect stronger data, including on outcomes, on informal and unpaid family caregiving, including proposals such as the Multigenerational Caregiving Data Act (S. 4513), introduced by Senator Kim in 2026.**²⁴⁵

Families should have the choice to arrange care for their loved ones informally or formally, and Congress should set policy to reflect this. **Senate Democrats request feedback on proposals, some of which were shared by advocates for seniors and people with disabilities as well as organizations that support caregivers during office hours, to improve care coordination between licensed LTC professionals and family caregivers that will improve outcomes for seniors and people with disabilities.** These include, but are not limited to:

- Including family caregivers in discharge planning to post-acute care settings and the home.
- Simplifying processes for family caregivers to help their loved ones navigate administrative burdens, such as enrolling in and benefiting from Medicare, Medicaid, and Social Security, as outlined in proposals such as Senator Markey's Alleviating Barriers

²⁴¹ Colette J. Browning, Connie J. Evashwick and Shane A. Thomas, "Editorial: The formal and informal workforce for a global aging population," *Frontiers in Public Health* Vol. 14 (2026), <https://doi.org/10.3389/fpubh.2026.1820846>.

²⁴² Mihret Walelgne Menberu, "America's Unpaid Caregivers: The Hidden Workforce," *West Health Mosaic*, December 18, 2025, <https://westhealthmosaic.com/articles/america-s-unpaid-caregivers-the-hidden-workforce>.

²⁴³ Greta Kilmer et al., "Changes in Health Indicators Among Caregivers — United States, 2015–2016 to 2021–2022," *Morbidity and Mortality Weekly Report* Vol. 73, no. 34 (2024): 740–746, <https://www.cdc.gov/mmwr/volumes/73/wr/mm7334a2.htm>.

²⁴⁴ Joe Caldwell et al., "Family Caregiving Counts: Adding Family Caregiver Questions to American Community Survey," Brandeis University Community Living Policy Center, 2025, <https://heller.brandeis.edu/community-living-policy/research-policy/pdfs/briefs/family-caregiving-counts.pdf>.

²⁴⁵ Multigenerational Caregiving Data Act, S. 4513, 119th Congress (2026).

for Caregivers Act (S. 1227) introduced in 2025, or granting them access to electronic health records when information sharing is necessary.²⁴⁶

- Recognizing family caregivers formally in integrated care models.
- Directing the Center for Medicare and Medicaid Innovation (CMMI) to test participant-direction pathways that train and compensate family caregivers.

Various states provide additional support for informal and unpaid caregivers. For example, Maryland provides a wrap-around care model that supports caregivers of adults 60 and older, caregivers of individuals with dementia at any age, and older relatives raising children or supporting adults with disabilities. This grant is provided through the OAA's National Family Caregiver Support Program. Under Maryland's grant, the state delivers a full continuum of support, including outreach, counseling, training, case management, respite care, and supplemental assistance to caregivers. A distinguishing feature of Maryland's program is a modest annual stipend (\$300–\$600) that caregivers can put toward respite, supplies, or home modifications.²⁴⁷ **Senate Democrats request feedback from on policy proposals supported by advocates for seniors and people with disabilities as well as organizations supporting caregivers support state programs that assist family caregivers. Specifically:**

- How are federal programs such as the National Family Caregiver Support Program (NFCSP) supporting states in providing training, respite care, counseling, and financial assistance to caregivers? How should this federal program be strengthened to help states provide these services?
- Which state programs such as the one in Maryland are effective in supporting family caregivers? What metrics demonstrate the effectiveness of these models?
- What other auxiliary services or supports might family caregivers benefit from? For example, could transportation, child care, or other kinds of services that address health-related social needs also benefit family caregivers and relieve some of the burdens of caregiving?

Senate Democrats heard from organizations supporting caregivers about the need to provide additional training for informal caregivers so they are better integrated into the care team. One mechanism to achieve this is through participant-directed care, an important component of a comprehensive LTC system described in Section I. **Senate Democrats request feedback on the design and implementation of workforce-related participant-direction program**

²⁴⁶ ABC Act, S. 1227, 119th Congress (2025).

²⁴⁷ "Family Caregivers Program," City of Baltimore Health Department, accessed October 2026, <https://www.baltimorecity.gov/health/our-work/aging-services/caregiver-support>.

components, such as training and supportive services. Specifically, Senate Democrats solicit information on who should be qualified to be paid as caregivers in a participant-directed model, how they should be trained, who should conduct the training of the workforce, if training and certification standards should vary across states, and how the cost of training should be incorporated into payment rates.

Finally, LTC researchers raised additional innovative models for providing care through community-based volunteer networks that help older adults age in their own homes and communities. One example that came up during listening sessions was the Village model, which leverages grassroots community networks to help older adults age in their own homes and communities.²⁴⁸ **Senate Democrats request data on the effectiveness of these models for facilitating social integration and low-intensive supports for older adults and people with disabilities, and how Congress can support these innovations through training requirements or other federal supports.**

²⁴⁸ “What Is A Village?,” Montgomery County Maryland Department of Health and Human Services, accessed October 2026, <https://www.montgomerycountymd.gov/department-health-human-services/about-us/aging-disability-services/what-village>.